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DRAFT REPORT

regarding

Patient Name Robert Wilson (Ref No. BJC/55)

PREPARED BY: Professor R Baker.....

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

I have studied the copies of the records provided to me by Hampshire Constabulary in order to consider three issues – the certified cause of death, the prescription of opiates and sedatives, and whether Mr Wilson fell into the category of patients who might have left hospital alive.

With respect to death certification, I have concluded that the certificate was inaccurate in that Mr Wilson did not have renal failure, and had liver dysfunction but not failure. He probably did have heart failure, although I believe the initiation of opiate medication was an important factor in leading to death.

With respect to the prescription of opiate drugs, I have concluded, on the evidence available to me, that the initiation of opiate medication on transfer to Dryad ward was inappropriate; I have also concluded that the starting dose was too high. The prescription of hyoscine and midazolam was justified by the use of opiates.

With respect to leaving hospital alive, I have concluded that Mr Wilson was in the category of patients who might have left hospital alive if he had not been commenced on opiate medicate on transfer to Dryad ward.

1. INSTRUCTIONS

I have been asked to provide a statement of evidential use that could be used in the event of criminal proceedings arising from the case of Mr Robert Wilson.

2. ISSUES

I was asked to address three questions:

1. Certified cause of death. In this case, was the certified cause of death supported by the medical history of the patient?
2. Prescription of opiates and sedatives. In the case of Mr Wilson was his prescribing in accordance with his clinical need?
3. Leaving hospital alive. In my statement (080904) I had referred to patients who were administered opiates and eventually died who may have recovered and left hospital had they not received this medication. The issue to be addressed was whether, in my opinion, Mr Wilson fell into this category.

3. BRIEF CURRICULUM VITAE

Code A

Code A

4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Mr Robert Wilson, provided to me by Hampshire Constabulary.

[2] A copy of my report dated 08 September 2004.

[3] The Palliative Care Handbook Guidelines on clinical management fourth edition, of the Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust, and the Rowans (Portsmouth Area Hospice), 1998.

5. CHRONOLOGY/CASE ABSTRACT (prepared by Hampshire Constabulary) *The numbers in square brackets[ ] refer to the page of evidence.*

1.1. Robert Wilson a 74 year old gentleman in 1998 attended Queen Alexandra Hospital, Portsmouth A&E Department on the 21st September 1998 [125-127] with a fracture of the left humerus and tuberosity [169].

1.2. Code A

1.3. When he attends A&E in September 1998 with a fracture of his left humerus it is originally intended to offer him an operation on his arm, which he refuses. However, he is kept in A&E overnight for observation [161-2]. It becomes apparent by the next day that he is not well, is vomiting [163] and he is needing Morphine for pain [11]. His wife is on holiday [11] and it is not thought possible for him to go home so he is transferred on 22nd September 1998 to the Care of the Elderly team at the Queen Alexandra Hospital [163].

1.4. The day after admission he is no longer thought fit enough to have an operation on his arm, although he would now be prepared to. He is recognised to have

Code A considerable oedema and abdominal distension on admission [167]. He has abnormal blood tests on admission including a mild anaemia of 10.5 with a very raised mean cell volume of 113 and his platelet count is reduced at 133 [239]. Five days later his haemoglobin has fallen to 9.7 and the platelet count has fallen to 123 [237]. There are no further full blood counts in the notes, although his haemoglobin was normal with haemoglobin of 13 in 1997 [241].

1.5. He is noted to have impaired renal function with a Urea of 6.7 and a Creatinine of 185 on admission (209) and on 25th September Urea of 17.8 and a Creatinine of 246 [203]. He is started on intravenous fluids on 27th September [12] and his renal function then continues to improve so that by the 7th October both his Urea and Creatinine are normal at 6.1 and 101 [199].

1.6. His liver function is significantly abnormal on admission and on 29th his albumin is 22, his bilirubin 82 (he would have been clinically jaundiced) there is then little change over his admission. On the 7th October is albumin is 23 and his bilirubin also 82 [199]. His AST is 66 [171].

1.7. His vomiting within 24 hours of admission may have been due to alcohol withdrawal but he had also been given Morphine for pain [11]. He is started on a Chlordiazepoxide regime [11] as standard management plan to try and prevent significant symptoms of alcohol withdrawal. This has some sedative effects as well.

1.8. His physical condition in hospital deteriorates at first. He is noted to have considerable pain for the first 2 – 3 days, he is found to have extremely poor nutritional intake and has eaten little at home [12]. His renal function deteriorates as documented above. He is communicating poorly with the nursing staff [28] and is restless at night on 30th September [30]. His Barthel deteriorates from 13 on 23rd September to 3 on the 2nd October [69], his continued nutritional problems are documented by the dietician on 2nd October [16]. In the nursing cardex he is reported as vomiting, having variable communication problems, and being irritable and cross on 1st October [30]. On 4th October [16] his arm is noted to be markedly swollen and very painful and it is suggested he needs Morphine for pain [31]. The following day he knocks his arm and gets a laceration [16].

1.9. There is ongoing communication with his family which is complicated by inter-family relationships between his first wife's family and his current wife. The plan by 6th October is that he will need nursing home care when he leaves hospital and his Barthel at this stage is 5 [16] [69]. However on the 5th the nursing cardex notes that he is starting to improve [32], although he remains catheterised and has been faecally incontinent on occasion.

1.10. On 7th October is now more alert and is now telling the staff that he wishes to return home [17]. The nursing staff notes that he is now much more adamant in his opinions [33]. However on 8th he had refused to wash for 2 days [18]. He is then reviewed at the request of the medical staff by a psycho-geriatrician. The opinion is that he has early dementia, which may be alcohol related, and is also depressed. He is noted to be difficult to understand with a dysarthria [117-118]. He is started on Trazodone as an antidepressant and as a night sedative, he is still

asking for stronger analgesics on 8th October [35]. The letter also mentions [429] rather sleepy and withdrawn..... his nights had been disturbed.

1.11. On the 9th October an occupational therapy assessment is difficult because he is reluctant to comply and a debate occurs about whether he is capable of going home [19]. By the 12th October [21] his Barthel has improved to 7 [69] so Social Services say that he no longer fits their criteria for a nursing home and he should now be considered for further rehabilitation [21]. The nursing cardex notes that his catheter is out [35] and he is eating better but he still gets bad pain in his left arm [36]. His arms, hands and feet are noted to be significantly more swollen on 12th October [36]. His weight has now increased from 103 kgs on 27th September to 114 kgs by 14th October [61, 63]. However his Waterlow score remains at "high risk" for all his admission [71]. A decision is made to transfer him for possible further rehabilitation, although the medical review on 13th October states in view of the medical staff and because of his oedematous limbs, he is at high risk of tissue breakdown. He is also noted to be in cardiac failure with low protein and at very high risk of self neglect Code A Code A He currently needs 24 hour hospital care [21].

1.12. On 14th October he is transferred to Dryad Ward and the notes [179] say "for continuing care". The notes document the history of fractured humerus, Code A Code A recurrent oedema and heart failure. No examination is documented. The notes state that he needs help with ADL, he is incontinent, Barthel 7, he lives with his wife and is for gentle rehabilitation.

1.13. The next medical notes [179] are on 16th October and state that he had declined overnight with shortness of breath. On examination he is reported to have a weak pulse, unresponsive to spoken orders, oedema plus plus in arms and legs. The diagnosis is "? silent MI, ? liver function" and the treatment is to increase the Frusemide. The nursing cardex for 14th October confirms he was seen by Dr Barton, that Oramorphine 10 mgs was given and he was continent of urine. On 15th October the nursing notes [265] state commenced Oramorphine 10 mgs 4 hourly for pain in left arm, poor condition is explained to wife. According to the cardex on 16th he is "seen by Dr Knapman am as deteriorated overnight, increased Frusemide".

1.14. (possible confusion with the nursing care plan [278], this states for 15th October, settled and slept well, Oramorphine 20 mgs given 12 midnight with good effect, Oramorphine 10 mgs given 06.00 hours. Condition deteriorated overnight, very chesty and difficulty in swallowing medications. Then on 16th it states has been on syringe driver since 16.30 hours. As will be seen from the analysis of the drug chart, Mr Wilson received the Oramorph at midnight on 15th and then 06.00 hours Oramorph on 16th. The first clinical deterioration is on the night of 15th – 16th October not the night of the 14th – 15th October.)

1.15. The next medical note is on 19th October which notes that he had been comfortable at night with rapid deterioration [179] and death is later recorded at 23.40 hours and certified by Staff Nurse Collins. The nursing cardex mentions a bubbly chest late pm on 16th October [265]. On the 17th Hyoscine is increased because of the increasing oropharyngeal secretions [265]. Copious amounts of fluid are being suctioned on 17th. He further deteriorates on 18th and he continues to require regular suction [266]. The higher dose of Diamorphine on

the 18th and Midazolam is recorded in the nursing cardex [266].

1.16. Two Drug Charts: The first is the Queen Alexandra drug chart [106-116]. This records the regular laxatives, vitamins and diuretics given for his liver disease. The reducing dose of Chlordiazepoxide stops on 30th September Code A Code A and the Trazodone started for his mild depression and night sedation. In terms of pain management Morphine, slow IV or subcutaneous 2.5 – 5 mgs written up on the prn side and 5 mgs given on 23rd September and 2.5 mgs twice on 24th September. Morphine is also written up IM 2 – 5 mgs on 3rd October and he receives 2.5 mgs on 3rd and 2.5 mgs on 5th. He is also written up for prn Codeine Phosphate and receives single doses often at night up until 13th October but never needing more than 1 dose a day after 25th September. Regular Co-dydramol starts on 25th September until 30th September when it is replaced by 4 times a day regular Paracetamol which continues until his transfer.

In summary, his pain relief for the last week in the Queen Alexandra is 4 times a day Paracetamol and occasional night time dose of Codeine Phosphate.

1.17. The second drug chart is the drug chart of the Gosport War Memorial Hospital [258-263]. His diuretics, anti-depressant, vitamins and laxatives are all prescribed regularly. The regular Paracetamol is not prescribed but is written up on the as required (prn) after the drug chart. This is never given. Regular prescriptions also contains Oramorphine 10 mgs in 5 mls to be given 10 mgs 4 hourly, starting on 15th October [261]. 10 mgs is given at 10 am, 2pm and 6 pm on 15th, 6am, 10 am and 2 pm on 16th. A further dose of 20 mgs at night given at 10 pm is given at 10 pm on 15th October. Although these prescriptions are dated 15th October it is not clear if they were written up on the 14th or 15th.

1.18. On a further sheet of this drug chart [262] regular prescription has been crossed out and prn written instead. Oramorphine, 10 mgs in 5 mls, 2.5 – 5 mls 4 hourly is then prescribed on this sheet. It is not dated but it would appear 10 mgs is given at 2.45 on 14th October and 10 mgs at midnight on 14th October. Further down this page Diamorphine 20 – 200 mgs subcut in 24 hours from Hyoscine 200 – 800 micrograms subcut in 24 hours, Midazolam 20 – 80 mgs subcut in 24 hours are all prescribed. It is not clear what date these were written up. The first prescription is 16th October and the 20mls of Diamorphine with 400 micrograms of Hyoscine are started at 16.10. On 17th October, 20 mgs of Diamorphine, 600 micrograms of Hyoscine are started at 5.15 and the notes suggest that what was left in the syringe driver at that stage was destroyed [262]. At 15.50 hours on 17th October, 40 mgs, 800 mgs of Hyoscine and 20 mgs of Midazolam are started and on 18th 60 mgs of Diamorphine, 1200 micrograms of Hyoscine (a new prescription has been written for the Hyoscine) and 40 mgs of Midazolam are started in the syringe driver at 14.50 and again the notes suggest the remainder that was previously in the syringe driver is destroyed.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

Figures in square brackets [ ] refer to page numbers of the notes.

1. Certified cause of death. In this case, was the certified cause of death supported by the medical history of the patient?

The certified cause of death was Ia congestive cardiac failure, Ib renal failure, II liver failure. The certifying doctor was Dr E.J. Peters.

Liver failure

Mr Wilson was known to have a poorly functioning liver. The primary diagnosis relating to his admission between 17/02/97 and 12/03/97 was Code A liver disease [129], and at that time he had abnormal liver function tests including low albumin level, and an ultrasound had shown a small liver, possibly cirrhotic, with marked ascites.

His liver function was also impaired at the time of admission in September 1998 [207, 199]. Jaundice does not seem to have been remarked upon in the notes relating to this admission. The working diagnosis during the admission in Queen Alexandra Hospital was Code A hepatitis [171]. A hand written entry in the records dated 13/10/98 records results of blood tests taken 12/10/98 [178]. At that time, the bilirubin had fallen to 48 umol/L and the AST to 37 IU/L, although the alkaline phosphatase was 181 IU/L. I would tend to interpret these results as indicating some improvement. The notes do not record a diagnosis of liver failure although this diagnosis is mentioned on blood test forms [199, 213, 217]. The liver function tests, whilst abnormal, are not sufficiently abnormal to suggest fulminant liver failure. Diuretics can precipitate hepatic encephalopathy in patients with cirrhosis (Jones, 2003), but the hepatic encephalopathy was not diagnosed and the records do not include mention of the signs of encephalopathy. Mr Wilson was noted to have some depression and mildly impaired short term memory when assessed by Dr Luznat, the consultant in old age psychiatry on 08/10/98 [118, 119], and the nursing records indicate he was sleepy

and had poor speech on 29/09/98 [29], but these features were not sufficiently consistent, progressive or severe to suggest hepatic encephalopathy. The course of Mr Wilson's final illness was one of gradual if limited progress until transfer to Dryad ward, which tends to rule out the progressive development of encephalopathy due to liver failure.

Renal failure

Mr Wilson also had renal dysfunction. His creatinine reached 246 umol/l and his urea 17.8 mmol/l on 25/09/98 [213], but there was some improvement over the following days. On 30/09/98 his creatinine was 165 umol/l and his urea 14.4 mmol/l [203], and by the 05/10/98 his creatinine had fallen to 97 umol/l and his urea to 7.5 mmol/l [201]. The results on the 05/10/98 were within the normal range, and remained so on 07/10/98 and 13/10/98 [178]. The improvement in renal function appears to have occurred following the temporary withdrawal of diuretics and the institution of intravenous fluids [170, 89] on 28/09/98.

Congestive cardiac failure

The note on admission to Dryad ward records the problems of 'alcohol problems', recurrent oedema, and CCF (congestive cardiac failure). Heart failure is a syndrome rather than a specific disease, that is, it is a collection of symptoms and signs that can be caused by several different diseases. Congestive cardiac failure is a term that is less commonly used today. It can mean different things to different doctors (Fry and Sandler, 1993), and may indicate right ventricular failure to some doctors, left ventricular failure to others, or failure of both ventricles to others. Mr Wilson had ankle, leg and sacral oedema which may have been explained by right heart failure (the low albumin level secondary to the Code A liver disease and poor nutrition would also have played a role in causing the oedema), although he did not have a raised jugular venous pressure [166] when admitted to Queen Alexandra Hospital. He did have 'crackles' in the lung bases especially the left, and this might have been a

feature of left heart failure [166]. Diagnosis of cardiac failure on clinical grounds alone is difficult (Khunti et al, 2000).

The notes indicate that Mr Wilson suffered from retention of fluid leading to swelling of his arm [174] and legs [81, 129, 118, 265]. Potential explanations for heart failure in Mr Wilson's case include ischaemic heart disease and Code A cardiomyopathy. He was treated with high doses of diuretics at his admission in 1997, specifically spironolactone 100mgs daily and frusemide 80 mgs daily [129]. During the admission in 1997, his weight declined from around 103kgm to around 93 kgm, suggesting that the diuretics had produced a satisfactory diuresis [367, 369]. In contrast, in 1998, his weight rose from 103 kgms on 27/09/98 [65] to 114 kgm on 14/10/98 [61], despite continued treatment with diuretics. This suggests that his cardiovascular status may have declined between the admissions in 1997 and 1998.

The medical notes on transfer to Dryad on 14/09/98 do not mention the need for additional treatment of the congestive cardiac failure [179]. Diuretics were continued, and Oramorph 10mg was prescribed, doses being given that day at 14.45 pm and 23.45 pm [262, 265]. However, there was no mention of pain at all in the medical records [179] and therefore the indications for Oramorph are unclear. Oramorph 10mg 4 hourly was commenced on 15/10/98, the first dose being given at 10.00 am, six doses being given up to 14.00 on 16/10/98. Mr Wilson was seen the next morning by Dr Knapman as he had declined overnight with shortness of breath. On examination he was reported as bubbling, had a weak pulse, unresponsive to spoken orders, and had oedema ++ in the arms and legs. The possibility of a silent myocardial infarct was raised (although not investigated), and the history of reduced liver function noted. The dose of frusemide was doubled. These notes indicate that Dr Knapman thought that congestive failure was an important factor in explaining Mr Wilson's condition. However, the fact that the deterioration coincided with the regular administration of Oramorph points to an alternative explanation, namely the side effects of opiate

medication. The side effects would include sedation leading to lack of responsiveness, and reduced ability to expectorate which could explain the 'bubbling' respiration.

In the afternoon of 16/10/98, the nursing staff noted that Mr Wilson was 'very bubbly', and that diamorphine by syringe driver had been commenced [265]. The dose began at 16.10 pm, and the prescription was written by Dr Barton [262]. The bubbly chest may have been explained by morphine. Hyoscine was also prescribed by syringe driver, midazolam being added on 17/10/98, the dose of diamorphine being increased to 40 mgs on 17/10/98 [278], and on the 18/10/98 to 60mgs [262].

2. Prescription of opiates and sedatives. In the case of Mr Wilson was his prescribing in accordance with his clinical need?

Mr Wilson was receiving soluable paracetamol four times daily from 30/09/98 until the morning of 14/10/98, prior to his transfer to Dryad ward [114, 115]. He had received 2.5-5mg morphine on 23-24/09/98 and 2.5mg on 3/10/98 and 5/10/98 [106.107], and he had also received codydramol until the paracetamol had been started. Although he did have pain throughout his stay in Queen Alexandra Hospital, it appears to have been reasonably well controlled by 13/10/98. The nursing record indicates that he had no complaints about pain on 13/10/98. nor on the morning of 14/10/98 [37]. Neither the medical or nursing records from Dryad ward mention an increase in pain later on the 14/10/98 [179, 265], although the nursing notes on 15/10/98 state that the Oramorph was for pain in the arm. On the information contained in the records, therefore, the commencement of Oramorph was not adequately justified.

The commencement of subcutaneous diamorphine on 16/10/98 followed a decline in Mr Wilson's condition, the cause of which was not clear [179]. The nursing records mention that the reason for commencing diamorphine by syringe driver was explained to the family, but the reason itself is not recorded in the records. An alternative approach to the decline on 16/10/98 would have been to stop the Oramorph and

observe whether Mr Wilson improved. For some reason which cannot be found in the records, it had been concluded that Mr Wilson was not going to recover and that terminal care was the appropriate course of action. Hyoscine was also prescribed, and I assume the intention was to control secretions. The dose of hyoscine was increased in accordance with the problems caused by the secretions (which were recorded as 'copious' on 17/10/98 [265]). The dose of diamorphine was increased, and midazolam was added, although the records do not explain the reasons for these prescribing decisions.

2. Leaving hospital alive. In my statement (080904) I had referred to patients who were administered opiates and eventually died who may have recovered and left hospital had they not received this medication. The issue to be addressed was whether, in my opinion, Mr Wilson fell into this category.

The comment referred to from my statement (080904) is:

As made clear in the report, I became concerned about aspects of care at Gosport War Memorial Hospital, including aspects of the care provided by Dr Barton. I concluded that it was probable that a small number of patients who had been given opiates and had died might, if they had not been given opiates, have sufficiently recovered to be discharged from hospital eventually. An attitude or culture of limited hope and expectations of recovery appeared to have existed at the hospital. I was unable to identify when this culture had first gained hold at the hospital and it may have existed before Dr Barton's appointment in 1988. In addition, I have not identified the underlying motivations responsible for this culture.

When Mr Wilson was transferred from Queen Alexandra Hospital to Dryad ward, he was in need of nursing and medical care and at risk of falling until fully mobilised. A short spell in a long term NHS bed was regarded as appropriate when he was reviewed on the ward round on 13/10/98 [177,178]. He appeared to be making some progress,

with improved renal function, less pain, and improvement in some of the measures of liver function [178]. He still had significant problems, however, including difficulty in moving and oedema [81]. Nevertheless, the Queen Alexandra Hospital records do not indicate that death was expected in the near future – with appropriate care, gradual mobilisation was anticipated. Yet shortly after admission to Dryad ward, he was commenced on regular Oramorph.

8. OPINION

1. Certified cause of death. In this case, was the certified cause of death supported by the medical history of the patient?

In my opinion, Mr Wilson had liver dysfunction but not full blown failure. His liver dysfunction did not cause death. In the presence of other life-threatening conditions, the liver dysfunction may impair the ability to recover, and it would have been reasonable to mention on the death certificate that Mr Wilson had chronic liver disease. The cause of his liver disease Code A was not mentioned on the ceritificate.

Mr Wilson did not have renal failure. He did have abnormal blood test results after his admission to hospital, but these improved with rehydration. Mr Wilson probably did have cardiac failure. There may have been other conditions as well. Haemoglobin estimations during his admission to Queen Alexandra Hospital had indicated mild anaemia. If this condition had deteriorated, the heart failure would also have become worse. However, I think this is rather unlikely since he was being closely observed in Queen Alexandra Hospital and signs of increasing anaemia would almost certainly have been recognised. Evidence of bleeding would have been noted if it had occurred. There is no convincing evidence in the records to

confirm a diagnosis of myocardial infarction such as history of chest pain, raised cardiac enzymes or ECG evidence. One could also speculate about possible occurrence of some unsuspected condition. However, despite all these speculations, it has to be acknowledged that his decline was associated with the regular administration of morphine, and was responded to by administration of diamorphine by syringe driver. The reason for commencing Oramorph is not recorded in the medical notes [179]; in particular, the reasons for not using a non-opiate drug for pain relief are not given. Even if Mr Wilson did have pain from the fracture that was not controlled by paracetamol, regular does of 10mg of oral morphine would not have been the appropriate treatment. Other non-opiate or weak opiate medication should have been used first. If these medications had failed to adequately reduce the pain, a low dose of morphine (2.5-5mg) as had been used in the early days of his admission might have been reasonable. Although Mr Wilson did have congestive cardiac failure, therefore, his death would have been hastened by opiate administration and the path to death may well have been initiated by the commencement of Oramorph on 14/10/98.

It is important to note that the general standard of completion of death certificates is unsatisfactory. For example, in a review of 1000 counterfoils of certificates in one teaching hospital in 1999-2000, only 55% of certificates had been completed to a minimally accepted standard (Swift and West, 2002). Of the remaining certificates, 25% had incomplete data, in 11% the part II section had been used inappropriately, and 9% were illogical or inappropriate. In her third report from the Shipman Inquiry, Dame Janet Smith observed: *A further problem with the current system is that the quality of certification is poor. Doctors receive little training in death certification.* (paragraph 17, page 4, Shipman Inquiry). The standard of completion

of the death certificate in Mr Wilson's case should therefore be regarded as fairly typical. Although Mr Wilson did not have renal failure, the history of recent abnormal renal function tests prompted use of this diagnosis; the mention of liver failure was probably a convenient way of describing the impaired liver function.

2. Prescription of opiates and sedatives. In the case of Mr Wilson was his prescribing in accordance with his clinical need?

The records do not contain information to explain why opiates were commenced. On the basis of the records alone, therefore, the prescribing of opiates was not indicated. The sedative midazolam was prescribed to accompany the diamorphine in the syringe driver, although the reason for the addition of midazolam is not given in the medical or nursing records.

The Palliative Care Handbook, fourth edition, published by the Portsmouth Healthcare NHS Trust, Portsmouth Hospitals NHS Trust and the Rowans (Portsmouth Area Hospice) in 1998 reproduces the WHO analgesic ladder in which step 1 (mild pain) involves the use of non opioids such as paracetamol, step 2 (moderate pain) weak opioids such as cocodamol [codeine and paracetamol], and step 3 (severe pain) strong opioids such as morphine. In Mr Wilson's case, medication for pain moved from step 1 to step 3 without any explanation. Hyoscine hydrobromide 0.4-2.4 mg over 24 hours by syringe driver is recommended in the Handbook for reducing secretions and is noted to be an excellent sedative. Midazolam 5-60mg over 24 hours is described as a sedative, higher doses to be used only for terminal sedation. The Handbook also indicates that a total daily dose of 30mg of morphine would be equivalent to 10mg of diamorphine by syringe driver in 24 hours.

The Handbook recommends starting morphine at a low dose and increase gradually according to need. This policy was applied in Queen Alexandra Hospital when occasional low (2.5-5mg) doses of morphine were needed early in Mr Wilson's admission. On Dryad ward, however, the starting dose was 10mg; on the 15/10/98 he had three doses of 10mg, and one at 10 pm of 20mgs (the time of this dose appears to be 22.00 hrs in the prescription record but is given as 24.00 hrs in the nursing record). This is a significant amount of opiate, more than would have been indicated even if step 2 of the WHO analgesic ladder had been tried first, and I would have expected sedation and drowsiness to occur.

My September 1998 copy of the British National Formulary (BNF; issue 36) notes that morphine 'may precipitate coma in hepatic impairment (reduce dose or avoid but many such patients tolerate morphine well); reduce dose or avoid in renal impairment' (page 201). It also states that in palliative care these cautions should not necessarily be a deterrent to the use of opioids.

The use of hyoscine to reduce secretions is common practice. Opiates can suppress the cough reflex, which reduces the ability to clear secretions (Schug and Cardwell, 2003). It also occurs in people who are too weak to expectorate effectively (Twycross and Lack, 1990). Midazolam, a benzodiazepine sedative, can be added to hyoscine if repeated administration of hyoscine leads to an agitated or confused state.

3. Leaving hospital alive. In my statement (080904) I had referred to patients who were administered opiates and eventually died who may have recovered and left hospital had they

not received this medication. The issue to be addressed was whether, in my opinion, Mr Wilson fell into this category.

In judging whether Mr Wilson might, if Oramorph had not been initiated on transfer to Dryad ward, eventually left Gosport War Memorial Hospital, several qualifications must be made. I am reliant on the hospital records only; records are often incomplete and I have not sought or obtained any information directly from the doctors, nurses, other staff or relatives who were involved in caring for Mr Wilson in the last days of his life. It is also difficult to predict with certainty the course of recovery that a patient will follow, especially when the patient is elderly and has a complex mix of several serious clinical problems, as did Mr Wilson. In addition to deterioration of existing conditions, new and unexpected problems can arise, including for example myocardial infarction [179]. It is also impossible to be certain about the degree of recovery, and whether the patient would have been fit for discharge to their own home or whether residential or nursing accommodation would be required. Bearing these qualifications in mind, in my opinion, Mr Wilson did fall into the category of patients who might have left hospital alive if the Oramorph had not been commenced on transfer to Dryad ward.

9. LITERATURE/REFERENCES

BNF – British National Formulary (1998). British Medical Association & Royal Pharmaceutical Society of Great Britain. BMJ Books, London.

Fry J, Sandler G (1993). Common Disease. Their nature, presentation and care. Fifth edition. Dordrecht: Kluwer Academic Publishers

Jones EA. (2003). Hepatocellular failure. In: Oxford Textbook of Medicine. Vol 2. 741-51. Eds Warrell DA, Cox TM, Firth JD. Oxford University Press, Oxford.

Khunti K, Baker R, Grimshaw G. (2000) Diagnosis of heart failure in general practice. *Br J Gen Pract* 2000;50:50-54

Schug SA, Cardwell HMD (2003). Clinical pharmacology – including tolerance. Chapter 3 in: Sykes N, Fallon MT, Patt RB, eds. Clinical Pain Management. Cancer Pain. London: Arnold.

Shipman Inquiry (2003). Third report. Death certification and the investigation of deaths by coroners. Cm5854. Manchester; the Shipman Inquiry.

Swift B, West K (2002). Death certification an audit of practice entering the 21st century. J Clin Pathol 55:275-9

Twycross RG, Lack SA (1990), Therapeutics in Terminal Cancer. Second edition. Edinburgh: Churchill Livingstone.

10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

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

Signature: _____ Date: _____

SUMMARY OF CONCLUSIONS

Mrs Elsie Lavender was an 84 year-old lady admitted to the Haslar Hospital on 5th February 1996 following a fall and then transferred to Gosport War Memorial Hospital on 26th February 1996. She had long-standing problems with diabetes, a peripheral neuropathy, poor eyesight and registered blind. After admission she is found to be doubly incontinent, totally dependent with a probable quadriplegia, constant pains down her shoulders and arms and is found to have serious and unexplained abnormalities in various blood tests.

In the Gosport War Memorial Hospital, she fails to make any improvement, deteriorates with a bed sore that eventually becomes black and blistered. She receives pain relief and palliation for her deteriorating physical condition including subcutaneous Diamorphine and Midazolam and dies on 6th March 1996.

The expert opinion is:

> Mrs Elsie Lavender provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.
>
> The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence...."..... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall episode of medical care provided between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital.

However, without proper assessment or documentation this is impossible to prove either way.

The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26th February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to satisfy myself beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days).

1. *INSTRUCTIONS*

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

2.3. If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

3. CURRICULUM VITAE

Code A

Code A

Version 4 of complete report 19th March 2005 – Elsie Lavender

Code A

Code A

Code A

Code A

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Elsie Lavender

[2] Full set of medical records of Elsie Lavender on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Hampshire Constabulary Summary of Care of Elsie Lavender

[6] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[7] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

[8] Medical report prepared by Dr James Gillespie

5 CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence, the numbers with 'H' in front are the Haslar notes, 'M' in front are the microfilm notes).

5.1. The Gosport notes record that Mrs Lavender was a insulin dependent diabetes mellitus since the1940's (53). She is referred to the Diabetic Service because of more troublesome hypoglycaemia in 1984 (65). In 1985 she is known to have a mild peripheral neuropathy (73). Her weight in 1988 is 85 kgs (73) and in 1987 her weight is 89 kgs (77). By 1988 she has very poor eyesight (47M). She is also documented to have high blood pressure in 1986 (29).

5.2. Elsie Lavender was admitted to Haslar hospital on 5th February 1996 through A&E having had a fall at home (H15, H16). She is recorded as having right shoulder tenderness (H25) is moving all four limbs and her cervical spine is thought to be normal, written as (CX spine√) (H16). The notes record that x-rays were taken of her skull and both shoulders (H24). In a subsequent neurological examination, she is noted to have reduced power 3/5, cannot move her right fingers and has an extensor right plantar (H24). A Barthel on the 5th (H631) is recorded as 5/20.

Her past medical history is noted as insulin dependent, diabetes mellitus for 54 years (age 29) appendicectomy and a hysterectomy. She is noted to have previous collapses in the past (H47) but without weakness, although her clerking in 1995 (H48) suggested that she might have had some sensory loss and a mild diabetic peripheral neuropathy. Her Barthel in 1995 was 14/20 (H495) and she was able to mobilise at that stage with a walking stick (H497). She had diabetes, eye disease, was registered blind in 1988 (H 97). She had hypoglycaemic episodes going back many years (H 71) and pneumonia in 1985 (H317).

On transfer to the ward, both her legs are noted to be weak 4/5 (H35) no sensory loss is noted. The notes also state she does not normally go upstairs and her bed is downstairs (H29). However, her son stated that a large pool of blood was found at the top of the stairs (H37). She apparently goes out once a week with her son is forgetful but not confused (H39).

Following admission, she is seen by a physiotherapist (157) who notes pain in both shoulders, can only stand with two people and is now having to be fed, washed and dressed, when previously independent.

No further neurological examination is recorded by the Haslar medical team and she is referred to Dr Lord on 13th February (H159). Dr Lord sees her and confirms that she still has bilateral weakness of both arms and legs (H163) and finds that her left plantar is extensor (H163) confirmed in his letter (H253) but is not sure about the right plantar which has previously been found to be extensor.

The importance of this finding is that it suggests that she has a bilateral neurological event in the brain, brain stem or spinal cord somewhere above the thoracic spine.

Dr Lord records "probable brain stem CVA"..... "she has had her neck x-rayed, I assume it was normal" (H167).
I was unable to find any x-ray request recorded in the notes for a cervical spine, nor any reports of an x-ray of a cervical spine or indeed reports on the x-rays that were recorded as being requested (i.e. the skull and shoulder x-rays).

Dr Lord notes her mild anaemia of 9.7 with an MCV of 76.5 (H17) and says that he will consider investigation into anaemia later (H164). Abnormal blood tests are also available in the notes on 9th February (H609) an albumin of 32, a Gamma GT 128 and Alkaline Phosphatase of 362. No investigations are done to determine whether these are a hepatic effect of her diabetes or a mixture of problems with the a raised alkaline phosphatase potentially coming from a fracture.

On the 20th February Mrs Lavender is again seen by a physiotherapist (H165), her bilateral shoulder pain is again documented and she needs two to transfer. Reviewing her drug charts (H684 and H690) she receives regular analgesia comprising Co-proxamol and Dihydrocodeine all through her admission.

5.3. The medical notes in Gosport (45M) 22nd February 1996 state that she "fell at home from the top to the bottom of the stairs and had lacerations on her head". It also states that she has severe incontinence and leg ulcers. Once in Gosport there is no rigorous clerking of the patient and no examination recorded. In some of the nursing cardex there is a series of assessments confirming that this lady is highly dependent. She has no mobility and bed rest is maintained all through her stay (100 -101). She has leg ulcers both legs (107 - 109). She is catheterised throughout, although there is no suggestion that she had a catheter prior to her admission to hospital (111). She has a sacral bed sore noted; "a red and broken sacrum on 21st February" (115) and this progresses to a black and blistered bed sore on the 27th February (115). She is thought to be constipated on a assessment, then continually leaks faeces throughout her admission (119).

5.4. Barthel is documented at 4/20 on 22nd February (165) (i.e. grossly dependent). Her mental test score is normal 10/10 on the same date (165). Lift handling score (171) also confirms high dependency.

5.5. Investigation tests reported on 23rd February 1996 find that she has a normal haemoglobin of 12.9 with a slightly reduced mean cell volume of 75.6 and gross thrombocytopenia (a low platelet count) of 36,000 (57M). The report on the film (58M) shows that this is a highly abnormal full blood count with distorted red blood cells and polychromasia. A repeat blood film is suggested. This is repeated on 27th February (57M) and thrombocytopenia is now even lower at 22,000. The urea is normal at 7.1 on 23rd February but has increased and is abnormal at 14.6 on 27th February (187). Her alkaline phosphatase is 572 (over 5 times the upper limit of normal) her albumin is low at 32 (187). No comment is made on any of these significantly abnormal blood tests in any of the Gosport notes, though the low platelet count is noted in nursing summary on 23rd February (151). The platelet count had been normal at 161 on admission to the Haslar (H17).

5.6. An MSU (59M) sent on 5th February showed a heavy growth of strep faecalis there are no other MSU or other blood culture results in the notes.

5.7. Medical progression (documented on pages 45M and 46M) is of catheterisation and treatment for a possible U.T.I on 23rd February. On 26th February, a statement that the patient is not so well and the family were seen regarding progress. Nursing cardex reports (153) a meeting with the son occurred on the 24th February and state "son is

happy for us just to make Mrs Lavender comfortable". "Syringe driver explained".

5.8. The medical notes on 5th March say deteriorated further, in some pain, therefore start subcutaneous analgesia. On 6th March "analgesia commenced, comfortable overnight I am happy for the night staff to confirm death". It is then confirmed at 21.28 hours on 6th March.

5.9. The nursing care plan first mentions significant pain on 27th February (95) and describes pain on most days up until 5th March where the pain is uncontrolled and the patient is distressed, at which point a syringe driver is commenced (97). On 6th March pain is controlled.

5.10. **Drug management in Gosport.** I shall concentrate on the use of analgesia. Throughout the patient received appropriate doses of insulin, Co-amilofruse (a diuretic), Digoxin, Iron and steroid inhalers up unto the last twelve hours. She also received a course of Trimethoprim (an antibiotic) between 23rd and 27th February.

5.11. Morphine slow release (MST) (67M)was started at 10 mgs bd on the 24th February and is given until 26th February when MST 20 mgs bd (145)is started, this continues until the 3rd March. On 4th March Oramorph 30 mgs bd is written up and given during 4th March (139). On 5th March Diamorphine is written up 100 – 200 mgs subcut in 24 hours (137). 100 mgs is prescribed and started at 08.30 in the morning, together with Midazolam 40 mgs (137) (61M). Midazolam had been written up at 40 – 80 mgs subcut in 24 hours. Diamorphine and Midazolam pump is filled at 09.45 hours (61M) on 6th March together with another 40 mgs of Midazolam.

5.12. When admitted into hospital Dihydrocodeine PRN for pain had been written up together Hyoscine. Diamorphine 80 – 160 mgs subcut in 24 hours was written up on 26th February together with Midazolam 40. – 80 mgs in 24 hours subcut, but these drugs were never prescribed (141).

5.13. The notes document (for example page 65M) Dr Lord was the consultant responsible for this patient although the patient only appears to have been seen medically at any stage by Dr Barton, and a different consultant Dr Tandy saw the patient in the Haslar Hospital.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1. This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Elsie Lavender. Also whether there were any actions or admissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs Lavender, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2. In particular I have discussed:
a) Her medical conditions
b) Whether she had become terminally ill during her admission.
c) Whether the treatment that was then provided was appropriate.

6.3. Mrs Lavender had a number of serious underlying medical conditions. The most serious of which was her insulin dependent diabetes mellitus going back to the 1940's complicated by hypoglycaemia's, which had led, to falls on previous occasions, peripheral neuropathy which may also contribute to falls and with a combination of diabetes and other processes she had become registered blind. She also had documented frailty prior to admission, for example, already having moved her bed downstairs with an exercise tolerance of 10 yards with a stick. Her son was documented to do her shopping (11). However, she was still living alone, was only documented to have stress incontinence (11) and was cognitively intact (MTS 10/10) (165).

6.4. She was then admitted to Haslar Hospital having had a fall, which was from the top to the bottom of the stairs. No explanation is given as to how she was at the top of the stairs, if she was already set up with her bed downstairs at home. Following this she is documented both at the assessment at Haslar Hospital and then on admission to Gosport Hospital as being severely dependent. She cannot use her arms properly, her hands and wrists are noted to be weak and she cannot stand and walk, she is so incontinent she needs a catheter and she has continual faecal leakage. Barthel is 4/10. I believe this lady was misdiagnosed and had quadriplegia from a high cervical Spinal cord injury secondary to her fall. This diagnosis appears to have been missed by all the doctors who saw her. Although the A&E notes in Haslar state "cervical spine normal" (H18), presumably on clinical, not x-ray, grounds. Also Dr Tandy mistakenly believes she had her neck x-rayed and it was normal (H163). No-one checks this statement is correct.

6.5. Other on-going serious medical problems have also not been explained. She has a documented low platelet count on admission to Gosport, which on repeat is extremely low and at a level that makes life threatening bleeding at any time quite probable. The blood film is also highly abnormal which suggests that there is now some systemic illness going on, probably involving this lady's bone marrow. In the absence of infection or a likely drug culprit, then cancer involving the bone marrow would be a possibility. She also has a very rapidly rising alkaline phosphatase, which suggests either liver, or bone pathology. No other information is now available that would help me clarify this further.

I would have expected that these very abnormal blood tests would have been reviewed and commented on by the doctor in charge of the case. There is no point in undertaking investigations if the results are ignored. The blood results appear to be complex to interpret and I would have expected a clinical assistant or General Practitioner to have taken advice from the consultant in charge of the case as to their relevance and whether further action was required. If further discussion did take place or the results were properly looked at, this is simply not recorded in the notes.

6.6. Other evidence that this lady was frail and ill is provided by the pressure sore which appears to deteriorate during admission and a low albumin documented on admission.

6.7. In my view this lady received a negligent medical assessment in both Haslar and Gosport. In particular she was not examined on admission to Gosport, or if she was it was not documented in the notes. Thus no medical explanation beyond the "possible brain stem CVA" is made. This would not explain all her physical symptoms, or her profound neurological deficit. Also no medical diagnosis was made for pain that she continually complained of down her arms, which again would fit with a high cervical Spinal cord fracture or similar injury. Also, no attempt was made to determine why this lady had a very low platelet count and rising alkaline phosphatase. Without making an adequate medical assessment it is impossible to plan appropriate management. The lack of an adequate medical assessment and adequate documentation make it very difficult to be certain as to what treatment should normally have been given.

Good medical practice (GMC, 2001) states that "good clinical care must include an adequate assessment of the patient's

condition, based on the history and symptoms, and if necessary, an appropriate investigation".... "In providing care you must , keep clear, accurate, legible and contemporaneous patient records, which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". The major gaps in the written notes as described above represents poor clinical practice to the standard set by the General Medical Council.

6.8. There can be no doubt though that the family, Dr Barton and the nursing staff all recognised this lady was seriously ill. Although the doctors fail to come to a diagnosis and therefore could not determine whether there was any treatable underlying problem. Evidence for this is that there was already discussion, within 2 days of admission, with the family about prognosis for recovery and how best to manage her illness. A syringe driver was already being discussed with the family on 24th February. Indeed all the markers of illness I have found, suggest this lady was very seriously ill.

6.9. Even if a high cervical Spinal cord fracture had been diagnosed, the potential for neurosurgical intervention in an elderly lady with diabetes is low and treatment with prolonged immobilisation has a very high mortality rate in itself. The unexplained low platelet count also suggests other significant serious pathology, which was never diagnosed, and on top of this we have somebody who needs all care and has leg ulcers and pressure sores. In my view, there were only two options open at this stage, **a)** to get a further specialist opinion or **b)** treat symptomatically and provide palliative care.

6.10. In view of the complexity of the medical problems, it would have been wise and appropriate to have obtained a further specialist opinion, probably from the consultant in charge of the case before deciding this lady was definitely terminally ill. I can see no evidence in the notes that this was considered.

If there was a failure to obtain further specialist opinion I believe this would be poor clinical practice to the standards set by the General Medical Council.

It was appropriate though to provide pain relief for someone who was both apparently in pain and distressed with loss of totally bodily function. To start MST at a normal low dose on the 24th February was appropriate.

6.11. If the pain was not resolved, increasing the dose to 20 mgs bd on both the 26th February adding the Oramorph 30 mgs bd on 4th March were all appropriate symptomatic responses.

6.12. An unusually large dose of Diamorphine (80 – 160 mgs subcut in 24 hours) is written up on the 26th February on the PRN (as required prescriptions) section of the drug chart. Midazolam 80 mgs subcut is also written up PRN. Although never prescribed, there is no justification in the notes for why such an apparently large dose of Diamorphine was written to be given if needed.

6.13. I have little doubt this lady was moving to a terminal phase of her illness by the 5th March. There had been no improvement in her quadriplegia, she remained faecally incontinent, the nursing cardex documents increasing pain, her platelet count has fallen further and her urea has doubled to 14.6 (187). At this stage a decision to start Diamorphine 100 mgs once a day subcutaneously and 40 mgs once a day Midazolam is made.

6.14. Midazolam is widely used subcutaneously in doses from 5 – 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was 40 mgs for 24 hours, which is within current guidance, although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours. (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th Edition 2003).

6.15. The Diamorphine was specifically prescribed for pain and is commonly used for pain in terminal care, Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. The dose of Diamorphine actually prescribed was 100 mgs in 24 hours. At that time Mrs Lavender was receiving 60 mgs a day of Oramorphine. Diamorphine subcutaneously is usually given at a maximum ratio of 1:2 (i.e. up to 30 mgs of Diamorphine in 24 hours for 60 mgs of Oramorphine). (Wessex Guidelines). However her pain was not controlled and it would be appropriate to give a higher dose of the Diamorphine. Conventionally this would be 50% greater than the previous days; (Wessex Guidelines) some people might give up to 100%. Thus a starting dose of Diamorphine of 45 – 60 mgs in 24 hours would seem appropriate. Mrs Lavender actually was prescribed a minimum dose of 100 mgs of Diamorphine, in my view excessive.

6.16. Diamorphine is compatible with Midazolam and can be used in the same syringe driver. It is documented above though that she

received a high dose of Midazolam and an excessive, and in my view, inappropriately large dose of Diamorphine. Together these drugs are likely to have caused excessive sedation and respiratory depression. However there is no evidence in the notes to prove these complications occurred.

6.17. Mrs Lavender is documented to be comfortable on the 6th and dies approximately 36 hours after the Midazolam and Diamorphine pumps were started.

The prediction of how long a terminally ill patient will live is virtually impossible and even Palliative Care experts show enormous variation (Higginson I J and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A prospective cohort study. BMC Palliative Care 2002 1:1.)

6.18. The doses of Midazolam and Diamorphine used were in my opinion excessively high and may have been prescribed with the intention of deliberately shortening the terminal phase of her life. However, I can not find evidence to satisfy myself the standard of "beyond reasonable doubt", they had the definite effect of shortening her life in more than a minor fashion of a few hours to a few days.

7. OPINION

7.1. Mrs Elsie Lavender provides an example of a very complex and challenging problem in geriatric medicine. It included multiple medical problems and increasing physical dependency causing very considerable patient distress. Several doctors, including Consultants, failed to make an adequate assessment of her medical condition.

7.2. The major problems in this lady's case are the apparent lack of medical assessment and the lack of documentation. Good Medical Practice (GMC 2001) states that "good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and if necessary an appropriate examination"..... "in providing care you must, keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatments prescribed". "Good clinical care must include – taking suitable and prompt action necessary"... "referring the patient to another practitioner, when indicated"..... "in providing care you must – recognise and work within the limits of your professional competence...."..... "prescribe drugs or treatments, including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs". The major gaps in the written notes, as

documented in my report, represent poor clinical practice to the standards set by the General Medical Council. In this case, I believe that the overall episode of medical care provided between Haslar and Gosport Hospital was negligent in that an inadequate assessment and diagnosis of this lady's conditions was made. If it was, it was never recorded. The lack of any examination at Gosport, the lack of any comment on the abnormal blood test make it impossible to decide if the care she subsequently received was sub optimal, negligent or criminally culpable. It seems likely to me that she had several serious illnesses, which were probably unlikely to be reversible, and therefore, she was entering the terminal phase of her life at the point of admission to Gosport Hospital. However, without proper assessment or documentation this is impossible to prove either way.

7.3. The initial symptomatic management of her terminal illness was appropriate. The prescription of the Diamorphine on the 26th February (never given) and the excessive doses of medication used in the final 36 hours was, in my view, sub optimal drug management. These may have been given with the intention of shortening life at the final phase of her terminal illness. However, I am unable to satisfy myself beyond reasonable doubt this did hasten death by anything other than a short period of time (hours to a few days).

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002
2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.
3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.
4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG. Palliative Medicine 1987; 1:149-153.
5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129
6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

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

2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

10. STATEMENT OF TRUTH

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

Signature:_____ Date: _____

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REPORT

regarding

ELSIE LAVENDER (BJC/30)

PREPARED BY: Dr Andrew Wilcock MB ChB FRCP DM
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Mrs. Lavender was a frail 83 year old with significant medical problems. She was admitted to the Royal Naval Hospital, Hasler, Gosport, following a fall down her stairs, following which she found it difficult to walk or move her hands or wrists. She complained of pain across her shoulders and down her arms. A hypoglycaemic episode (low blood sugar) was considered a possible cause of her fall. She was seen by Dr Tandy 11 days later who documented some improvement in her mobility and abnormal neurological findings. Her conclusion was that Mrs Lavender had suffered a brain stem stoke and she was transferred to Gosport War Memorial Hospital, Daedalus Ward for rehabilitation.

During this admission, the medical care provided by Dr Barton was suboptimal: there was a failure to keep clear, accurate, and contemporaneous patient records; there was inadequate assessment of Mrs Lavender's condition, in particular her pain; symptoms and signs that warranted an examination were not acted upon (e.g. search for a possible infection due to raised white cell count, increased blood sugars and insulin requirements; a neurological examination due to her increasing back pain, urinary retention; and faecal incontinence). The morphine prescribed for Mrs Lavender's pains, may have been inappropriate (the type of pains she had may not have been that responsive to opioids) or excessive (as the dose was increased or as her kidney function deteriorated) and the possible role this may have had in her deterioration was not considered. Treatments were continued that may have aggravated her condition (e.g. the diuretic). Ultimately Mrs Lavender was prescribed doses of diamorphine and midazolam that were excessive for her needs.

If it were that Mrs Lavender had naturally entered the terminal phase of her life, at best Dr Barton could be seen as a doctor who whilst failing to keep clear, accurate, and contemporaneous patient records had in good faith been attempting to allow Mrs Lavender a peaceful death, albeit with what appears to

be an inappropriate and excessive use of medication due to a lack of sufficient knowledge. However, in my opinion, based on the medical and nursing records, there is reasonable doubt that Mrs Lavender had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lavender by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lavender by not carefully assessing the possible causes of her decline that may have been reversible with appropriate treatment (e.g. antibiotics for an infection, stopping the diuretics, reducing the dose of morphine) and unnecessarily exposing her to possibly inappropriate and excessive doses of morphine and ultimately excessive doses of diamorphine and midazolam that could have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton leaves herself open to the accusation of gross negligence.

2. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

3. ISSUES

3.1 Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

3.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

4. BRIEF CURRICULUM VITAE

Code A

5. DOCUMENTATION

This Report is based on the following documents:

[1] Set of medical records on paper and CD-ROM of Elsie Lavender (BJC-30).

[2] Set of medical records on paper of Elsie Lavender (JR-11A).

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[6] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

[7] Portsmouth Health Care NHS Trust Policies:

i) Control of Administration of Medicines by Nursing Staff Policy (January 1997).

ii) Prescription Writing Policy (July 2000).

iii) Policy for Assessment and Management of Pain (May 2001).

iv) Compendium of Drug Therapy Guidelines, Adult Patients (1998).

v) Medicines Audit carried out by the Trust referred to as Document 54 on page 52 in the Chi Report (reference 6).

[8] General Medical Council, Good Medical Practice (October 1995).

[9] British National Formulary (BNF). Section on Prescribing in Terminal Care (March 1995).

[10] British National Formulary (BNF). Section on Prescribing in the

Elderly (March 1995).

[11] Medical report regarding Elsie Lavender (BJC/30) Dr James Gillespie.

6. CHRONOLOGY/CASE ABSTRACT

Events at the Royal Naval Hospital

Mrs Elsie Lavender, an 83 year old widow who lived alone, was admitted on the 5th February 1996 to the Royal Naval Hospital, Hasler, Gosport under the care of Surgeon Commander Taylor, following a fall down her stairs at home. Mrs Lavender had no recollection of the fall but a pool of blood was found at the top of her stairs (page 154 of 695) and she was found at the bottom. She sustained a full thickness (down to the bone) laceration to her forehead that required suturing and a more superficial one to her right shin (page 145 of 695). She complained of pain in both shoulders, but not initially of neck or back pain (page 141 of 695). She reported that she was unable to move her right fingers. When examined by the casualty officer her cervical spine was apparently normal (page 141 of 695), she was tender over the right shoulder and upper left arm (page 143 of 695) and although able to move her right fingers the strength was reduced (graded 3/5; active movement against gravity (but not resistance)) The plantar reflex (elicited by firmly stroking up along the outer edge of the sole of the foot and across the base of the toes) was abnormal in her right foot as it was 'up-going', i.e. the big toe ± other toes extend upwards, when normally they flex downwards (page 145 of 695). This suggests damage to the nerves responsible for muscle movements somewhere along their path from the brain and down the spinal cord. X-rays of her chest, skull and both shoulders were performed. All were regarded as normal (page 145 of 695). In his report, Dr Gillespie states that the chest X-ray was essentially

normal but that the skull x-ray was missing from the x-ray packet. Given the severity of the fall and uncertain nature of its cause, Mrs Lavender was admitted under the medical team for observation and investigation. Her past medical history revealed her to be an insulin dependent diabetic for many years, asthmatic, registered blind and to have atrial fibrillation (an irregular heart rhythm). She had been admitted 11 months earlier following a collapse most likely due to hypoglycaemia (low blood sugar) (page 479 of 695). A neurological examination carried out by the medical senior house officer reported normal tone, power 4/5 (active power against gravity and resistance (but reduced from normal)) in her arms and legs, and 'can move fingers and thumb' (page 152 of 695). No sensory deficit is recorded, but this may reflect a cursory examination; previously reduced sensation in Mrs Lavender's hands and feet had been found in keeping with damage to her nerves, most likely from her diabetes (pages 48, 295 of 695). Reflexes were recorded as normal in both her arms. In her legs, her knee reflexes were normal, both ankle reflexes were absent and her right plantar reflex was up-going (page 152 of 695). Results of blood tests suggested an iron-deficiency anaemia with a haemoglobin of 9.7g/dl. There were no other signs or symptoms suggestive of chronic blood loss. White cell and platelet counts were normal (page 154 of 695). Her son reported that recently her blood sugars had been on the low side and she had experienced a very low sugar one month earlier (hypoglycaemic episode) that required treatment by the district nurses (page 154 of 695). Hypoglycaemia was thus considered a possible cause of her fall (page159 of 695).

On the 6th February, Mrs Lavender complained of pain in right arm. Examination revealed tenderness over the bone and muscles of the arm

and her hands were swollen (page 155 of 695). Later that day, she developed a raised temperature and was commenced on antibiotics empirically, as no obvious source of infection was found (page 156 of 695). Mrs Lavender temperature settled and she received 2 weeks of antibiotics, finishing on 19th February 1996 (page 687 of 695). On the 7th February, she complained of left shoulder/upper arm pain (page 156 of 695). On the 8th February, she was seen by the physiotherapist who noted that Mrs Lavender would not make any voluntary active movement when requested due to pain in both shoulders. When the physiotherapist moved her arms for her (passive/assisted movement) there was a full range of movement in both shoulders. She was only able to stand with the help of two others and took a few steps only. The physiotherapist concluded that the pain in the shoulders was a major problem (page 157 of 695). She was prescribed coproxamol 2 tablets every 6 hours and dihydrocodeine 30mg every four hours as required (page 690 of 695). The use of both of these analgesics was very variable. The most taken in one day was on the 12th February when 3 doses of coproxamol and 2 doses of dihydrocodeine were given (page 690 of 695).

Entries on the 9th and the 12th February report that pain in the arms/shoulders continued (page 158 of 695). Her blood sugars were low and her dose of insulin was reduced. A repeat haemoglobin on the 12th February was 10.1g/dl, platelet and white cell counts were normal (but the lymphocyte count reduced at 1.21×10^9/L)(page 205 of 695). Biochemistry revealed a low sodium 132mmol/l (lower limit 134mmol/l), total protein 60g/l (lower limit 63g/l) albumin 30g/l (lower limit 39g/l) and a raised urea 9.3mmol/l (upper limit 6.1mmol/l), alkaline phosphatase 401IU/l (upper limit

126IU/l) and gamma-glutamyl transferase 139IU/l (upper limit 78IU/l)(page 179 of 695). Apart from the haemoglobin, alkaline phosphatase and gamma-glutamyl transferase (latter two not tested) the remaining haematological and biochemical abnormalities were present at least 11 months earlier (pages 175 and 183 of 695).

On the 13th February she was referred for a geriatrician review and was seen by Dr Tandy, Consultant in Geriatrics on the 16th February 1996 (pages 159 and 162 of 695). In the letter summarising that assessment, Dr. Tandy noted that Mrs Lavender complained of weakness in both her hands and difficulty standing since her fall along with pain across her shoulders and down her arms. Mrs Lavender felt that the mobility was starting to improve in her hands. She had stood with the help of the physiotherapist but was still requiring two nurses to help transfer (page 5 of 103). The iron-deficiency anaemia and long-standing stress incontinence were noted (page 5 of 103).

Examination by Dr Tandy confirmed weakness of both hands and wrists, (power of 4/5; active power against gravity and resistance (but reduced from normal))(page 163 of 695). Sensation to light touch was reduced in the right hand in the area supplied by the median nerve (thumb, index, middle and adjacent half of the ring finger) that Dr Tandy considered due to long-standing entrapment of the median nerve at the level of the wrist (carpel tunnel syndrome). Reflexes were generally reduced and her ankle jerks were absent. Her plantar reflex was up-going on the left but not the right (page 163 of 695 and page 5 of 103). *This is opposite to what was found before.*

Dr Tandy was under the impression that Mrs Lavender's neck (cervical spine) had been x-rayed and assumed this was normal. This is incorrect, Mrs Lavender had had only skull, shoulder and chest x-rays. Dr Tandy's assessment was that she had most likely experienced a brain stem stroke leading to her fall (page 163 of 695 and page 5 of 103). Atrial fibrillation is a risk factor for stroke as small blood clots can form in the heart that then travel to the brain to cause a stroke. Dr Tandy placed Mrs Lavender on the waiting list for transfer to Gosport War Memorial Hospital for rehabilitation to try and get her home (page 164 of 695).

Physiotherapy and medical entries on the 20th February 1996 noted that Mrs Lavender's upper limb function was improving as she was starting to feed herself (but not able to use cutlery) but that she still complained of shoulder pain. Mrs Lavender still required the help of two people to stand and could not use a walking aid because of hand weakness. Iron was prescribed for her anaemia (pages 165 and 166 of 695).

A repeat full blood count on the 21st February revealed an increased haemoglobin of 11.0g/dl (normal) and a fall in her platelet count to $120x10^9/l$ (lower limit $150x10^9/l$). This result was signed, but not dated by one of the medical team (page 201 of 695). There is no entry in the notes commenting upon this result.

Over the course of Mrs Lavender's admission her blood sugars remained variable, either too high or too low, and the dose of insulin had to be altered several times (pages 665, 666, 660, 659 and 687, 689, 681, 682 of 695).

Events at Gosport War Memorial Hospital

Mrs Lavender was transferred to Daedalus Ward, Gosport War Memorial Hospital on the 22nd February 1996, under the care of Dr Lord. The Royal Naval Hospital nursing transfer form noted that Mrs Lavender's medication consisted of digoxin 125microgram once a day (for her atrial fibrillation), co-amilofruse (frusemide 40mg and amiloride 5mg) 1 tablet once a day (a diuretic or 'water tablet'), salbutamol inhaler 2 puffs four times a day, becotide inhaler, 2 puffs twice a day, mixtard, insulin 24 units in the morning, 12 units in the evening and iron sulphate 200mg twice a day (page 71 of 103). She was however, also still taking coproxamol 2 tablets or dihydrocodeine 30mg as required, and had taken a total of 2 coproxamol and 30mg of dihydrocodeine on the 21st February 1996 (page 684 of 695). Mrs Lavender required minimal assistance with feeding but full assistance with her hygiene needs. There were ulcers on both legs dressed every other day. Her pressure areas were intact although the skin over the buttocks was red (page 71 of 103).

There are six entries in the medical notes that cover a period of 13 days, taking up just over one page in length (pages 44 and 45 of 103). They are brief and make events difficult to follow in any depth. What follows is a record of events summarised from the medical notes, summary notes and nursing care plan.

The entry in the medical notes dated 22nd February 1996, reads 'Transferred to Daedalus Ward, GWMH. PMH (past medical history) fall at home from the top to the bottom of the stairs, laceration on head. Leg ulcers, severe incontinence needs a catheter. IDDM (insulin dependent diabetes mellitus) needs mixtard insulin bd (twice a day), regular series

B.S. (blood sugars), transfers-with 2, incontinence of urine, help to feed and dress. Bartell 2. Assess general mobility. ?suitable rest home, if home found for cat' (page 45 of 103). Pain was not mentioned nor assessed in the medical notes. In the summary notes, it was noted that Mrs Lavender experienced pain in her arms and shoulders (page 91 of 103). Her medication was continued unchanged (pages 65, 66, 67 of 103), apart from an increase in the dose of dihydrocodeine to 60mg to be taken as required (page 65 of 103).

The medical notes entry on the 23rd February 1996 reported that Mrs Lavender was catheterised the previous night and that there was some residual urine. The summary notes report that 750ml of urine was drained in the first hour (page 91 of 103) and the nursing care plan reports that one litre or more of urine was drained within 1½ hours after catheterisation (page 75 of 103). This suggests that Mrs Lavender was in urinary retention with 'overflow' incontinence of urine. Blood and protein was found in the urine and trimethoprim (an antibiotic) prescribed for a presumed urinary tract infection (pages 45, 67 and 91 of 103). It is unclear if a sample of urine was sent for microbiology; I could find no results in the notes. Blood for routine haematology and biochemistry testing was taken on 23rd February 1996 (page 91 of 103). The blood count revealed a further drop in the platelet count ($36x10^9/L$)(page 58 of 103). It was commented on the results form that as it was a very small sample, the validity of the platelet count was in question and an early repeat was suggested (page 58 of 103). The main findings of the biochemistry testing were a low sodium at 133mmol/L (stable; probably due to her diuretic therapy) and a raised alkaline phosphatase at 572 IU/L (increasing). As the

alkaline phosphatase can be increased in liver or bone problems, identifying the liver or bone isoenzyme can help differentiate between the two. The isoenzyme test was 'to follow' but I can find no result in the notes (pages 41 and 42 of 103). However, the recent finding of a raised gamma-glutamyl transferase suggests it was more likely liver.

On the 24th February 1996 the summary sheet reports that pain was not controlled properly by DF118 (the dihydrocodeine). Mrs Lavender had received four doses of dihydrocodeine 60mg on the 23rd February and one dose at 06.03 on the 24th February 1996 (page 65 of 103). She was seen by Dr Barton and commenced on MST 10mg twice a day (pages 67 and 91 of 103). MST is a slow release formulation containing morphine. There is no medical notes entry on the 24th February 1996 that details the pain problem or the commencement of the morphine.

No additional dihydrocodeine was requested by/offered to Mrs Lavender on the 25th February (she only had two further doses, one on the afternoon of the 3rd March and one on the morning of the 5th March 1996), but the summary sheet entry at 19.00 hours on the 25th February reports that Mrs Lavender appears to be in more pain, screaming "my back" when moved but uncomplaining when not (page 92 of 103).

On the 26th February 1996, the medical notes reported 'not so well over weekend. Family seen and well aware of prognosis and treatment plan. Bottom very sore, needs Pegasus mattress, institute SC (subcutaneous) analgesia if necessary' (page 45 of 103). The summary notes report that Dr Barton increased the MST to 20mg twice a day (page 92 of 103). At 14.30 hours they note Mrs Lavender's son and his wife were seen by Dr Barton '...prognosis discussed. Son is happy for us to just make Mrs

Lavender comfortable and pain free, syringe driver explained' (page 92 of 103). Mrs Lavender was prescribed on the 'as required' section of the drug chart a syringe driver containing diamorphine 80–160mg and midazolam 40–80 mg (page 65 of 103). There was no explanation in the medical or nursing notes of why it was that Mrs Lavender's prognosis was apparently limited. This dose of diamorphine approximately equates to a 6–12-fold increase in Mrs Lavender's dose of morphine. It was however, never used. The summary sheet noted that due to a high blood sugar, Mrs Lavender's dose of insulin had to be increased (pages 62 and 92 of 103).

The full blood count was repeated on the 27th February 1996 and revealed a further fall in the platelet count 22 x 10^9/L, an increased white blood cell count 13 x 10^9/L, due to an increase in neutrophils (10.8 x 10^9/L) and a normal haemoglobin 12.5g/dL (page 57 of 103). The biochemistry tests for renal function were also repeated on the 27th February 1996. The urea and creatinine had both increased, to 14.6mmol/L and 120micromol/L respectively, in keeping with a deterioration in kidney function (page 42 of 103). There is no mention of these results in the medical notes and no further investigation or consideration for the causes of the low platelet count, raised white cell count or deteriorating renal function. On the 27th February 'painful shoulders and upper arms' became part of the nursing plan (page 84 of 103). An entry reports 'analgesia administered, fairly effective' (page 84 of 103).

On the 29th February 1996, the summary sheet noted that due to a high blood sugar, Mrs Lavender received an additional dose of human actrapid insulin (pages 62 and 92 of 103). Mrs Lavender received two doses in all, before the prescription was crossed off (page 62 of 103).

Entries in the 'painful shoulders and upper arms' nursing care plan each day between 28th February and 4th March 1996 seem to suggest that the pain was mainly on movement and on the 2nd and 3rd of March it was described as 'slight' (page 83 of 103).

Nursing care plan notes from 1st March to the 6th March 1996 reported leakage of faecal fluid, despite rectal digital examination (excluding faecal impaction), suppositories and a manual evacuation (pages 85 and 87 of 103).

There is no mention of pain in the summary notes or medical notes again until the 4th March 1996. The summary notes reported 'Patient complained of pain and having extra analgesia p.r.n (as required). Oramorph sustained release tablets dose increased to 30mg b.d. (twice a day) by Dr Barton (pages 62 and 92 of 103). The Oramorph SR tablets are a different brand of slow release morphine, similar to MST. There is no medical notes entry on the 4th March 1996 that details the pain problem or the increase in the morphine. In the nursing plan notes, the entry for the 4th March 1996 reads 'seen by physio- exercises:- 3 turns of head to right + 5 neck retractions every 2 hours. Elsie needs reminding. Analgesia increased' (page 83 of 103).

The next entry in the medical notes, on the 5th March 1996, reads 'Has deteriorated over the last few days. Not eating or drinking. In some pain, therefore start SC analgesia. Let family know' (page 45 of 103). The summary note entry for the 5th March 1996 reads 'patients pain uncontrolled, very poor night. Syringe driver commenced 5th March 1996 at 09.30 hours, containing diamorphine 100mg and midazolam 40mg...' (page 92 of 103). Both drugs were written as a range, i.e. diamorphine

100–200mg and midazolam 40–80mg; although neither dose needed adjusting (page 65 of 103). A dose of diamorphine 100mg approximately equates to a 5-fold increase in Mrs Lavender's dose of morphine. The nursing care plan notes 'pain uncontrolled, patient distressed, syringe driver commenced 09.30, son informed' (page 83 of 103).

On the 6th March 1996 the medical notes entry reads 'Further deterioration. SC analgesia commenced. Comfortable and peaceful. I am happy for nursing staff to confirm death' (page 45 of 103). The summary sheet entry for the 6th March 1996 reads 'seen by Dr Barton. Medication other than through syringe driver discontinued as patient unrousable' (page 93 of 103). The next entries in the medical notes and summary sheet were at 21.28 hours, the pronunciation of Mrs Lavenders death (pages 45 and 93 of 103). I am advised that on the death certificate, the cause of death was stated as 1a Cerebrovascular accident and 2 Diabetes Mellitus.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine and midazolam

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24hours. Indications for its use include swallowing difficulties or a comatose patient. In the United Kingdom, it is commonly used in patients with cancer in their terminal phase in order to continue to deliver analgesic medication. Other medication required for the control other symptoms, e.g. delirium, nausea and vomiting can also be added to the pump.

Diamorphine is a strong opioid that is ultimately converted to morphine in the body. In the United Kingdom, it is used in preference to morphine in syringe drivers as it is more soluble, allowing large doses to be given in very small volumes. It is indicated for the relief of pain, breathlessness and cough. The initial daily dose of diamorphine is usually determined by dividing the daily dose of oral morphine by 3 (BNF number 29 (March 1995)). Others sometimes suggested dividing by 2 or 3 depending on circumstance (Wessex protocol). Hence, 60mg of morphine taken orally a day could equate to a daily dose of 20 or 30mg of diamorphine SC. It is usual to prescribe additional doses for use 'as required' in case symptoms such as pain breakthrough. The dose is usually 1/6th of the 24hour dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24hours, a breakthrough dose would be 5mg. One would expect it to have a 2–4 hour duration of effect, but the dose is often prescribed to be given hourly if required. As the active metabolites of morphine are excreted by the kidneys, caution is required in patients with impaired kidney function.

Midazolam is a benzodiazepine, a diazepam like drug. It is commonly used in syringe drivers as a sedative in patients with terminal agitation. Sedation can be defined as the production of a restful state of mind. Drugs that sedate will have a calming effect, relieving anxiety and tension. Although drowsiness is a common effect of sedative drugs, a patient can be sedated without being drowsy. Most practitioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patient's symptoms rather than to render them unresponsive. In some patients however, symptoms will only be relieved with doses that make the patient unresponsive. A typical starting dose for an adult is 30mg a day. A

smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The Wessex protocol suggests a range with the lowest dose of 5mg a day. The regular dose would then be titrated every 24hours if the sedative effect is inadequate. This is generally in the region of a 33–50% increase in total dose, but would be guided by the severity of the patients symptoms and the need for additional 'as required' doses. These are generally equivalent to 1/6th of the regular dose, e.g. for midazolam 30mg in a syringe driver over 24hours, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4hours, and it may need to be given more frequently. As an active metabolite of midazolam is excreted by the kidneys, caution is required in patients with impaired kidney function.

ii) The principle of double effect.

The principle of double effect states that:

'If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not kill the patient.'

This is a universal principle without which the practice of medicine would be impossible, given that every kind of treatment has an inherent risk. Many discussions on the principle of double effect have however, involved the use of morphine in the terminally ill. This gives a false impression that the use of morphine in this circumstance is a high risk strategy. When correctly used (i.e. in a dose appropriate to a patient's need) morphine does not appear to shorten life or hasten the dying process in patients with cancer. Although a greater risk is acceptable in more extreme circumstances, it is obvious that effective measures which carry less risk to

life will normally be used. Thus, in an extreme situation, although it may occasionally be necessary (and acceptable) to render a patient unconscious, it remains unacceptable (and unnecessary) to cause death deliberately. As a universal principle, it is also obvious that the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care.

8. OPINION

Mrs Lavender was a frail 83 year old with insulin dependent diabetes mellitus who was admitted following a serious fall from the top to the bottom of her stairs. Initially, it was considered likely that the fall was due to a hypoglycaemic episode (low blood sugar). She was at risk of hypoglycaemia as her blood sugars had recently been running low. Following the fall, Mrs Lavender complained of pain across her shoulders and down her arms and was unable to use her hands or to stand. Examination confirmed weakness in the right hand and an 'up going' plantar reflex in her right foot. Investigations revealed iron deficiency anaemia. Pain in her shoulder and arms continued, although there had been some improvement in the use of her hands by the time Dr Tandy saw her (11 days after admission). On examination she found weakness of both hands and wrists and an 'up going' plantar reflex in the left foot. Dr Tandy's opinion was that Mrs Lavender had suffered a brain stem stroke. Mrs Lavender's diabetes and atrial fibrillation would increase her risk of having a stroke. In my current practice I no longer see patients who are admitted with a stroke and Dr Tandy's experience will be greater than mine. However, given that Mrs Lavender had recently experienced a severe fall, I am unsure how certain one could be in attributing all of Mrs

Lavender's symptoms and signs as being caused by a brain stem stroke, particularly as her neurological findings could also be in keeping with cervical spinal cord and nerve root trauma sustained in the fall down the stairs. I would have thought it prudent whatever the findings on the initial examination of the cervical spine in casualty to have obtained a cervical spine X-ray. Whatever the cause of her fall, when considering Mrs Lavender's pain, it is my opinion that:

1. Mrs Lavender's pain across her shoulders and into her arms was most likely to be related to her fall.
2. Her pain was likely to be a 'mixed' pain; that is originating from damage to muscles and soft tissues (e.g. ligaments) of the neck and, possibly from impingement on the nerve roots and spinal cord within the cervical spine. Muscle and nerve injury pain respond poorly to strong opioids.
3. As her injuries healed over subsequent weeks, it is reasonable to expect that the pain would also settle. As such, failure of the pain to settle or any worsening of the pain should, in my view, prompt a careful reassessment that includes appropriate investigation, e.g. a cervical spine imaging (given her neurological findings) and certainly the area of the spine causing Mrs Lavender to scream out in pain "my back" (page 92 of 103). I am unable to find in the notes which part of her back this pain was.

Events at Gosport War Memorial Hospital

Infrequent entries in the medical notes make it difficult to closely follow Mrs Lavender's progress over the last two weeks of her life. There are six entries, taking up just over one page in length.

Mrs Lavender's most relevant problems during her stay, in summary and in approximate chronological order, appear to have consisted of weak hands and

wrists, poor mobility, pain in her shoulders and arms that was mainly on movement for which she went on to receive increasing doses of morphine; urinary retention and a probable urinary tract infection; a falling platelet count; being generally 'unwell'; increased blood sugars and insulin requirements; increasing white cell count, deteriorating renal function; leakage of faecal fluid; worsening of her pain and further deterioration. A syringe driver was then commenced with doses of diamorphine and midazolam sufficient to render her unresponsive until she died 36 hours later. Her cause of death was registered as cerebrovascular accident. A lack of assessment and documentation make the validity of this difficult to comment upon, but her final deterioration as outlined in the nursing and medical notes does not appear in my opinion to be typical of a cerebrovascular accident. Based on the sequence of events and biochemical and haematological findings, it seems more likely that her immobility resulting from her fall, led to an infection. Given that Mrs Lavender had suffered a recent accident that may have contributed in some way to her death, it is usual practice to discuss such deaths with the coroner.

There is a lack of documentation to demonstrate that there had been an adequate assessment of many of the problems Mrs Lavender had through the undertaking of an appropriate history, physical examination and investigation.

Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

The medical care provided by Dr Barton to Mrs Lavender following her transfer to Gosport War Memorial Hospital, Daedalus Ward is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (General Medical Council, Good Medical Practice, October 1995, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination; providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; referring the patient to another practitioner when indicated
- in providing care you must keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs or appliances that serve the patients' needs.

Specifically:

i) The notes relating to Mrs Lavender's transfer to Daedalus Ward are inadequate. On transfer from one service to another, a patient is usually re-clerked highlighting in particular the relevant history, examination findings and planned investigations to be carried out.

ii) The cause of Mrs Lavender's urinary retention was not assessed.

iii) Mrs Lavender was treated for a urinary tract infection with the antibiotic trimethoprim. Neither a diagnostic urine specimen nor a check urine specimen (to see if the infection had cleared) were sent for microbiology. It is therefore unclear if the urinary tract infection was successfully treated or not. This should have been considered when Mrs Lavender was noted to be 'not so well' (see point v).

iv) There is a lack of medical notes relating to the pain or its assessment and the commencement of morphine (MST 10mg) twice a day on the 24th February 1996.

v) On the 26th February 1996 the medical notes report Mrs Lavender to be 'not so well over weekend'. There is a lack of detail that explains in what way she was not so well. There are no records that an appropriate history, examination or investigations had been undertaken to try and determine the reason for Mrs Lavender feeling less well. Instead, without any assessment of the pain, the MST was increased to 20mg twice a day and a syringe driver prescribed to be used 'as required' that contained diamorphine and midazolam in doses that would be excessive to Mrs Lavenders needs.

vi) Blood tests from the 27th February 1996 revealed a low platelet count and deteriorating kidney function. There is no mention of this in the medical notes, and no action was taken.

vii) On the 29th February 1996 there is no mention in the medical notes that Mrs Lavender's blood sugars were high requiring additional doses of insulin. The fact that this could have been due to an untreated infection does not appear to have been considered.

Despite entries in the nursing care plan and summary sheets relating to Mrs Lavender's pain there is no mention of this in the medical notes.

viii) The nursing care plan reports leakage of faecal fluid. There is no mention of this problem in the medical notes or consideration of the possible significance of this symptom given Mrs Lavenders history of trauma.

ix) The morphine was increased again on the 4th March 1996. There is no pain assessment or entry in the medical notes that relates to this increase.

x) The entry in the medical notes of the 5th March reports that Mrs Lavender had deteriorated over the last few days. It is not clear in what way she had deteriorated. There is no history or examination that considers the possible reasons for her decline.

xi) Mrs Lavender's pain appeared poorly controlled on the night of the 4th March but there is no assessment of the pain in the medical notes prior to a syringe driver containing diamorphine 100mg and midazolam 40mg being commenced. The doses of diamorphine and midazolam used in response to Mrs Lavender's worsening pain, are excessive for her needs, even if it were considered that her pain was morphine responsive and she was dying from natural causes.

If the care is found to be suboptimal what treatment should normally have been proffered in this case?

Issue i (failure to take an adequate history and examination on transfer; failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed)

Upon her transfer to Daedalus Ward there should have been an adequate assessment of Mrs Lavender's condition based on the history and clinical signs and, if necessary, an appropriate examination. In my view there is inadequate documentation of Mrs Lavender's relevant history, in particular a lack of an assessment of her pain. As the Wessex guidelines (page 2) point out, an accurate pain assessment is essential both for diagnostic and therapeutic purposes. An assessment should have included as a minimum the noting of the site, severity, aggravating/relieving factors that together with a physical examination would help identify the most likely cause(s) of the

pain(s). This was important as it was likely that Mrs Lavender would have been experiencing several different types of pain as a result of her injury. There may have been soft tissue, muscle and nerve injury pains. Muscle and nerve injury pains are less likely to respond to opioid analgesics. This is highlighted in the Wessex protocol (page 3) 'remember some pains are opioid responsive, others are only opioid semi-responsive and need other approaches'.

There was no physical examination of Mrs Lavender on her transfer. This would be important to act as a baseline against which to compare any future changes. A thorough neurological examination would have been particularly important given the history of her fall, the possibility of a brain stem stroke being raised and the abnormal neurological findings mentioned in Dr Tandy's letter.

Issue ii (failure to adequately assess the patient's condition)

Urinary retention is rare in women and should have prompted an assessment to explore the possible causes of it in Mrs Lavender. Long-standing diabetes can cause damage to the nerves controlling bladder function and may have been responsible. Another cause of urinary retention is injury to the spinal cord. Given Mrs Lavender's history of a severe fall and complaints of back pain, in my opinion she should have been reassessed, including a careful neurological examination. This would have included assessment of anal tone and perineal sensation.

Issue iii (failure in providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; failure to adequately assess the patient's condition)

A urinary tract infection is sometimes treated 'blind' with antibiotics such as trimethoprim, without obtaining a sample of urine for microbiology. The risk with this practice is that the bacteria causing the infection may be resistant to the antibiotic. If there are reasons to doubt that the infection is responding to

treatment, e.g. patient remains unwell, urinary symptoms persist, then a urine specimen should be sent for microbiology testing and/or consideration given to changing the antibiotic.

Issues iv and ix (failure to adequately assess the patient's condition; failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed)

Given that Mrs Lavender's pain required frequent 'as required' doses of dihydrocodeine immediately after her transfer, it was reasonable to provide her with analgesia on a regular basis. An assessment of the pain should however have been done in order to determine the cause(s) of her pain(s) as this would influence the way the pain(s) were managed. For example, were non-drug methods such as positioning, massage, TENS (transcutaneous electrical nerve stimulation) appropriate? If drug measures were considered appropriate, and the pain was considered to be opioid responsive one option would have been to combine the use of paracetamol (step 1 analgesic) with the dihydrocodeine (step 2 analgesic) regularly. If reasonable doses of dihydrocodeine were not relieving the pain some practitioners may well commence a small dose of morphine as Dr Barton did. However, if the pain was not particularly opioid responsive, the dihydrocodeine or morphine may do little or nothing for the pain but could expose the patient to unwanted effects of opioids, e.g. drowsiness, delirium, nausea, vomiting etc. This is relevant, as given her traumatic fall, muscle or nerve injury pain that generally respond poorly to opioids may have been significant factors in Mrs Lavender's pain. Further, it was commented upon that Mrs Lavender was comfortable at rest, only to be in pain when moved (termed 'incident' pain). These can be difficult pains to manage, even if opioid responsive, as the dose of opioid required to improve the pain on movement can be excessive for the patient whom for the

majority of the time is resting and pain free. Typically in this situation the patient becomes increasingly drowsy as the dose of opioid increases.

Despite increasing the morphine dose, a thorough pain assessment was not carried out.

Issues v, vi and vii (failure to adequately assess the patient's condition; failing in providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; failure to prescribe only the treatment, drugs or appliances that serve the patients needs)

There was a failure to adequately assess and document clearly why Mrs Lavender was less well around the 26th February. This should have been based on a history, examination (e.g. temperature, chest) and findings of appropriate investigations (e.g. urine specimen for microbiology). Mrs Lavender was at increased risk of infection due to her immobility and diabetes, and this should have specifically been considered as a cause for her being less well. Other findings that pointed to the possibility of there being an infection, e.g. the raised blood sugars, increased insulin requirements, raised white cell count and falling platelet count do not appear to have been acted upon.

In the absence of a diagnosis that explained why Mrs Lavender was less well, it is unclear what information Dr Barton was in a position to give Mrs Lavender's son regarding his mother's situation and prognosis. Unless Mrs Lavender was clearly entering her terminal stage and was actively dying, it would have been appropriate to have made reasonable efforts to identify the cause of her feeling less well as it could have been treatable. Even if she were considered to be dying, it would be unusual to respond by prescribing a

syringe driver 'as required' that contained doses of diamorphine and midazolam that were excessive to her needs (see technical issues).

The causes of Mrs Lavender's low platelet count and deteriorating kidney function should have been considered in light of her overall situation. There are many causes of a fall in platelet count, and infection is one. It does not appear that Dr Barton discussed this finding (or Mrs Lavender's situation at any point) with a consultant or obtained advice specifically about the low platelet count from a haematologist. The decline in kidney function could have been due to a urinary tract infection not responding to the antibiotics and this should have been actively considered. Alternatively, as she was less well, she may have been drinking less and as a result had become dehydrated. Mrs Lavender's diuretic (water tablet) that could aggravate the situation was continued unchanged when stopping it should have been considered. With a deterioration in her kidney function, the possibility that cummulation of the metabolites of morphine could have been contributing to her decline was not considered.

Issue viii (failure to adequately assess the patient's condition)

There is no mention of the problem of faecal leakage in the medical notes. There are a number of possible reasons why Mrs Lavender may have been experiencing this, including her age, diabetes, immobility and diarrhoea. As it can also be caused by injuries to the brain or spinal cord, this symptom is significant given Mrs Lavenders history of a severe fall, her other symptoms and complaints of back pain. There should have been a neurological examination that would have included assessment of anal tone and perineal sensation.

Issue x (failure to adequately assess the patient's condition; failing in providing or arranging investigations or treatment where necessary; taking suitable and prompt action when necessary; failure to keep clear, accurate, and

contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; failure to prescribe only the treatment, drugs or appliances that serve the patients needs)

Although Mrs Lavender was reported to have further declined, there was no clear documentation in what way this was. There should have been a search for the possible causes in case these were reversible. In particular, an infection should have been ruled out.

Given the expectation that the pain should improve as her injuries healed, a reason for the pain worsening on the evening of 4th March should have been sought. For example, were there new findings on examination? Had her neurology altered?

As the pain had got worse despite increasing the morphine, consideration should have been given to the fact that the pain was not responding to the morphine. This should have prompted an assessment of the causes of her pain and review of her treatment. If her pain was not responsive to morphine, was the amount she was taking too much? Was this playing a part in her deterioration?

Issue xi (failure to keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; failure to prescribe only the treatment, drugs or appliances that serve the patients needs)

The medication used in response to Mrs Lavender's worsening pain, detailed below, appears excessive for her needs, even if it were considered that her pain was morphine responsive and she was dying from natural causes. Medication to control symptoms is usually commenced at a starting dose appropriate to the patient (e.g. considering age, frailty etc.) and their particular

symptom control needs and titrated upwards only to control these symptoms without necessarily rendering the patient unresponsive. There is no justification given for how the doses of diamorphine and midazolam were determined for Mrs Lavender. Using a 1:2 or 1:3 dose conversion ratio to calculate the dose of subcutaneous diamorphine from her oral morphine dose, Mrs Lavender's dose should have been in the order of 20–30mg of diamorphine per day. A daily dose of diamorphine of 100mg (with scope to increase the dose to 200mg a day) is likely to be excessive for Mrs Lavender's needs and to cause drowsiness. Increasing doses of opioids excessive to a patients needs are also associated with an increasing risk of delirium, nausea and vomiting and respiratory depression. There are no clear prescribing instructions on why, when and by how much the dose can be altered within this range and by whom. For these reasons, prescribing any drug as a range is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient should decide on and prescribe any change in medication. Such decisions should not be left to a nurse.

The daily dose of midazolam was prescribed as 40–80mg. There is no justification within the medical notes for the use of midazolam. Although the nursing care plan notes that Mrs Lavender was distressed, this appeared to relate to her uncontrolled pain. It is usual practice in this situation to concentrate on providing pain relief rather than on sedating the patient. If a patient is particularly distressed, small doses of sedative are sometimes given, but usually on an 'as required basis' whilst awaiting any changes made to the analgesia to become effective. In this regard, midazolam 2.5mg by intermittent SC injection would have been reasonable. The dose of 40mg of midazolam is likely to lead to drowsiness in a frail elderly patient. If Mrs

Lavender was considered to have muscle spasm, terminal agitation, or anxiety then a smaller daily dose such as 10mg may have sufficed. Again, there are no prescribing instructions on why, when and by how much the dose can be altered within this range and by whom.

If there were concerns that a patient may experience; for example, episodes of pain or anxiety, it would be much more usual, and indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, or diazepam/midazolam respectively that could be given intermittently 'as required' orally or SC. This allows a patient to receive what they need, when they need it, and guides the doctor in deciding if a regular dose is required, the appropriate starting dose and subsequent dose titration.

In short, the diamorphine and midazolam appear to have been prescribed without sufficient safeguard in relation to altering the dosage and in a way that exceeded Mrs Lavender's needs. In regard to the latter, Mrs Lavender was unrousable after the syringe driver had been commenced and no alteration in the dose of diamorphine or midazolam was required.

If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

Dr Barton does not appear to have provided Mrs Lavender a good standard of clinical care as defined by the GMC (General Medical Council, Good Medical Practice, October 1995, pages 2–3).

Although it is possible that Mrs Lavender was dying 'naturally', it is also possible that her physical state had deteriorated in a temporary or reversible way and that she was not in her terminal phase. In this regard, there should have been a more thorough assessment and clearer documentation of the

possible contributing factors, such as an infection, to Mrs Lavender becoming 'less well'.

A failure to assess Mrs Lavender's pain correctly could have resulted in her receiving increasing doses of morphine for pain(s) that occurred mainly on movement and that were not fully opioid responsive (e.g. muscle and nerve injury pains). This may have provided little pain relief but exposed her to the adverse effects of opioids such as drowsiness. That this may have contributed to her further deterioration was not considered or acted upon. The effect of deteriorating kidney function on morphine metabolites that may have exacerbated the above was not considered or acted upon.

There were symptoms, signs and investigations in keeping with deteriorating kidney function, a possible infection and possible spinal cord injury that should have prompted a more thorough assessment of Mrs Lavender's condition, including a neurological examination.

In the absence of a thorough assessment that could confirm whether Mrs Lavender was likely to be experiencing a reversible or irreversible decline, it is difficult to know what could have been said to her son with any certainty. However, the prescribing of a syringe driver, even though never used, with large doses of diamorphine and midazolam to be used 'if required' appeared excessive and premature. The syringe driver started some days later also contained doses of diamorphine and midazolam that were excessive for Mrs Lavender's needs.

In patients with cancer, the use of diamorphine and midazolam when appropriate for the patients needs does not appear to hasten the dying process. This has not been examined in patients dying from other illnesses to my knowledge, but one would have no reason to suppose it would be any different. The key issue is whether the use and the dose of diamorphine and midazolam are *appropriate* to the patients needs. In situations where they are inappropriate or excessive to the patients needs, it would be difficult to exclude

with any certainty that they did not contribute more than minimally, negligibly or trivially to the death of the patient.

Although the principle of double effect could be invoked here (see technical issues), it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs.

If it were that Mrs Lavender had naturally entered the terminal phase of her life, at best, Dr Barton could be seen as a doctor who, whilst failing to keep clear, accurate, and contemporaneous patient records had been attempting to allow Mrs Lavender a peaceful death, albeit with what appears to be an inappropriate and excessive use of medication due to a lack of sufficient knowledge.

However, in my opinion, based on the medical and nursing records, there is reasonable doubt that she had definitely entered her terminal stage. Given this doubt, at worst, Dr Barton could be seen as a doctor who breached the duty of care she owed to Mrs Lavender by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Lavender by failing to adequately assess the cause of her pain and deterioration, failing to take suitable and prompt action when necessary and exposing her to inappropriate and/or excessive doses of diamorphine and midazolam that could have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton leaves herself open to the accusation of gross negligence.

9. LITERATURE/REFERENCES

British National Formulary 29 (March 1995).

Prescribing in Terminal Care, pages 12–15.

British National Formulary 47 (March 2004).

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

General Medical Council, Good Medical Practice, October 1995, pages 2–3.

'Wessex Protocol' Salisbury Palliative Care Services May 1995 pages 3–4, 30–31.

10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

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

Signature: Code A Date: 1.5.05

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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: BLACK, DAVID ANDREW

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

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: D BLACK Date: 27/06/2005

SUMMARY OF CONCLUSIONS

Mrs Enid SPURGIN was a 92-year-old lady admitted to the Haslar Hospital on 19th March 1999 following a fall. She undergoes an operation for a proximal femoral fracture and then transferred to the Gosport War Memorial Hospital on 26th March 1999. She is known to have become increasingly frail with poor eyesight, depression and mild memory impairment.

In the Gosport War Memorial Hospital she is in continual pain for which no definite diagnosis is made. She develops a wound infection and then deteriorates rapidly and receives pain relief and palliation for her terminal decline, including subcutaneous Diamorphine and Midazolam and dies on 13th April 1999.

The expert opinion is:

Mrs Enid SPURGIN presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture. The prognosis after such a fracture, particularly in those with impairments of daily living before their fracture is generally poor, both in terms of mortality or in terms of morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and complications. A significant problem in Mrs SPURGIN's case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, (GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and

symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include - taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must - recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

I believe that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport. The failure to address the cause of this lady's pain, consider any other actions from 26th March until 7th April. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

Subsequent management of this lady's pain was within current practice with the exception of the starting dose of Diamorphine. The starting dose of Diamorphine at 80mg in the syringe drive is at best poor clinical judgement. However, I am unable to satisfy myself beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be sub-optimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

2. ISSUES

2.1 Was the standard of care afforded to this patient in the days leading up to her death in

keeping with the acceptable standard of the day.

2.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case.

2.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups.

3. CURRICULUM VITAE

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4. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Enid SPURGIN

[2] Full set of medical records of Enid SPURGIN on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Commission for Health Improvement Investigation Report on Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital (July 2002).

[6] Palliative Care Handbook Guidelines on Clinical Management, Third Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

5. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence; 'M' in front are the microfilm notes).

5.1 At the time of her death in 1999 Edith SPURGIN was a 92-year-old lady. She had been previously noted to have a stress fracture of her right hip, not needing operative intervention in 1981. (M38). She was also noted to have Paget's disease in her pelvis in 1988 (M39). She had a probably myocardial infarction in 1989 (M6). In 1997 she had been seen by a Code A a Consultant Psycho-Geriatrician, for depression(144). He also noted poor eyesight (145). At that time she was on an anti-depressant and was noted to have a normal minim-mental test score of 27/30 (148). She was followed up by a Community psychiatric nurse over the following year who believed that she was now showing evidence of memory impairment (152) (158).

5.2 Enid SPURGIN was admitted to the Haslar Hospital on the 19th March1999 following a fall, was diagnosed as having a proximal femoral fracture, treated by an operation "a dynamic hip screw", on 20th March 1999 (20). The notes for Haslar are not currently available to me, the only information is the hand written one page summary that says post operatively she can be mobilised from bed to chair with two nurses and can walk short distances with a Zimmer frame. It noted she has been incontinent at night and has a small sore on the back of her right leg, which is swollen. This letter states that the only medication she is on is Paracetamol prn. The only nursing information from Haslar is an admission assessment and pressure sore assessment

on 19th March (64 & 66).

5.3 The next medical notes we have until her death, are written on a single page from Gosport Hospital (24). This states that the patient was transferred to Dryad Ward on 26th March, with a history of a fractured neck of femur and no significant past medical history. The medical notes state she was not weight bearing, she was not continent, her skin was tissue ? (illegible). The medical plan was " *sort out analgesia*".

5.4 The next medical note is on the 7th April, "still in a lot of pain and very apprehensive. MST increased to 20 mgs bd yesterday, try adding Flupenthixol. For x-ray of right hip as movement still quite painful - also about 2" shortening right leg."

5.5 The next medical note is 12th March, "now very drowsy (since Diamorphine infusion established) reduced to 40 mgs per 24 hours, if pain recurs increase to 60mgs". Able to move hips ? (illegible) pain, patient not rousable. Final note is dated 1.15 am 13th April. Died peacefully.

5.6 Nursing notes from Mrs SPURGIN's admission on 26th March continually refer to pain. The first night she has difficulty in moving, Oramorphine is given (80). The admission care plan mentions she was experiencing a lot of pain and movements (84). The desired outcome is "to eliminate pain if possible and keep Enid comfortable, which should facilitate easier *movement and mobilisation*". *27th March, "is having regular Oramorphine but still in pain"* (84). 28th March (84) "has been vomiting with Oramorph, advised by Dr BARTON to stop Oramorph is now having Metoclopramide three times a day and Co-dydramol".

5.7 On 29th (85) pain needed to be reviewed and on 31st March 10 mgs bd of MST (Morphine slow release tablets) is documented. "Mrs SPURGIN walked with the Physiotherapist but was in a lot of pain". She was still having pain on 1st and 3rd April (85).

5.8 On 4th April (86) it is noted that the wound is now oozing serous fluid and blood. On 7th April, it is documented that she was seen by Dr BARTON who thought the wound site was

infected and started Mrs SPURGIN on Metronidazole and Ciprofloxacin (both antibiotics) (107). On the 8th April, her MST is increased to 20 mgs bd, on 9th it is documented that she should remain on bed rest until Dr REED had reviewed the x-ray of the hip.

5.9 Mrs SPURGIN clinically deteriorates significantly on the 11th April. She is now very drowsy and unrousable at times and refusing food and drink (107). The wound looks red and inflamed and feels hot (107). A discussion with Dr BARTON (107), a decision is made to commence a syringe driver.

5.10 The patient is seen by Dr REED (108) Diamorphine is reduced. On the early morning of 13th April, death is confirmed (108).

5.11 Dependency is also confirmed by a Waterlow score of 32 on the 26th March (i.e. very high risk for pressure sores) (92) and a Barthel of 6/20 on 29th March (94) and 5/20 on 10th April (94).

5.12 Drug management in Gosport concentrate on the use of analgesia:

5.13 At the point of admission Oramorphine 10 mgs in 5 mls (2.5 - 5 mgs 4 hourly prn) is written up on the "as required" part of the drug chart. A few doses are documented to have been given on 31st March - 11th April.

5.14 On the regular prescription Oramorphine 2.5 mgs 4 hourly and 5 mgs at night is written up, first dose given by 10 am on 26th March (125). This is then changed to 5 mgs four hourly with 10 mgs at night up until 28th March, then the Oramorphine is then discontinued and Co-dydramol 2 tablets 6 hourly written and prescribed from 28th March - 1st April (125).

5.15 Metoclopramide 10 mgs three times a day is written up continuously from 28th March to 11th April, but is only actually given to the patient intermittently. Morphine slow release tablets 10 mgs bd (MST) are written up on 31st March and given to 6th April. MST 20 mgs bd is written up on 6th April and given to 11th April.

5.16 Ciprofloxacin 500 mgs bd is written up on 7th April and continued until 11th April and Metronidazole 400 mgs bd is also written up on 7th April and given to 11th April. (134)

5.17 Finally, Diamorphine 20 - 100 mgs is written up on 12th April. 80 mgs in a syringe driver started at 8 am and according to the drug chart "dose is discarded at 16.40 hours and reduced the dosage to 40 mgs in 24 hours". The pump is discontinued at 1.30 am on the patients death on 13th March. Midazolam 20 - 80 mgs is written and is prescribed. 20 mgs put in the syringe driver at 8 am. It appears this was increased to 40 mgs at 16.40 hours and discontinued at 1.30 am on 13th April.

6. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

6.1 This section will consider whether there were any actions so serious that they might amount to gross negligence or any unlawful acts, or deliberate unlawful killing in the care of Enid SPURGIN. Also whether there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Mrs SPURGIN, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

6.2 It is difficult to provide a comprehensive opinion in the absence of the Haslar notes and the very sparse nature of the Gosport notes.

6.3 Mrs SPURGIN a very elderly lady of 92 years, had a number of chronic conditions including poor eyesight, depression, mild memory impairment, ischaemic heart disease, previous fracture of her right hip and known Paget's disease of her pelvis. She had a fall at home resulting in a further proximal femoral fracture and required a dynamic hip screw. This would have been a more complex procedure because of the previous fracture and the possibility that there was Paget's disease in her femur. However, from the one page summary from Haslar, it would appear that she was making reasonable progress at the point of transfer to Gosport. The prognosis in a 92 year old lady with her previous problems, that she would be likely to

return to independent existence at home would already be extremely low.

6.4 The problem documented in Gosport on the point of admission is continued pain, this is difficult to reconcile with the one page summary from Haslar, which says that Mrs SPURGIN is purely on intermittent Paracetamol. There are various possibilities. She may have been undertreated for pain in Haslar, she may have had a dislocation in the ambulance transferring her (this does occur), she may have been starting to develop infection in the wound or she may have had some other orthopaedic problem that was not picked upbetween leaving Haslar and arriving in Gosport. I was also unable to find any report of the x-ray that was taken at Gosport on 7th April.

6.5 The medical assessment undertaken in Gosport was inadequate. There is no record of a significant history or general examination being performed, or if it was it was not recorded. No explanation at all is sought for why this lady is in pain, particularly if she had not been in pain in Haslar.

Good medical practice (GMC, 2001) states "good medical care must include an adequate assessment of the patients condition based on the history and symptoms and if necessary an appropriate investigation"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any other drug or treatments prescribed". The major gaps in the written notes particularly on admission presents poor clinical practice, to the standards set by the General Medical Council.

6.6 However, it was appropriate to provide pain relief. Normally this would be done in a stepwise fashion, starting with the milder pain killers, such as the Paracetamol, she was already on in Haslar. Then to stronger oral medication (such as moderate opioids) and then to stronger opioid analgesia. However, she is started on a regular dosage of stronger opioid analgesia immediately from the point of her admission into Gosport. The reason for this is not documented and represents poor clinical practice.

6.7 The nursing notes document that her pain does not settle and is considerably interfering with her attempts at rehabilitation. She is then troubled with vomiting and the opioid analgesia is in fact stopped and replaced with oral co-dydramol. Her vomiting does apparently settle but her pain continues, so she is restarted on a strong opioid analgesia on 31st March. I believe this was appropriate pain management at this stage.

6.8 She is seen by a consultant on 7th April, who is clearly concerned that there is continuing pain and arranges for an x-ray. There is no record of the result of this x-ray in the notes. However, there appears to be a working assumption that she may have a wound infection and is appropriately started on antibiotics. On 11th April there is a rapid deterioration in her condition. This is documented in the nursing notes but there is no medical note made on the 11th April. The nursing notes suggest that she was seen by Dr BARTON on 11th April, and a decision was made to start a syringe driver. However, I do wonder if this is incorrect and that she was seen early in the morning of 12th April as a syringe driver starts at 8am and not on the 11th April. No medical note is made by Dr BARTON.

6.9 In view of the clinical deterioration on 11th April, despite the patient receiving appropriate antibiotics, I believe it was appropriate to start a syringe driver, as there is no doubt in my view that Mrs SPURGIN was now dying. The likeliest cause is an unresolved infection in the wound and in her hip but the original cause of the pain remains undiagnosed. The opportunity for any possible remediation is well past at this stage. Diamorphine is then written up, prescribed at 80 mgs per 24 hours. The prescription in the notes was 20 - 200 mgs of Diamorphine in 24 hours and it is not clear whether Dr BARTON or the nurse in charge suggested the dose of 80 mgs. At that time Mrs SPURGIN was on 20 mgs twice a day (i.e. 40 mgs) of Morphine Sulphate, slow release. Diamorphine subcutaneously is usually given at a maximum ratio of 1 - 2 (i.e. up to 20 mgs Diamorphine in 24 hours for 40 mgs of Morphine) (Wessex Guidelines). However, her pain was not controlled and it would have been appropriate to give a higher dose of Diamorphine. Conventionally this would be 50% greater than the previous days, (Wessex Guidelines). Some people might give up to 100%. Thus a starting dose of Diamorphine of 40 mgs in 24 hours would seem appropriate. Mrs SPURGIN was prescribed 80 mgs which in my view was excessive, though this was reduced to 40 mgs after the intervention of the consultant

Dr REED, some 8 hours later.

6.10 Midazolam was also added to the infusion pump on 12th April. Midazolam is widely used subcutaneously in doses from 5 - 80 mgs for 24 hours and is particularly used for terminal restlessness. The dose of Midazolam used was originally 20 mgs for 24 hours which is within current guidelines. This was increased to 40 mgs later in the day, which although remains within current guidelines, many believe that elderly patients may need a lower dose of a maximum 20 mgs in 24 hours (Palliative Care. Chapter 23 in Brocklehurst Text Book of Geriatric Medicine, 6th edition, 2003). Morphine is compatible with Midazolam and can be used in the same syringe driver.

6.11 Mrs SPURGIN is thought to have been excessively sedated, the dose of Diamorphine is reduced on 12th April. She subsequently dies.

The prediction of how long a terminally ill patient will live is virtually impossible and even palliative care experts show enormous variation (Higginson I J and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A prospective cohort study. BMC Palliative Care 2002 1:1.)

6.12 In my view the dose of Diamorphine used in the last hours was inappropriately high, however, I cannot satisfy myself to the standard of "beyond reasonable doubt" that this had the definite effect of shortening her life in more than a minor fashion of a few hours.

7. OPINION

7.1 Mrs Enid SPURGIN presents a common problem in geriatric medicine. A very elderly lady with a number of chronic conditions is becoming increasingly frail and has a fall leading to a proximal femoral fracture. The prognosis after such a fracture, particularlyin those patients with impairments of daily living before their fracture is generally poor, both in terms of mortality or in terms of morbidity and returning to independent existence. Up to 25% of patients in such a category will die shortly after their fracture from many varied causes and

complications. A significant problem in Mrs SPURGIN's case is the apparent lack of medical assessment and lack of documentation at Gosport. Good medical practice, (GMC 2001) states that " good clinical care must include an adequate assessment of the patients condition, based on the history and symptoms and if necessary, an appropriate examination"..... "in providing care you must keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drug or other treatments provided". "Good clinical care must include - taking suitable and prompt action when necessary"..... "referring the patient to another practitioner, when indicated"..... "in providing care you must - recognise and work within the limits of your professional competence"..... "prescribe drugs or treatments including repeat prescriptions, only where you have adequate knowledge of the patients health and medical needs.

I believe that there are a number of areas of poor clinical practice in this case to the standards set by the General Medical Council. The lack of a medical assessment, or documentation of that assessment on admission to Gosport. The failure to address the cause of this lady's pain, or consider any other action from 26th March until 7th April. The use of Oramorphine on a regular basis from admission without considering other possible analgesic regimes.

7.2 Subsequent management of this lady's pain was within current practice with the exception of the starting dose of Diamorphine. The starting dose of Diamorphine at 80mg in the syringe drive is at best poor clinical judgement. However, I am unable to satisfy myself beyond reasonable doubt that this high dose of Diamorphine hastened death by anything other than a very short period of time (hours).

8 LITERATURE/REFERENCES

1. Good Medical Practice, General Medical Council 2002

2. Withholding withdrawing life, prolonging treatments: Good Practice and decision making. General Medical Council 2002.

3. Palliative Care, Welsh J, Fallon M, Keeley PW. Brocklehurst Text Book of Geriatric Medicine, 6th Edition, 2003, Chapter 23 pages 257-270.

4. The treatment of Terminally Ill Geriatric Patients, Wilson JA, Lawson, PM, Smith RG.

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Palliative Medicine 1987; 1:149-153.

5. Accuracy of Prognosis, Estimates by 4 Palliative Care Teams: A Prospective Cohort Study. Higginson IJ, Costantini M. BMC Palliative Care 2002:1:129

6. The Palliative Care Handbook. Guidelines on Clinical Management, 3rd Edition. Salisbury Palliative Care Services, May 1995.

9. EXPERTS' DECLARATION

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

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

3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

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

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

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

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

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

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

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

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10. STATEMENT OF TRUTH

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

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: BLACK, DAVID ANDREW

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

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: D BLACK Date: 23/11/2005

CONTENTS

To examine and comment upon the statement of Dr Jane BARTON re Enid SPURGIN . In particular, it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This report is based on the following document:

2.1 Job Description for Clinical Assistant Post to the Geriatric Division in Gosport as provided to me by the Hampshire Constabulary (February 2005).

2.2 Statement of Dr Jane BARTON re Enid SPURGIN as provided to me by Hampshire Constabulary (November 2005). Appendix 1

2.3 Statement of Dr Jane BARTON as provided to me by Hampshire Constabulary (February 2005). Appendix 2

2.4 Report regarding Enid SPURGIN (BJC/ 45) Professor D BLACK 2005.

3. COMMENTS

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3.1 Comments on Job Description (2.1)

3.1.1 This confirms the Clinical Assistant is responsible for a maximum of 46 patients and confirms that all patients are under the care of a named Consultant Physician who would take overall responsibility for their medical management. A Clinical Assistant should take part in the weekly consultant ward rounds.

3.1.2 A specific responsibility is the writing up of the original case notes and ensuring the follow up notes are kept up to date and reviewed regularly.

3.1.3 The post is for five sessions a week i.e. is half what a full time doctor would commit to the post. However, the time to be spent in the unit is not specified as the time is allowed to be "worked flexibly".

3.1.4 There appears to be some confusion between the statements in the job summary, that "patients are slow stream or slow stream for rehabilitation but holiday relief and shared care patients are admitted" and the statement in the previous sentence "to provide 24 hour medical care to the long stay patients in Gosport". The job description appears to be confusing patients for rehabilitation with long stay patients.

3.1.5 There is no comment on the medical cover to be provided when the post holder is unavailable for out of hours or longer period of leave such as holidays. Lack of explicit cover might explain some gaps in the notes.

3.2 Report on the statement of Dr Jane BARTON re Enid SPURGIN (2.2).

3.2.1. I agree with the drug information in paragraph 16 of Dr BARTON's statement. Thus although paragraph of 5.13 of my report is correct, in paragraph 5.14 the dosages written should all read mls not mgs.

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3.2.2. The word mentioned in paragraph 5.3 of my report that I was unable to read is: paper.

3.2.3 I agree that a further single dose of Oramorphine 5mg was given on the 11th April at 7.15am (paragraph 34 of Dr BARTON's statement). Thus the total dose of Morphine given on the 11th of April was 45mg, not 40mg as written in paragraph 6.9 of my report.

3.2.2 These alterations do not effect the conclusions in my report.

3.3 Report on the Statement of Dr Jane BARTON as provided to me by the Hampshire Constabulary (2.3):

3.3.1Page 1 paragraph 3: States that she works eight general practice surgery sessions. It is my understanding that most full time General Practitioners work eight or nine sessions. This suggests to me that she is undertaking a full time General Practitioner job and a half time community hospital job. Despite the fact the job description says that the job can be worked flexibly, an opinion should be obtained from an experienced General Practitioner as to whether this workload is actually deliverable within a reasonable working week.

3.3.2 Page 1 paragraph 4: The job description states 46 beds, Dr BARTON states 48 beds. The CHI report says 44 beds (20 on Dryad and 24 on Daedalus) Dr BARTON uses the phrase "continuing care for long stay elderly patients". The job description also referred to slow stream or slow stream rehabilitation as well as holiday relief and shared care patients. There may have been confusion between staff in terms of the objectives of individual patient management.

3.3.3 Page 1 paragraph 5: This statement is incorrect as the post of Clinical Assistant is not a training post but a service post in the NHS. The only medical training grade posts are pre-registration house officers, senior house officers, specialist registrars and GP registrars.

3.3.4 Page 1 paragraph 5: States that she and her partners had decided to allocate come of the

sessions to "out of hours aspects of the post". This would appear to be a local arrangement of the contractual responsibilities: it needs to be clarified if this was agreed with the Portsmouth and South East Hampshire Health Authority. This would influence how much time was expected to be provided for the patients and influence the pressure on Dr BARTON to deliver the aspects of care provided.

3.3.5 Page 2 paragraph 3: This does confirm that there were consultants responsible for all the patients under the care of Dr. BARTON. Thus a consultant should always have been available for discussing complex or difficult management decisions. However,(page 3 paragraph 1) , in my view it would be completely unacceptable of the Trust to have left Dr BARTON with continuing medical responsibilities for the inpatients of Gosport Hospital without consultant supervision and regular ward rounds. This would be a serious failure of responsibility by the Trust in its governance of patients and in particular failings and in my view the Trust would need to take part of the responsibility for any clinical failings.

3.3.6 Page 3 paragraph 3: This again suggests that Dr BARTON was trying to provide her half time responsibilities by fitting the work around her full time responsibilities as a General Practitioner. She suggests 5 patients were admitted each week, implying approximately 250 admissions and discharges a year. With a bed occupancy around 80%ealth Authority, this would suggest an average length of stay of 5 - 6 weeks. However, CHI state the actual figures were somewhat less, 1997/98 were 169 FCE's for Dryad and Daedalus and 197 FCE's in 1998/99. A new patient assessment including history and examination, writing up the notes, drug charts, talking to the nurses, talking to any relatives present and undertaking blood tests if these had to be taken by a doctor rather than any other staff, would take a maximum of 60 minutes.

Page 5 paragraph 2: The patients who were genuinely long stay or continuing care do not need to be reviewed medically every day, nor would a medical record be made daily. Indeed with average length of stay of six or more weeks, it is clear that many patients were genuinely long-stay patients and one would expect them to be medically reviewed no more than once a week and any medical comments to be no more than once a week. However, whenever patients'

physical or mental state has changed and they are reviewed by a doctor, it would be normal practice to always make a comment in the notes. Patients who are in rehabilitation and making a good progress, then review and comments in the notes once or twice a week would also be the norm.

It is my view that with less than 200 FCE's and a total of 44 inpatients, then this should be satisfactorily managed by somebody working half time as a Clinical Assistant with regular consultant supervision.

3.3.7 Page 4 paragraph 2: This suggests that Dr BARTON is stating that she takes personal responsibility for most changes in medication, rather than it being a nursing decision.

3.3.8 Page 9 paragraph 2: An individual doctor must take responsibility for their prescribing however I would agree that consultants should also take responsibility for ensuring patients under their care were having appropriate medical management. It does appear that there was a consultant responsible for all patients in both Dryad and Daedalus Ward.

4. Conclusions

4.1 Having read all the documents provided by Hampshire Constabulary, I would wish to make minor changes to my expert report.

4.2 I agree with the drug information in paragraph 16 of Dr BARTON's statement. Thus although paragraph 5.13 of my report is correct, in paragraph 5.14 the dosages written should all read mls not mgs.

4.3 The word mentioned in paragraph 5.3 of my report that I was unable to read is: paper.

4.4 I agree that a further single dose of Oramorphine 5mg was given on the 11th April at 7.15am (0715) (paragraph 34 of Dr BARTON's statement) . Thus the total dose of Morphine given on the 11th of April was 45mg, not 40mg as written in paragraph 6.9 of my re

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4.5 These alterations do not effect the conclusions in my report

APPENDIX 1

APPENDIX 2

DRAFT REPORT

regarding

ENID SPURGIN (BJC/45)

PREPARED BY: Dr Andrew Wilcock MB ChB FRCP DM
Reader in Palliative Medicine and Medical Oncology

AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. SUMMARY OF CONCLUSIONS

Mrs Spurgin was a relatively fit and independent 92 year old widow who lived alone. Whilst walking her dog, she fell and fractured her right hip which was surgically repaired using a dynamic hip screw on the 20th March 1999. Within hours of the surgery there was leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. Pain in Mrs Spurgin's hip/thigh on movement continued to be a problem noted by Dr Reid when he reviewed Mrs Spurgin on the 24th March 1999. Surgeon Commander Scott reviewed Mrs Spurgin but no specific comment was recorded in the medical notes regarding Mrs Spurgin's pain, no changes were made to her analgesia and on the 26th March 1999 she was transferred to Dryad Ward, Gosport War Memorial Hospital. With regards to the standard of care proffered to Mrs Spurgin in Haslar Hospital, the report of Mr Redfern raises several concerns.

During her admission to Dryad Ward, the medical care provided by Dr Barton and Dr Reid was suboptimal: there was a lack of clear, accurate, and contemporaneous patient records; inadequate assessment of Mrs Spurgin's condition; a lack of consultation with colleagues to seek appropriate advice and support; the use of diamorphine and midazolam in doses excessive to Mrs Spurgin's needs.

When Mrs Spurgin became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare there was no medical assessment or even simple observations documented. Mrs Spurgin was

not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites due to dehydration. Potentially beneficial treatments (e.g. intravenous hydration, reduction in the dose of morphine, different antibiotics) were not proffered nor advice obtained from the orthopaedic team or a microbiologist. Instead a syringe driver containing diamorphine (equivalent to a 4–6 fold increase in her morphine dose) and midazolam was commenced. On a subsequent review by Dr Reid, as a result of finding Mrs Spurgin unresponsive, the diamorphine dose was halved, however the midazolam dose was doubled.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to the use of inappropriate doses of diamorphine and midazolam that would have contributed more than minimally, negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

2. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day. Where appropriate, if the care is felt to be suboptimal, comment upon the extent to which it may or may not disclose criminally culpable actions on the part of individuals or groups.

3. ISSUES

3.1 Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

3.2 If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3.3 If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

4. BRIEF CURRICULUM VITAE

Code A

Code A

5. DOCUMENTATION

This Report is based on the following documents:

[1] Full paper set of medical records of Enid Spurgin, including the medical certificate of cause of death.

[2] Full set of medical records of Enid Spurgin on CD-ROM.

[3] Operation Rochester Briefing Document Criminal Investigation Summary.

[4] Hampshire Constabulary Operation Rochester Guidance for Medical Experts.

[5] Hampshire Constabulary Summary of Care of Enid Spurgin.

[6] Palliative Care Handbook Guidelines on Clinical Management, Third

Edition, Salisbury Palliative Care Services (1995); Also referred to as the 'Wessex Protocols.'

[7] Portsmouth Health Care NHS Trust Policies:

i) Control of Administration of Medicines by Nursing Staff Policy (January 1997).

ii) Prescription Writing Policy (July 2000).

iii) Policy for Assessment and Management of Pain (May 2001).

iv) Compendium of Drug Therapy Guidelines, Adult Patients (1998).

v) Draft Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, Medical Director (December 1999).

vi) Medicines Audit carried out by the Trust referred to as Document 54 on page 52 in the Chi Report (reference 6).

[8] General Medical Council, Good Medical Practice (July 1998).

[9] British National Formulary (BNF). Section on Prescribing in Terminal Care (September 1998).

[10] British National Formulary (BNF). Section on Prescribing in the Elderly (September 1998).

[11] Statement of Dr Jane Barton as provided to me by Hampshire Constabulary (undated).

[12] Statement of Dr Jane Barton RE. Enid Spurgin, 15th September 2005.

[13] Draft Report regarding Statement of Dr Jane Barton RE. Enid Spurgin (BJC/45), Dr A Wilcock, 5th January 2006.

[14] Draft overview of Enid Spurgin (BJC/45), Dr A Wilcock, 1st November 2005.

[15] Draft Report regarding Enid Spurgin, Mr D R M Redfern, 22nd January 2006.

6. CHRONOLOGY/CASE ABSTRACT

Events at Royal Haslar Hospital, 19th–26th March 1999

Mrs Spurgin, a 92 year old widow who lived alone, was admitted on the 19th March 1999 to Haslar Hospital having been pulled over by her dog onto her right hip resulting in a fracture (page 66 of 135).

Mrs Spurgin was considered 'basically well with no major medical problems' (page 68 of 135). Most of her past medical history was orthopaedic with fractures of her right patella, sternum (page 13 of 135), fifth metacarpal of her right hand (page 86 of 135), stress fracture left hip (page 37 of 51), crush fractures lumbar spine vertebrae (page 38 of 51), lumbar back ache, right hip pain, Pagets disease of the sacrum and right ilium, stress fracture right hip (page 44 of 51); a probable inferior myocardial infarction in 1989 (page 6 of 51), depression secondary to failing physical health in 1997 (page 171 of 175) and removal of a cataract in 1998 (page 153 of 175).

Mrs Spurgin's fracture was repaired surgically using a dynamic hip screw on the afternoon of the 20th March 1999 (page 75 of 135). Mrs Spurgin's pre-operative care raised concerns for the anaesthetist who reviewed her at 12.00h on the 20th March 1999 (page 68 of 135). On admission, she had been made 'nil by mouth' as she was possibly going to theatre the same day (page 68 of 135). This did not occur, but she remained nil by mouth and no intravenous fluids were administered. As a result Mrs Spurgin was likely to be dehydrated; she had not taken any fluid in nor passed urine for over 24h. The anaesthetist was also concerned Mrs Spurgin had received minimal analgesia and in addition to intravenous

fluids gave her morphine 2mg IV. On review 2h later the anaesthetist noted that Mrs Spurgin had passed urine, but also that she had hallucinated following the morphine (page 69 of 135). An outline of the sequence of events that led to Mrs Spurgin receiving inadequate fluid pre-operatively was given by Dr Woods (the SHO) later in the notes (page 80 of 135).

Mrs Spurgin's post-operative course was not straight forward. A review at 21.30h on the 20th March 1999 noted '+++ooze' (i.e. leakage) from the wound but only 40ml in the wound drain (page 69 of 135). Mrs Spurgin complained of discomfort in the leg and pain on palpation and her right thigh was noted to be twice the size of her left. It was considered most likely she had developed a haematoma. This is a collection of blood due to bleeding into the operation site. As the amount increases, the greater the swelling and, if in an enclosed space, the greater the pressure it exerts. The increasing pressure can lead to a compartment syndrome compressing blood vessels and damaging surrounding tissue and nerves (see technical issues). The reviewing doctor examined Mrs Spurgin with this in mind, noting two collections underneath the wound and checking the circulation and nerve function in the leg, which appeared to be satisfactory (page 79 of 135). The clinical impression formed by the doctor was that Mrs Spurgin may have a potential bleeding vessel in the wound (to explain why her leg had become rapidly so swollen), and that she was at risk of compartment syndrome (due to increasing pressure from the haematoma) and hypovolaemia (low blood volume; due to bleeding into the wound)(page 79 of 135). Mrs Spurgin's haemoglobin was reduced at 82g/L (normal range 105–160g/L), having being 122g/L on the day of admission

(page 67 of 135) which suggests she had lost a significant amount of blood as a result of the fracture, its repair and the bleed into the wound. Subsequently, Mrs Spurgin received a three unit blood transfusion on the 21st March 1999 which corrected her anaemia (haemoglobin 111g/L on 22nd March 1999; page 92 of 135).

On the 21st March 1999 concerns remained about Mrs Spurgin's hydration level due to her poor urine output. Her blood tests suggested that she was dehydrated (urea 13.3mmol/L, creatinine 136micromol/L; normal range 3.2–7.5 and 71–133 respectively; page 90 of 135). Her right hip was noted to be painful+++ and her thigh enlarged but there was no ooze from the wound (page 82 of 135). The nursing notes reported that Mrs Spurgin had a lot of pain on movement with a plan to give morphine before moving her (page 27 of 135).

On the 22nd and the 24th March 1999 Mrs Spurgin was reviewed on the wardround by Surgeon Commander Scott, whom I presume was the consultant responsible for her care. There was no specific mention of her painful swollen right thigh, but she was referred to Dr Lord for rehabilitation and a referral letter written in the notes (pages 82, 83 and 84 of 135). This noted that Mrs Spurgin was transfused with three units of blood, but 'has otherwise made a remarkable post-op recovery.' There is no mention of the haematoma, but it does go on to state '...she has proved quite difficult to get mobilised and her post-op rehabilitation may prove somewhat difficult. Additionally the quality of her skin, especially her lower legs is poor and at great risk of breaking down....' (page 83, 84 of 135). On the 23rd March 1999, the nursing notes reported that Mrs Spurgin had difficulty and pain++ with mobility (page 25 of 135).

Mrs Spurgin was reviewed by Dr Reid on the 24th March 1999 (pages 11 and 84 of 135). Dr Reid notes that Mrs Spurgin was '...previously well, but still in a lot of pain which is the main barrier to her mobilisation at present' and asked that her analgesia be reviewed. Dr Reid stated that he would be happy to take Mrs Spurgin to Gosport War Memorial Hospital provided that the orthopaedic team was satisfied that 'orthopaedically all is well with the right hip' (page 84 of 135). In his formal letter that followed, Dr Reid reported that prior to the fall Mrs Spurgin was 'very active and in good health' and repeated his concerns regarding Mrs Spurgin's hip, noting that 'the main problem was pain and swelling of the right thigh. Even a limited range of passive movement was painful. I was concerned about this and I would like to be reassured that all is well from an orthopaedic point of view' (page 11 of 135).

Surgeon Commander Scott reviewed Mrs Spurgin again on the 25th March 1999. It was noted that her right leg was increasingly swollen and that a haematoma had developed and broken down. It is unclear if 'broken down' relates to her wound breaking down as a result of the haematoma but dressing with jelonet and elevation were recommended (page 85 of 135). Commander Surgeon Scott considered that Mrs Spurgin could go to Gosport War Memorial Hospital but to warn them that her skin required great care (page 85 of 135). The nursing notes reported that Mrs Spurgin had had a settled evening and mobilised to the commode with two staff. Mrs Spurgin was transferred the following day on the 26th March 1999 (pages 25 and 26 of 135).

Mrs Spurgin's analgesia consisted of morphine and paracetamol p.r.n. 'as required'; she received morphine 5mg IM at 19.15h and 23.00h on the 20th

March 1999 and at 11.15h on the 21st March 1999 (page 38 of 135). Paracetamol 1G was taken on the following dates (number of doses): 19th (one); 21st (two), 22nd (two), 24th (one) and 25th March 1999 (one) (page 38 of 135).

Events at Dryad Ward, 26th March 1999 until 13th April 1999.

26th March 1999

The nursing transfer note written by Royal Haslar Hospital for Dryad Ward noted that Mrs Spurgin was mobile from bed to chair with two nurses and could walk short distances with a zimmer frame; she was continent during the day but occasionally incontinent at night; the skin on her lower legs was paper thin; her right lower leg was very swollen and needed elevating and there was a small break on the posterior aspect that had been steri-stripped. She needed encouragement with eating and drinking but could manage independently. No drugs were included as she was only on paracetamol p.r.n. 'as required' (page 20 of 175).

The medical note entry reports Mrs Spurgin's fracture of the right femur on the 19th March 1999, nil of significance in her past medical history and that she was non-weight bearing, had tissue paper skin and was not continent. The plan was to 'sort out her analgesia' (page 24 of 175).

The drug chart reveals that Mrs Spurgin was prescribed oral morphine (Oramorph) 5–10mg p.r.n. and also regularly: 5mg every 4h (at 06.00, 10.00, 14.00, 18.00h) and 10mg at 22.00h along with lactulose (a laxative) 10ml twice a day (pages 123 and 125 of 175).

Blood tests were undertaken which revealed a mild anaemia (haemoglobin 10.1g/dL; page 46 of 175) and elevated urea of 9.5mmol/L (normal 3.0–

7.6mmol/L; page 40 of 175). Swabs from her nose, throat, axillae, groins and wound, probably as a routine, were taken to screen for Methicillin resistant staphylococcus aureus (MRSA) and were all negative (pages 32 and 58 of 175).

The nursing summary notes record that Mrs Spurgin had been admitted 'for rehabilitation and gentle mobilisation.' Despite the information in the transfer letter from Haslar Hospital, on Dryad Ward her transferring had been difficult; Mrs Spurgin had complained of a lot of pain for which she was given oral morphine regularly 'with effect' (page 106 of 175). Her 'very dry tissue paper skin' in the lower legs, the small break on back of right calf, and her swollen legs were noted (page 106 of 175). A nursing care plan for Mrs Spurgin's wounds, specifies only that her right leg was swollen and oedematous (page 88 of 175). A handling profile reported pain in the right hip (page 102 of 175).

A nursing care plan was produced for 'Enid is experiencing a lot of pain on movement' and listed the nursing action as 'give prescribed analgesia and monitor effect; position comfortably and seek advice from physiotherapists regarding moving and mobilising' (page 84 of 175).

The nursing care plan for 'Enid requires assistance for settling for the night' noted that she used the slipper bed pan but had difficulty in moving; slept for long periods; Oramorph given as boarded for pain in hip' (pages 80 and 81 of 175).

The nursing summary for the night reported 'requires much assistance with mobility at present due to pain/discomfort. Oramorph 10mg given 23.15h and 5mg at 06.00h' (page 106 of 175).

27th March 1999

The nursing notes reported that it required two nurses to transfer Mrs Spurgin (page 114 of 175) and despite regular Oramorph, Mrs Spurgin was still in pain (page 84 of 175).

The drug chart shows that the regular oral morphine was increased to 10mg every 4h (at 06.00, 10.00, 14.00, 18.00h) and 20mg at 22.00h (page 125 of 175).

28th March 1999

The nursing notes reported that Mrs Spurgin had been vomiting with the Oramorph. Dr Barton advised to stop the Oramorph and Mrs Spurgin received metoclopramide (an anti-emetic) and codydramol for pain relief instead (pages 84 and 85 of 175).

The drug chart shows that the last oral morphine dose was at 10.00h and that codydramol 2 tablets 4 times a day (a total of dihydrocodeine 80mg and paracetamol 4G/24h) were commenced at 18.00h and taken regularly until the 31st April 1999 (page 125 of 175). Metoclopramide (an anti-emetic) 10mg three times a day was also commenced and taken intermittently until the 11th April 1999 (page 134 of 175).

29th March 1999

The nursing notes recorded a request for Mrs Spurgin's analgesia to be reviewed (page 85 of 175) and a mobility evaluation indicated that she required two nurses to move around the bed, a hoist to get in and out of bed and was unable to walk (page 103 of 175).

The drug chart shows that senna (a laxative) 2 tablets at night were commenced and taken until the 10th April 1999 (page 134 of 175).

30th March 1999

The nursing notes record that the steristrips on Mrs Spurgin's surgery wound were removed. A dressing was applied to one small area near top that was oozing slightly (page 89 of 175).

31st March 1999

The nursing notes record that Mrs Spurgin was commenced on modified release morphine (MST) 10mg twice a day. She walked with the physiotherapist in the morning but was in a lot of pain (page 85 of 175). Oramorph 5mg was given for pain relief at 13.15h with 'not too much effect' (pages 85 and 123 of 175). Mrs Spurgin slept well (page 81 of 175). The drug chart records the commencement of MST 10mg twice a day until the 6th April 1999 (page 134 of 175).

1st April 1999

The nursing notes record that Mrs Spurgin was seen by the physiotherapist and that the recommendation was that she remain on her bed rather than in a chair over the Easter holiday but to walk with a zimmer frame once or twice a day (page 85 of 175). The physiotherapy report specifies that Mrs Spurgin should walk twice a day with a gutter frame (page 96 of 175). Mrs Spurgin was noted to have pain on movement (page 85 of 175). Her right hip wound was 'oozing large amounts of serous fluid

and some blood' from a hole in the wound 1–1.5cm long. This was steristripped but continued to ooze (page 81 of 175).

2nd April 1999

The nursing notes record that a different type of dressing (Granuflex) was applied to the wound on Mrs Spurgin's right calf as her leg was oedematous (swollen) (page 89 of 175).

3rd April 1999

The nursing notes record that the MST 10mg twice a day continued and that Mrs Spurgin continued to complain of pain on movement (page 85 of 175).

4th April 1999

A nursing care plan was commenced for Mrs Spurgin's right hip wound 'oozing serous fluid and blood. Steristrip in-situ at present' (pages 86 and 87 of 175). On the same day, the dressings were renewed, no new leakage was seen, the steristrip was intact and a dry dressing reapplied (page 87 of 175).

6th April 1999

The nursing notes record that swabs to test for the presence of infection were taken from the from right hip and right calf wounds. The dressing was removed off the hip wound and left uncovered. The calf wound was leaking and redressed (page 87 of 175). Subsequently, the calf wound cultured the bacterium staphylococcus aureus, sensitive to the antibiotics

erythromycin, flucloxacillin and penicillin. This result was available on the 9th April 1999 (page 52 of 175).

The nursing summary notes record that Mrs Spurgin was seen by Dr Barton and that the MST was increased to 20mg (page 106 of 175). Mrs Spurgin's nephew visited who offered to employ a live-in carer for when she was discharged home (as she was adamant about not going to a nursing home). Mrs Spurgin had been incontinent of urine a few times and the use of a catheter discussed (pages 106 and 107 of 175).

The drug chart shows the increase in the MST to 20mg twice a day which continued until 20.00h on the 11th April 1999 (page 134 of 175).

7th April 1999

The nursing notes reported that Mrs Spurgin's hip wound was red and inflamed and she was seen by Dr Barton and commenced on antibiotics (metronidazole 400mg and ciprofloxacin 500mg both twice a day)(pages 89 and 107 of 175). She was later reviewed by Dr Reid who noted that Mrs Spurgin was still in a lot of pain and very apprehensive. Her MST had been increased to 20mg twice a day yesterday. He prescribed flupenthixol and requested an X-ray of the right hip to be done, as movement was still quite painful and the right leg was 2 inches shorter than the left (page 24 of 175).

The drug chart shows prescriptions for a five day course of antibiotics (ciprofloxacin and metronidazole; page 134 of 175) and the flupenthixol 0.5mg twice a day, given until the 11th April 1999 (page 8 of 175).

8th April 1999

The nursing notes reported that Mrs Spurgin's wound was oozing slightly overnight but that the redness at the edges of the wound was subsiding (page 87 of 175).

9th April 1999

The nursing notes reported that Mrs Spurgin was to remain on bed rest until Dr Reid saw the X-ray of her hip (page 85 of 175). It was noted that Mrs Spurgin had spilt two drinks in bed and had had a nightmare early morning (page 81 of 175). Because of episodes of urinary incontinence and being 'very distressed when put on to commode earlier today' Mrs Spurgin agreed to have a catheter inserted at 19.30h which drained 500ml overnight (page 115 of 175).

10th April 1999

The nursing notes reported that the catheter was draining 'concentrated urine – small amount. Enid not drinking despite encouragement and help'. Mrs Spurgin spilt her drink prior to settling and had a 'very poor night (page 81 of 175).

11th April 1999

The nursing notes recorded that Mrs Spurgin 'appears to be leaning to the left. Does not appear to be as well and experiencing difficulty in swallowing. Stitch line inflamed and hard area. Complaining of pain on movement and around stitch line. Oramorph 5mg given at 07.15h' (pages 81, 85 and 123 of 175). Other entries report 'commenced antibiotics a few

days ago, wound not leaking today but hip feels hot and Enid complaining of tenderness all around site. Enid very drowsy and irritable' (page 87 of 175); 'Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way. Did settle for long periods' (page 83 of 175). A bladder washout was performed due to leakage (I assume bypassing) of dark concentrated urine. It was flushed without problem and 'very little drainage' was noted at 17.00h (page 115 of 175).

The nursing summary notes record that Mrs Spurgin's nephew was telephoned at 19.10h as Enid's condition had deteriorated over the afternoon; '....She is very (the nurse's emphasis) drowsy - unrousable at times. Refusing food and drink and asking to be left alone. Site around wound in right hip looks red and inflamed and feels hot. 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. He will telephone ward later this evening. Seen by Dr Barton to commence syringe driver' (page 107 of 175). However, in her statement, Dr Barton believes this last point refers to her seeing Mrs Spurgin on the morning of 12th April 1999.

12th April 1999

The nursing notes reported that Mrs Spurgin's condition 'remains ill. Urine very concentrated. Syringe driver satisfactory. Appears to be in some discomfort when attended to. Breathing very shallow' (page 83 of 175).

Mrs Spurgin was seen by Dr Reid who made an entry into the medical notes 'now very drowsy (since diamorphine infusion established) – reduce

to 40mg/24h – if pain recurs increase to 60mg. Able to move hip without pain but patient not rousable!' (Dr Reid's emphasis)(page 24 of 175).

The nursing summary notes also recorded the decisions taken on the wardround and that Mrs Spurgin's nephew had been spoken to and was aware of the situation (page 108 of 175).

The drug chart shows that Mrs Spurgin was prescribed, on the regular prescription part of the drug chart, diamorphine 20–200mg, midazolam 20–80mg, hyoscine (hydrobromide) 200–800microgram (marked p.r.n. in the margin) and cyclizine (an anti-emetic) 50–100mg (marked p.r.n. in the margin) all SC/24h (page 131 of 175). A syringe driver was commenced at 08.00h containing diamorphine 80mg/24h and midazolam 20mg/24h (page 131 of 175). It was altered at 16.40h to one containing a reduced dose of diamorphine 40mg/24h and an increased dose of midazolam 40mg/24h (page 131 of 175).

13th April 1999

An entry was made at 01.15h confirming that Mrs Spurgin had died (pages 24 and 83 of 175).

On the death certificate, the cause of death was given as 1a Cerebrovascular accident, with an onset of 48h prior to death.

7. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

i) Syringe drivers, diamorphine, midazolam and hyoscine hydrobromide

A syringe driver is a small portable battery-driven pump used to deliver medication subcutaneously (SC) via a syringe, over 24h. Indications for its use include swallowing difficulties or a comatose patient. In the United Kingdom, it is commonly used in patients with cancer in their terminal phase in order to continue to deliver analgesic medication. Other medication required for the control other symptoms, e.g. delirium, nausea and vomiting can also be added to the pump.

Diamorphine is a strong opioid that is ultimately converted to morphine in the body. In the United Kingdom, it is used in preference to morphine in syringe drivers as it is more soluble, allowing large doses to be given in very small volumes. It is indicated for the relief of pain, breathlessness and cough. The initial daily dose of diamorphine is usually determined by dividing the daily dose of oral morphine by 3 (BNF number 36 (September 1998)). Others sometimes suggest dividing by 2 or 3 depending on circumstance (Wessex protocol). Hence, 60mg of morphine taken orally a day could equate to a daily dose of 20 or 30mg of diamorphine SC. It is usual to prescribe additional doses for use 'as required' in case symptoms such as pain breakthrough. The dose is usually 1/6th of the 24h dose. Hence for someone receiving 30mg of diamorphine in a syringe driver over 24h, a breakthrough dose would be 5mg. One would expect it to have a 2–4h duration of effect, but the dose is often prescribed to be given hourly if required. As the active metabolites of morphine are excreted by the kidneys, caution is required in patients with impaired kidney function.

Midazolam is a benzodiazepine, a diazepam like drug. It is commonly used in syringe drivers as a sedative in patients with terminal agitation. Sedation can be defined as the production of a restful state of mind. Drugs that sedate will have a calming effect, relieving anxiety and tension. Although drowsiness is a common effect of sedative drugs, a patient can be sedated without being drowsy. Most practitioners caring for patients with cancer in their terminal phase would generally aim to find a dose that improves the patients' symptoms rather than to render them unresponsive. In some patients however, symptoms will only be relieved with doses that make the patient unresponsive. A typical starting dose for an adult is 30mg a day. A smaller dose, particularly in the elderly, can suffice or sedate without drowsiness. The BNF (September 1998) recommends 20–100mg SC over 24h. The Wessex protocol suggests a range with the lowest dose of 5mg a day. The regular dose would then be titrated every 24h if the sedative effect is inadequate. This is generally in the region of a 33–50% increase in total dose, but would be guided by the severity of the patients symptoms and the need for additional 'as required' doses. These are generally equivalent to 1/6th of the regular dose, e.g. for midazolam 30mg in a syringe driver over 24h, the 'as required' dose would be 5mg given as a stat SC injection. The duration of effect is generally no more than 4h, and it may need to be given more frequently. As an active metabolite of midazolam is excreted by the kidneys, caution is required in patients with impaired kidney function.

Hyoscine hydrobromide is an antimuscarinic drug most commonly given to reduce excessive saliva or retained secretions ('death rattle'). It also has anti-emetic, antispasmodic (smooth muscle colic) and sedative properties.

Repeated administration can lead to cummulation and this can occasionally result paradoxically in an agitated delirium, highlighted in both in the BNF and the Wessex protocol (page 41). It is usually given in a dose of 600–2400microgram SC over 24h (BNF (September 1998)) or 400–600microgram as a stat SC dose. The Wessex protocol gives a dose range of 400–1200microgram over 24h.

The titration of the dose of analgesic or sedative medication is guided by the patients symptom control needs. The number and total dose of 'as required' doses needed over a 24h period are calculated and this guides the increase necessary in the regular dose of the drugs in the syringe driver in a way that is proportional to the patients needs. The ideal outcome is the relief of the symptoms all of the time with no need for additional 'as required' doses. In practice, this can be difficult to achieve and the relief of the symptoms for the majority of the time along with the use of 1–2 'as required' doses over a 24h period is generally seen as acceptable.

ii) The principle of double effect

The principle of double effect states that:

'If measures taken to relieve physical or mental suffering cause the death of a patient, it is morally and legally acceptable provided the doctor's intention is to relieve the distress and not kill the patient.'

This is a universal principle without which the practice of medicine would be impossible, given that every kind of treatment has an inherent risk. Many discussions on the principle of double effect have however, involved the use of morphine in the terminally ill. This gives a false impression that the use of morphine in this circumstance is a high risk strategy. When

correctly used (i.e. in a dose *appropriate* to a patient's need) morphine does not appear to shorten life or hasten the dying process in patients with cancer. Although a greater risk is acceptable in more extreme circumstances, it is obvious that effective measures which carry less risk to life will normally be used. Thus, in an extreme situation, although it may occasionally be necessary (and acceptable) to render a patient unconscious, it remains unacceptable (and unnecessary) to cause death deliberately. As a universal principle, it is also obvious that the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care.

iii) Compartment syndrome.

See also the report by Code A

Thick layers of tissue called fascia separate groups of muscles in the leg into different compartments. There is limited scope for expansion within a compartment, and a significant swelling, such as a large haematoma, will lead to an increase in pressure, compressing the surrounding muscles, blood vessels and nerves. If the pressure builds sufficiently, the blood flow to the tissues is reduced and this can lead to permanent injury to the muscle and nerves. The hallmark symptom of compartment syndrome is severe pain that does not respond to elevation or pain medication. There may also be:

- tense, swollen and shiny skin overlying the limb
- severe pain when the muscle is moved actively or passively
- pain when the compartment is squeezed.

In more advanced cases, there may be:

- decreased sensation

- muscle weakness
- pallor of the skin.

8. OPINION

Events at Royal Haslar Hospital, 19th–26th March 1999

Mrs Spurgin was a relatively fit and independent 92 year old widow who lived alone. She underwent surgical repair of a fractured right hip using a dynamic hip screw. Mrs Spurgin's post-operative course was not straight forward; within hours of her surgery she had to be reviewed because of leakage from the wound and swelling of her right thigh to twice its normal size, causing discomfort and pain on palpation. It was considered most probable that she had developed a haematoma due to a bleeding vessel in the wound. A large haematoma can exert a pressure effect, compressing blood vessels and damaging surrounding tissue and nerves. The reviewing doctor appropriately examined Mrs Spurgin with this in mind, checking the circulation and nervous function in her leg, which appeared satisfactory. Pain in Mrs Spurgin's hip/thigh on movement continued to be recorded as a problem in the nursing notes and by Dr Reid when he reviewed Mrs Spurgin on the 24th March 1999. He considered the pain the main barrier to rehabilitation, asked for her analgesia to be reviewed and to be reassured that orthopaedically all was well with her hip. Surgeon Commander Scott reviewed Mrs Spurgin several times between the 22nd–25th March 1999 but no specific comment was recorded in the medical notes regarding Mrs Spurgin's pain, no changes were made to her analgesia but on the 25th March she was considered able to be transferred to Gosport War Memorial Hospital once a bed was available. Despite pain

being recorded as a problem, at no point did Mrs Spurgin receive regular analgesia; three doses of morphine given as required within the first 24h of her surgery and subsequently, only paracetamol as required, at most 2G in 24h. One explanation for this apparent discrepancy would be that Mrs Spurgin was relatively comfortable at rest and only experiencing significant pain on movement and/or weight bearing.

With regards to the standard of care proferred to Mrs Spurgin during her admission to Haslar Hospital, I am not experienced enough in orthopaedics to comment, but the report of Code A raises several concerns.

Events at Dryad Ward, 26th March 1999 until 13th April 1999.

Infrequent entries in the medical notes during Mrs Spurgin's stay on Dryad Ward make it difficult to closely follow her progress over the last eighteen days of her life. There are three entries prior to the confirmation of death, taking up one page in length. In summary and approximate chronological order, Mrs Spurgin was admitted to Dryad Ward for rehabilitation and gentle mobilisation. It was noted that Mrs Spurgin complained of a lot of pain on movement for which she was commenced on regular oral morphine. Despite this there was no mention of pain nor a formal pain assessment in the medical clerking. Mrs Spurgin initially was prescribed a total of 30mg/24h of oral morphine regularly. This was increased the next day to 60mg/24h and was the probable cause of her nausea and vomiting. The response to Mrs Spurgin's vomiting appears nonsensical; if it were that her pain was considered severe enough to warrant morphine regularly, the addition of a regular anti-emetic would be seen as an appropriate response. Instead the morphine was substituted for the weaker

analgesic codydramol. Because of continued pain on movement, the codydramol was substituted three days later for oral morphine again, now in a modified release preparation (MST) in a dose of 20mg/24h, subsequently increased to 40mg/24h. Mrs Spurgin's hip wound began to leak large amounts of serous fluid and blood. This initially improved with steristrips but on the 7th April 1999 it was red and inflamed and antibiotics (metronidazole and ciprofloxaxin) commenced. Although the use of antibiotics was appropriate for a possible wound infection, it was not, in my experience, a typical combination used for a post-operative wound infection. Dr Reid reviewed Mrs Spurgin and found that movement of the right leg was still painful. It was now 18 days after Mrs Spurgin's operation and a progressive improvement in pain and mobility can generally be anticipated. This was not the case for Mrs Spurgin and Dr Reid was concerned enough to ask for an X-Ray and it should be confirmed if this was undertaken or not and, if so, the result found. However, an orthopaedic assessment was not sought. Because Mrs Spurgin was 'apprehensive' Dr Reid commenced flupenthixol 0.5mg twice a day. I am unfamiliar with the use of flupenthixol (an antipsychotic) for managing anxiety in the elderly.

The pain on movement did not improve although Mrs Spurgin denied pain when left alone. Mrs Spurgin became less well; she spilt drinks and had a nightmare. She was noted to be very drowsy – unrousable at times, irritable, leaning to the left and experiencing difficulty in swallowing. The wound was inflamed, hot and tender. She was catheterised but drained only small amounts of concentrated urine. The exact cause of Mrs Spurgin's deterioration is unclear as no medical assessment was undertaken. Even simple observations like temperature, heart rate and blood pressure were not carried

out. However, in my opinion, her situation could be consistent with septicaemia from an infection despite her current antibiotics ± cummulation of morphine metabolites as she became dehydrated. Even in her statement, Dr Barton anticipates that Mrs Spurgin's drowsiness was a consequence of her infection (point 40).

On the 12th April 1999, a syringe driver was commenced containing diamorphine 80mg/24h. This is equivalent to oral morphine 160–240mg/24h and thus represents a 4–6 fold increase Mrs Spurgin's dose of morphine. There is no apparent justification for an increase of this magnitude in the dose of analgesia, and, in my opinion, was excessive to Mrs Spurgin's needs. This would explain why Dr Reid noted Mrs Spurgin to have been very drowsy since the diamorphine infusion was commenced (he states she was not rousable! (his emphasis)) and why he was able to move her hip without pain. The syringe driver also contained midazolam 20mg/24h, a dose likely to sedate a 92 year old. Given that the major risk of excessive opioid is respiratory depression, in an unrousable patient, it would have been reasonable for a doctor to have assessed respiratory function, e.g. respiratory rate and the level of oxygen saturation in the blood (pulse oximetry). If there was evidence of respiratory depression, discontinuation of the opioid and careful use of the opioid antagonist naloxone to partially reverse the effects of the opioid would have been indicated to rouse the patient and restore satisfactory ventilation. Even if naloxone was not deemed necessary, other practitioners would stop the opioid until the patient was more awake, and subsequently restart at a lower dose. Others may continue the opioid but at a lower dose. Although Dr Reid halved the diamorphine dose to 40mg/24h, this was still equivalent to oral morphine 80–120mg/24h, i.e. a 2–3 fold increase on Mrs Spurgin's previous

dose. In my opinion, given Mrs Spurgin's dose of oral morphine 40mg/24h, using a 2:1 or 3:1 conversion ratio, an appropriate starting dose of diamorphine would have been 15–20mg/24h. Further, there was a simultaneous increase in the midazolam to 40mg/24h, a dose that in my opinion would sedate a 92 year old. In this regard, despite the reduction in opioid, the increase in midazolam would have contributed to Mrs Spurgin remaining sedated until her death at 01.15h on the 13th April 1999.

The cause of death was given as a cerebrovascular accident. The clinical evidence on which this is based should be clarified. In her statement, Dr Barton suggests 'the reference to her leaning to the left raised the possibility that Mrs Spurgin might have had a cerebrovascular accident'. However, on its own, this is a non-specific finding which could occur in an elderly patient with a reduced level of consciousness due to any cause. If it were strongly considered that Mrs Spurgin had had a cerebrovascular accident, one would expect that this significant change in her clinical condition to have been recorded in the medical notes and accompanied by a medical assessment. In my opinion, the circumstances of Mrs Spurgin's deterioration and death are not typical of a cerebrovascular accident and thus there is a lack of sufficient supporting clinical evidence and certainty that a cerebrovascular accident was the most likely cause of her death.

Was the standard of care afforded to this patient in the days leading up to his death in keeping with the acceptable standard of the day?

The overall care given to Mrs Spurgin whilst at Haslar Hospital has raised concerns as detailed in the report by Mr Redfern.

The medical care provided by Dr Barton and Dr Reid to Mrs Spurgin following her transfer to Dryad Ward, Gosport War Memorial Hospital is suboptimal when compared to the good standard of practice and care expected of a doctor outlined by the General Medical Council (Good Medical Practice, General Medical Council, July 1998, pages 2–3) with particular reference to:

- good clinical care must include an adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination
- in providing care you must keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed
- in providing care you must prescribe only the treatment, drugs, or appliances that serve patients' needs
- in providing care you must be willing to consult colleagues.

Specifically:

i) The notes relating to Mrs Spurgin's transfer to Dryad Ward are inadequate. On admission, a patient is usually clerked highlighting in particular the relevant history, examination findings, planned investigations and care plan.

ii) There was insufficient assessment and documentation of Mrs Spurgin's pain and its treatment.

iii) An orthopaedic opinion was not sought even when the pain did not improve with time or increasing doses of morphine that were associated with undesirable effects.

iv) An appropriate medical assessment was not undertaken when Mrs Spurgin deteriorated, becoming more drowsy and her wound more painful and inflamed.

v) Doses of diamorphine and midazolam that were excessive to her needs were administered.

If the care is found to be suboptimal what treatment should normally have been preferred in this case?

In relation to the above:

Issue i (lack of clear documentation that an adequate assessment has taken place)

A medical assessment usually consists of information obtained from the patient or others and existing medical records (the history), and the findings of a physical examination that is documented in a structured fashion. Although the history can be restricted to the most salient points, it is unusual to omit relevant sections, e.g. a basic physical examination, etc.

Clerking of a patient also provides a baseline for future comparison. If new problems subsequently develop, and abnormal physical findings are found on examination, it can be helpful for the doctor when considering the differential diagnosis and management to know if the findings are really new or old. A clear assessment and documentation of subsequent medical care are particularly useful for on-call doctors who may have to see a patient, whom they have never met, for a problem serious enough to require immediate attention.

Issue ii (lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; prescribing only the treatment, drugs, or appliances that serve patients' needs)

Part of the plan outlined by Dr Barton was to sort out Mrs Spurgin's analgesia. Particularly when pain relief is considered such a prominent part of the care plan for a patient, it would be considered good practice to take and document a full pain history and undertake an appropriate examination. This is to help diagnose the most likely cause of the pain and thus guide a rational and appropriate management plan.

Dr Barton considered Mrs Spurgin unable to weight bear and that her pain to require regular morphine. This was in contrast to the transfer note, written on the same day of transfer, which recorded Mrs Spurgin to be mobile with help and requiring only p.r.n. 'as required' paracetamol. There is no documented history or examination which suggests that the possible reasons for this apparent increase in pain were considered. This is relevant, because, if increasing pain was associated with a wound infection for example, this would require appropriate antibiotics rather than morphine. Further, given that pain generally improves quickly and progressively in patients who have undergone surgical repair of their fractured neck of femur, the need to commence strong opioid analgesia for severe pain one week post-operatively should have been a particular prompt to have undertaken a thorough assessment.

It is unclear on what basis Dr Barton considered that regular morphine was necessary, rather than initially trying a regular weak opioid ± paracetamol. In general, practitioners progressively increase the strength of regular analgesia and the dose against the patients pain, in the order non-opioid (e.g.

paracetamol) → weak opioid (e.g. codeine) → strong opioid (e.g. morphine). Although some may omit the weak opioid step and go straight to a strong opioid, this usually involves a smaller initial dose of morphine (e.g. 20–30mg/24h). Although the starting dose of morphine and its increase prescribed by Dr Barton were in keeping with the BNF, in the context of omitting a regular weak opioid step and in view of Mrs Spurgin's advanced age, it would have been prudent in my opinion to have used a smaller dose. Mrs Spurgin's nausea and vomiting could be in keeping with the doses she received being excessive, although up to half of patients can experience nausea and vomiting when commencing morphine.

Issue iii (in providing care you must be willing to consult colleagues)

Because of Mrs Spurgin's nausea and vomiting, the morphine was discontinued and she received regular codydramol for about 3 days. However, because of persistent pain, Dr Barton recommenced a smaller dose of morphine. This was 11 days after Mrs Spurgin's operation and this level of pain and analgesic requirement should have prompted a search for the cause of the pain. In this regard there is no evidence that Dr Barton considered, examined Mrs Spurgin or documented the possible reasons why Mrs Spurgin's pain was so problematic, discussed her with Dr Reid or the orthopaedic team. Similarly, when the morphine was increased to 40mg/24h, 17 days after Mrs Spurgin's operation, neither Dr Barton nor Dr Reid contacted the orthopaedic team. An X-ray was apparently requested, but I am unable to ascertain if it was carried out.

Finally, it should be ascertained if the choice of ciprofloxacin and metronidazole for a post-operative (orthopaedic) wound infection was in

keeping with Trust guidelines, and, if not, why the advice of a microbiologist was not obtained.

Issue vi ((lack of clear documentation that an adequate assessment has taken place; lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; in providing care you must be willing to consult colleagues)

Mrs Spurgin became less well, increasingly drowsy, dehydrated, agitated, spilling things and had a nightmare. When a patients' clinical condition changes for the worse, a thorough medical assessment should be carried out to ascertain the possible cause(s) and to identify if they are reversible with appropriate treatment. The assessment would consist of the history, examination and appropriate investigation. There is no assessment or even simple observations documented. This is relevant, as in my opinion, Code A Spurgin was not anticipated to be dying and her symptoms and signs were in keeping with a potentially reversible septicaemia/toxaemia arising from an infection (the wound had become tender and inflamed despite the antibiotics) ± the effects of increasing blood levels of morphine metabolites; even though the morphine dose had not been increased, in dehydration morphine *metabolites cumulate as if the dose of morphine had been increased.* Intravenous hydration, reduction in the dose of morphine and different antibiotics may well have been of benefit to Mrs Spurgin and it should be ascertained why these were not considered appropriate. Particularly the latter, as in her statement, Dr Barton's appears to consider that an infection was contributing to Mrs Spurgin's drowsiness. For patients this unwell with an infection, particularly despite the existing use of antibiotics, the choice of

further antibiotic(s) would usually be made with the help of a microbiologist and modified subsequently based on results of wound, blood and urine cultures etc. There is no documentation to suggest that Dr Barton discussed Mrs Spurgin's management with Dr Reid, the orthopaedic team or a microbiologist before commencing a syringe driver containing diamorphine and midazolam.

Issue v (lack of clear, accurate, and contemporaneous patients records which report drugs prescribed; prescribing only the treatment, drugs, or appliances that serve patients' needs; willing to consult colleagues)

On the 12th April 1999, Dr Barton prescribed diamorphine 20–200mg, midazolam 20–80mg, hyoscine (hydrobromide) 200–800microgram (marked p.r.n. in the margin) and cyclizine (an anti-emetic) 50–100mg (marked p.r.n. in the margin) all SC/24h.

It is unusual that drugs to be given by syringe driver are prescribed 'as required' especially in a wide dose range. This is because of the inherent risks that would arise from a lack of clear prescribing instructions on why, when and by how much the dose can be altered within this range and by whom. For example, the lower dose range of diamorphine was 20mg/24h, but Mrs Spurgin was commenced on 80mg/24h. For these reasons, prescribing a drug as a range, particularly a wide range, is generally discouraged. Doctors, based upon an assessment of the clinical condition and needs of the patient usually decide on and prescribe any change in medication.

If there were concerns that a patient may experience, for example, episodes of pain, anxiety or agitation, it would be much more usual, and

indeed seen as good practice, to prescribe appropriate doses of morphine/diamorphine, diazepam/midazolam and other drugs that could be given intermittently 'as required' orally or SC alongside the fixed regular dose of analgesic. This allows a patient to receive what they need, when they need it and guides the doctor in subsequent dose titration of the regular dose of analgesic.

The wide dose range of diamorphine 20mg–200mg, is not justified at all in the notes and in my opinion includes doses excessive for Mrs Spurgin's needs. Doses of opioids excessive to a patient's needs are associated with an increased risk of drowsiness, delirium, nausea and vomiting and respiratory depression.

The equivalent subcutaneous dose of diamorphine is generally calculated by dividing the oral morphine dose by 2 or 3 (see technical issues). As Mrs Spurgin had been receiving oral morphine 40mg/24h, this is approximately equivalent to diamorphine 15–20mg/24h. A syringe driver was commenced containing diamorphine 80mg/24h, equivalent to oral morphine 160–240mg/24h, representing a 4–6 fold increase in Mrs Spurgin's dose of morphine. There is no justification for an increase of this magnitude in the dose of analgesia, and, in my opinion, was excessive to Mrs Spurgin's needs. *The syringe driver also contained without apparent justification, midazolam* 20mg/24h, a dose likely to sedate a 92 year old. As a result, Dr Reid found her unrousable and unresponsive to movement of her hip (a painful stimulus). Given the depth of her sedation, it would have been reasonable to have assessed her respiratory function, e.g. respiratory rate and the level of oxygen saturation in the blood (pulse oximetry), but this did not occur. In my opinion the syringe driver should have been discontinued and Mrs Spurgin's condition

monitored closely for evidence of respiratory depression, pain or agitation. Other practitioners may well choose to continue the opioid but at a lower dose as Dr Reid did. However, the dose he selected, diamorphine 40mg/24h, is equivalent to oral morphine 80–120mg/24h, i.e. still a 2–3 fold increase on Mrs Spurgin's previous dose. Further, there was a simultaneous increase in the midazolam to 40mg/24h, a dose that in my opinion would sedate a 92 year old, and was unjustified given that she was already unresponsive.

In her statement, Dr Barton makes the point that even 40mg of diamorphine was not seemingly successful in relieving Mrs Spurgin's pain as she was 'in some discomfort when attended to'. This, in my view, continues to underscore the point that the pain that Mrs Spurgin was experiencing on movement was not relieved by a dose of diamorphine that was associated with undesirable effects (i.e. sedation). This is unusual for someone who had undergone repair of a fractured neck of femur with a dynamic hip screw and reinforces the point that an orthopaedic review should have been sought.

If the care is found to be suboptimal to what extent may it disclose criminally culpable actions on the part of individuals or groups?

Both Dr Barton and Dr Reid had a duty to provide a good standard of medical practice and care. In this regard, Dr Barton and Dr Reid fell short of a good standard of clinical care as defined by the GMC (Good Medical Practice, General Medical Council, July 1998 pages 2–3) with particular reference to a lack of clear note keeping, adequate assessment of the patient, providing treatment that could be excessive to the patients' needs and willingness to consult colleagues.

In my view, Mrs Spurgin was not anticipated to be dying and very likely that her pain and subsequent deterioration were due to potentially reversible (and possibly preventable) causes that could be managed by the timely provision of hydration, a reduction in morphine dose and appropriate antibiotics. The pain was out of keeping with that usually seen in this situation, and failed to improve with time or increasing doses of morphine. Thus there were several prompts for both Dr Barton and Dr Reid to have sought an orthopaedic review.

Morphine and diamorphine are safe drugs when used correctly. The key issue is whether the use and the dose of diamorphine and other sedatives are *appropriate* to the patients' needs. Although some might invoke the principle of double effect (see technical issues), it remains that a doctor has a duty to apply effective measures that carry the least risk to life. Further, the principle of double effect does not allow a doctor to relinquish their duty to provide care with a reasonable amount of skill and care. This, in my view, would include the use of a dose of strong opioid that was *appropriate* and not excessive for a patient's needs.

In short, Dr Barton in particular, but also Dr Reid, could be seen as doctors who breached the duty of care they owed to Mrs Spurgin by failing to provide treatment with a reasonable amount of skill and care. This was to a degree that disregarded the safety of Mrs Spurgin by failing to adequately assess her condition and taking suitable and prompt action when she complained of pain that appeared excessive to her situation and when her physical state deteriorated in what was a potentially reversible way. Instead the actions of Dr Barton and Dr Reid exposed Mrs Spurgin to inappropriate doses of diamorphine and midazolam that would have contributed more than minimally,

negligibly or trivially to her death. As a result Dr Barton and Dr Reid leave themselves open to the accusation of gross negligence.

9. LITERATURE/REFERENCES

British National Formulary 36 (September 1998).

Prescribing in Terminal Care, pages 11–14

Prescribing for the elderly, pages 15-16

Good Medical Practice, General Medical Council, July 1998, pages 2–3

Palliative Care Handbook, Guidelines on Clinical Management, Third Edition

'Wessex Protocol' Salisbury Palliative Care Services May 1995.

10. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

11. STATEMENT OF TRUTH

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

Signature: _____ Date: _____

'rom: Code A
ent: 05 Sep 2007 13:05
'o: 'Ellson, Sarah'
:c: 'Tomlinson, Tamsin'
ubject: RE: Dr Barton
lello,

have now discussed with Peter and he is of the view that the defence should only be given three months
› prepare their case.

-le is of the view that if the defence require 6 months it will be for Adjudication to determine whether or
ot they can have it.

Code A

---

rom: Code A
ent: 05 Sep 2007 10:07
o: 'Ellson, Sarah'
:c: Tomlinson, Tamsin
ubject: RE: Dr Barton

lello,

will need to consult Peter and he is out of the office until this afternoon.

have just checked with Adjudication and the first available date for a 8 week hearing in London is from 1
lay 2007.

Code A

---

rom: Ellson, Sarah Code A
ent: 04 Sep 2007 17:51
o: Code A
:c: Tomlinson, Tamsin
ubject: Dr Barton

ıst had a long and helpful call with Ian Barker at MDU in anticipation of protocol call.

ıave brought him round from initial view that it might not be worth having call at this stage ecause it is too early to know the scope of the case. We both agree having a date to work to ıd being able to book Counsel will be helpful. They will be using Alan Jenkins and Tim ıngdale QC.

he difficulty is that I have sketched out a timetable

copy and disclose materials in possible cases asap (when we are preparing instructions to ounsel)
confirmation of cases to be issued shortly after our con (Oct/Nov) + poss nature of charges draft charges and any outstanding evidence by end of 2007

n th[redacted]asis - which is still quite tight for us given that we will need to book a block of time with ounsel so he can review and advise - Ian Barker says he would not be ready for a June earing - he is saying more like September (he is equating the preparation time to a murder ase and says 6 months would not be sufficient - I am not sure I agree the analogy and know ıe Criminal system obviously also tries to get cases on asap)

need to know whether GMC are concerned to get this on as soon as possible or whether you ould prefer to go for the September date for which we will get defence "buy in" and an agreed metable. If we press for earlier we may face an application any time between now and May aying they are not and cannot be ready - if successful the case would leave a major gap in the ;MC calendar and by then would cause re-listing problems. I am inclined to go for co-operation nd certainty but know that the case ought to be heard as soon as possible. Service standards re in this case of no relevance but of course the principle is cases ought to be listed sooner ather than later. In the scheme of things a further 3 months would not be significant.

Ve [redacted] also be seeking a London listing but I did explain that there is limited space in London nd other major cases might need to be listed in London. I think we will be asking for an 8 eek listing which is only a guestimate but Ian agreed with my back of the envelope alculations.

an you let me have the GMC view/instructions so that I can prepare for Thursday's call - thanks

arah Ellson | Partner
)r Field Fisher Waterhouse LLP
d: **Code A**

onsider the environment, think before you print!

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

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/eb www.ffw.com **CDE**823

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/e use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with quivalent standing and qualifications.

rom: Code A
ent: 06 Sep 2007 18:57
o: Peter Swain Code A
ubject: Dr Barton
eter,

his case has been listed for 8 September 2008 for 40 days in London.

s you aware the defence wanted several months to prepare their case and we stated that 3 months was ufficient, due to our differing views Adjudication made the decision as to when the case should be listed.

Code A

'rom: Code A
ent: 06 Sep 2007 13:34
'o: Code A 'Ellson, Sarah'; Code A
Code A
ubject: RE: Dr Barton

ıttachments: Dr Barton.doc
)ear All,

ollowing a request by the GMC the telecon minutes have been amended.

'lease can I request for all parties to confirm their agreement with the amended minutes.

lany thanks,

Code A

---

rom: Code A
ent: 06 September 2007 11:07
'o: 'Ellson, Sarah'; Code A
ubject: Dr Barton

)ear All,

'lease find attached the minutes from today's telecon. Please don't hesitate to contact me if you wish to ıake any amendments.

ıhead of the next telecon on 24 January 2008, 11am, I attach the agenda and dial up details.

·est wishes,

Code A

Code A
ıdjudication Co-ordinator
;eneral Medical Council
Code A

E/Committee/PCC/Listings/GMC Case Protocol stage 3 form

GMC Case Protocol - Stage 3 Telephone Conference
Sarah Ellson & Tamsin Tomlinson, Field Fisher Waterhouse
Ian Barker, Medical Defence Union
Code A Investigation Office
Code A Adjudication Listings

Case: Dr Barton

Conference date: 6 September 2007, 10am

Areas to be covered

	Action	Outcome
1.	GMC to complete investigation	4 January 2008
2.	GMC to disclose evidence and final charge	18 January 2008
3.	Doctor to indicate timetable for preparation of defence GMC suggested 3 months preparation time however the defence requested more due to the complexity of the case, which the GMC did not challenge. The Investigation Officer asked Adjudication to make the decision. The telecon was adjourned and the Adjudication Manager was consulted, it was agreed that an extended preparation time will be allocated.	8 August 2008
4.	Agree timetable	GMC, Defence
5.	Provisional hearing date	8 September 2008 – 31 October 2008
6.	Time estimate	40 days

7.	Location of hearing	London
8.	Date of next telephone conference	24 January 2008, 11am

rom: Code A
ent: 06 Sep 2007 18:30
o: Code A
c: Code A Tomlinson, Tamsin
ubject: RE: Dr Barton

Code A

his is a more accurate reflection.

hanks Code A

---

rom: Code A
ent: 06 Sep 2007 13:34
o: Code A 'Ellson, Sarah'; Code A
Code A
ubject: RE: Dr Barton

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est wishes,

Code A

Code A
djudication Co-ordinator

General Medical Council

Tel: Code A

rom: Code A
ent: 06 Sep 2007 13:04
o: Code A
c: 'Ellson, Sarah'; Code A
ubject: RE: Dr Barton
Code A

hank for your reply.

would be grateful if you could still update the minutes to reflect that it was the GMC's view that djudication should determine the defence preparation time due to our differing views, as this is very ertinent information.

Code A

---

rom: Code A
ent: 06 Sep 2007 11:45
o: Code A
c: 'Ellson, Sarah'; Code A
ubject: RE: Dr Barton

ear Code A

s is also confirmed by my colleague Christine Haynes, who was also present on the telecon for training urposes: **after** Defence stated their case for why additional time needs to be allocated, the GMC raised o objections to the arguments put forward/the request for additional time.

t this point, I recall you stated that defence and the GMC had differing opinions and Adjudication needs o determine the time allowed, however, Defence responded by pointing out that at no point during the ele has FFW expressed any objection to the case Defence has put forth, as FFW did not contest this ither "GMC raised no objections" was noted in the minutes. Further to this, once I returned to the telecon o confirm Adjudication's decisions, Defence re-stated that FFW have expressed no objections to the Case or additional preparation time.

hope this clarifies the minutes.

lany thanks,

Code A

---

rom: Code A
ent: 06 September 2007 11:17
o: Code A
c: Code A ; Tomlinson, Tamsin
ubject: RE: Dr Barton

lello Code A

am concerned that you have stated in minutes that the GMC had no objections to the defence reparation time, whereas to clarify I recall saying that the GMC and the defence had differing views as ıe amount of time the defence could be allowed to prepare their case and it was for Adjudication to etermine the amount of time that the would be allowed.

would be grateful if you would amend the minutes to reflect this.

hanks Code A

---

rom: Code A
ent: 06 Sep 2007 11:07
o: 'Ellson, Sarah'; Code A
ubject: Dr Barton

)ear All,

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Code A

Code A
ıdjudication Co-ordinator
;eneral Medical Council
el: Code A

Re: Dr Barton

rom: Ellson, Sarah [Code A]
ent: 06 Sep 2007 10:39
o: [Code A]
c: Tomlinson, Tamsin
ubject: RE: Dr Barton

ot to worry I think leaving it to Adjudication was the right approach but we do now have a realistic and orkable timetable.

amsin is now going to book Counsel for a con which will need to be after he has had some reading me! I am guessing October (subject to his diary) - I am away 6-28 October but I do not want this to elay matters and Tamsin, you and Tom will undoubtedly be able to progress matters while I am way. I will be involved in drafting the instructions before I go.

arah Ellson | Partner
r Field Fisher Waterhouse LLP
d: [Code A]

---

rom: [Code A]
ent: Thursday, September 06, 2007 10:25 AM
o: Ellson, Sarah
ubject: RE: Dr Barton

li Sarah,

orry I 've only just seen this email but it has now been overtaken by events.

o you a have date in mind for a meeting with Counsel?

[Code A]

---

rom: Ellson, Sarah [Code A]
ent: 05 Sep 2007 19:38
o: [Code A]
c: Tomlinson, Tamsin
ubject: Re: Dr Barton

[Code A]

will obviously follow your clear instructions on this but just want to clarify I think the defence will be asking for 9 ıot 6) months. Given the size of the case and the amount of time we will have had (if you include the Eversheds me) I have some sympathy with this and I do think having a realistic timetable with certainty would be helpful. [owever perhaps we should see how adjudication deal with tomorrow - I am quite happy with the approach the the fDU must explain why 3 months is not enough (in fact it will be 4.5 if we get that May slot).

Re: Dr Barton

[appy to speak before or after protocol call if you would like.

arah Ellson | Partner

or Field Fisher Waterhouse LLP
Code A

----Original Message-----
rom: Code A
o: Ellson, Sarah Code A
C: Tomlinson, Tamsin Code A
ent: Wed Sep 05 13:05:04 2007
ubject: RE: Dr Barton

[ello,

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Code A

---

rom: Code A
ent: 05 Sep 2007 10:07
o: 'Ellson, Sarah'
c: Tomlinson, Tamsin
ubject: RE: Dr Barton

[ello,

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have just checked with Adjudication and the first available date for a 8 week hearing in London is from 19 May

Re: Dr Barton

)07.

Code A

·om: Ellson, Sarah Code A
ɜnt: 04 Sep 2007 17:51
o: Code A
c: Tomlinson, Tamsin
ıbject: Dr Barton

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Re: Dr Barton

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confirmation of cases to be issued shortly after our con (Oct/Nov) + poss nature of charges

draft charges and any outstanding evidence by end of 2007

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arah Ellson | Partner

or Field Fisher Waterhouse LLP

Code A

onsider the environment, think before you print!

Re: Dr Barton

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

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/eb www.ffw.com <http://www.ffw.com/> CDE823

Re: Dr Barton

ieneral Medical Council

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he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

.egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

el: 0845 357 8001
ax: 0845 357 9001

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mc@gmc-uk.org

ieneral Medical Council

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:egents Place, 350 Euston Road, London. NW1 3JN

he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

el: 0845 357 8001
ax: 0845 357 9001

RE: GMC : Dr Barton, Case Management Procedure (Old Rules)

rom: Code A
ent: 09 Aug 2007 15:05
o: Rebecca Faulkner Code A
ubject: RE: GMC : Dr Barton, Case Management Procedure (Old Rules)
ebecca,

ıave consulted FFW and we hope to make disclosure by the end of August and we should also be in a ɔsition to let the MDU know which cases we are proceeding with by then. It thus would be prudent to have ıe telecon sometime in September depending upon all parties availability.

Code A

---

rom: Rebecca Faulkner Code A
ent: 08 Aug 2007 10:14
o: Code A
ubject: FW: GMC : Dr Barton, Case Management Procedure (Old Rules)

Code A

an you help me out on the below ? Not sure how to respond on the disclosure issues she raises - is this ecessary before the telecon ?

hanks,
Code A

---

rom: Mason, Sara Code A
ent: 07 August 2007 18:49
o: Rebecca Faulkner Code A
c: [redacted], Debbie
ubject: RE: GMC : Dr Barton, Case Management Procedure (Old Rules)

ear Rebecca

hank you for your email. Ian has not have received the emails below; the email address used is incorrect. e would have responded to you if he had. Although this is an old rules case, I confirm that we would wish r Barton represented at any case management meeting arranged. I understand however that Ian still does ɔt even know with which cases the GMC plan to proceed to a hearing, and is also still waiting for further isclosure, in particular of expert evidence, from the GMC Solicitors. It would be helpful to have this ıformation and documentation before any meeting is arranged, as without it neither Ian or I are likely to be ble to make any meaningful contribution. As far as arranging the meeting is concerned, it would make ıore sense for it to be held after Ian's return (not least because I am myself away for two weeks on annual ıave the week after next). If you email me some dates this week, I will check his diary and ensure that it is ĸed on a date that he can do so there is no further delay.

look forward to hearing from you.

egards,

ara Mason
olic

-----Original Message-----
From: Rebecca Faulkner Code A
Sent: 07 August 2007 14:02
To: Rebecca Faulkner Code A Mason, Sara
Cc: Code A
Subject: RE: GMC : Dr Barton, Case Management Procedure (Old Rules)

Dear Sarah,

I understand that Mr Barker is now on leave until 28 August. Are you able to offer some assistance on the below correspondence ?

Kind regards,

Rebecca

From: Rebecca Faulkner Code A
Sent: 24 July 2007 13:43
To: Rebecca Faulkner Code A
Cc: 'Tamsin Tomlinson Code A
Subject: RE: GMC : Dr Barton, Case Management Procedure (Old Rules)

Good afternoon,

As I do not yet appear to have received a response to my below email, I would therefore, like to offer you an additional 7 days to consider this matter further. I would be grateful to receive your confirmation by **2 August 2007** if you wish to participate in the two-stage pre-adjudication case management procedure. If you are no longer representing Dr Barton, I would be very grateful if you could let me know.

I look forward to hearing from you. In the meantime, if you would like any further information, or if you would like to discuss any practical arrangements, please do not hesitate to contact me.

Kind regards,
Rebecca

RE: GMC : Dr Barton, Case Management Procedure (Old Rules)

From: Rebecca Faulkner Code A

Sent: 09 July 2007 15:13

To: Code A

Cc: Tamsin Tomlinson Code A

Subject: GMC : Dr Barton, Case Management Procedure (Old Rules)

Dear All,

We have been requested to contact you, inviting you to participate in Case Management Procedure for the hearing of Dr J A Barton.

This has been referred under Old Rules (as opposed to New Rules listing procedure that we have followed since 2004) and I would be grateful if you could indicate if you wish to take part .

The protocol requires two telephone conferences between the following parties :

GMC Adjudication Sections's listings officer (Chair)
The doctors representative
The GMC Solicitor
The GMC Caseworker

The first telephone conference called, called a Stage 3, is fixed to set a timetable for the case, including a provisional listing date, time estimate and location. The second telephone conference - called a Stage 5, is to confirm the listing date and time estimate and to resolve any outstanding procedural or legal issues.

For your reference I attach proformas of the Stage 3 and Stage 5 and also the BT Meet Me guide for assistance in dialling in to a telecon.

I would be very grateful if you could indicate to me, no later than 23 July 2007, if you wish to take part in the protocol.

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

Yours sincerely,

Rebecca
<< OLE Object: Picture (Metafile) >> << OLE Object: Picture (Metafile) >> << OLE Object: Picture (Metafile) >>

Rebecca Faulkner

Adjudication Co-ordinator
General Medical Council
Manchester DDI : Code A

RE: GMC : Dr Barton, Case Management Procedure (Old Rules)

oad London SE1 8PJ.

---

his email has been scanned by the MessageLabs Email Security System.
or more information please visit http://www.messagelabs.com/email

---

'rom: Ellson, Sarah Code A
ent: 13 Aug 2007 09:38
'o: Code A
ubject: RE: Barton

am down on 5 September but training NMC panellists 9-5 - I would prefer not to stay overnight but ould come down night before and have a meeting late on 4 September or very early on 6 September.

am in Birmingham/Rugby/Coventry 17/18/27 September which makes travelling to London less easy ıose weeks but I could come especially

have an HFEA appeal in London either 2 or 3 October but the date has yet to be confirmed - then I eed to be in the Manchester office before I go away.

'erhaps we are back to waiting for them to suggest a date.

arah Ellson | Partner
ɔr Field Fisher Waterhouse LLP
Code A

---

rom: Code A
ent: Monday, August 13, 2007 8:45 AM
o: Ellson, Sarah
ubject: RE: Barton

lello Sarah,

m on leave from 7 to 14 September. Are there any other dates when your in London in September?

Code A

---

rom: Ellson, Sarah Code A
ent: 13 Aug 2007 08:35
o: Code A
c: Tomlinson, Tamsin
ubject: Barton

Code A

‹now that you are waiting to hear from NMC about a meeting to discuss this case but I think e need to press the NMC so that we can start contacting witnesses in the knowledge of where ıy overlap may be.

ıave some time in London in the afternoon of either Monday 10 September or Tuesday 11 eptember if that is any good for you/them.

ly diary for September is filling up and I am away from 6-28 October.

arah Ellson | Partner
ır Field Fisher Waterhouse LLP
Code A

onsider the environment, think before you print!

eld Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
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'eb www.ffw.com **CDE**823

ieneral Medical Council

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:egents Place, 350 Euston Road, London. NW1 3JN

'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
ax: 0845 357 9001

rom: Code A
ent: 21 Sep 2007 09:58
o: Michael Cotton Code A
ubject: Dr Jane Barton
lichael,

eter Swain asked me to advise you that the FTPP had been provisionally listed for 8 September 2008 nd the hearing is expected to last for 40 days.

Code A

Field Fisher Waterhouse

Case Report
August 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Hall / Sarah Ellson
Date of Rule 8 letter:	Old rules
Date considered by Case Examiner:	14/02/02
Date IIS issued/FFW Instructed:	
Class of Case (1-5)	Class 5
Target date for completion of investigation:	
Interim Order Expires:	IOPs held 21 June 2001, 21 March 2002, 19 September 2002 – No orders made

Summary: Dr Barton is a GP. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis at the Gosport War Memorial Hospital. Dr Barton retired from this post in 2000. A number of complaints were made by relatives of elderly patients who had died at GWMH in 1998. The common complaint was that patients admitted to the GWMH for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. Hampshire Police carried out three extensive investigations between 1998 and 2006 and the deaths of 92 patients were examined. Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation. 10 cases were referred to the CPS. The Crown Prosecution Service reviewed the evidence and concluded that the prosecution test was not satisfied and there was insufficient evidence for criminal proceedings.

The 10 cases were ED, EL, SG, RW, ES, RL, LP, HS, GP and AC [RW and AC together with EP, AW and GR were included in the GMC rule 6 referral letter sent in 2002 after the first police referral]. There are 2 further cases where the patient's relatives have expressed an interest in the investigation.

Investigations: We have received documents (38 boxes) from Eversheds and have contacted all the family members associated with the 15 cases. We have considered the experts reports from the Police investigation and would hope to use these for the GMC investigations. We understand the Coroner is considering opening an inquest into the 10 cases identified by the Police. We have been arranging with the GMC to meet with the NMC about this case.

Recommendation: Complete review of medical records and expert reports, visit witnesses as necessary, production statements from witnesses for their Police statements, approach experts, liaise with Coroner and Police.

Listing time estimate: 8 weeks.

Counsel: Tom Kark

Listed: 8 September – 31 October 2008 **Prospects of Success:** Medium

'rom: Hall, Tamsin Code A
ent: 12 Oct 2007 16:32
'o: Code A
ubject: Barton - Expert

ıttachments: 6143936_1.DOC

li Code A

'rofessor Black, consultant geriatrician, has provisionally agreed to act as an expert in the ;arton case. He wrote reports on 11 of the 13 cases so should not have to do too much /ork. I enclose his CV for your information.

had approached Dr Wilcock, palliative care expert, but he is not willing to act.

le has quoted a fee of £200 per hour inclusive of expenses. We had budgeted £20,000 for ıe expert fees for this case. It is hard to estimate exactly what his fees will end up being, ependant on for example how much time we need him to attend of the hearing.

le is able to attend for some of the conference on Friday. Perhaps you could confirm that ou are happy for him to attend and then I could negotiate his fees with him if we then ecide to continue with his instructions. (It may be that he will agree to an hourly rate with a apped amount).

'he conference for Friday is arranged for 10:30. I look forward to seeing you then.

{egards

'amsin

;onsider the environment, think before you print!

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/eb www.ffw.com **CDE**823

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RECENT SIGNIFICANT PRESENTATIONS

Code A

Code A

CONTRIBUTIONS

Code A

Code A

Code A

Code A

Code A

rom: Code A
ent: 16 Oct 2007 10:47
o: 'Hall, Tamsin'
ubject: RE: Barton - Expert
amsin,

nank for your email,

xpert

think it's prudent for Professor Black to attend part of the conference as it may help as determine whether e also require a Pallative Care expert.

ther doctors

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fter the conference could you provide us with a revised costs estimate please.

onference

ould you let me know what time the conference is likely to finish please.

hanks Code A

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rom: Hall, Tamsin Code A
ent: 12 Oct 2007 16:32
o: Code A
ubject: Barton - Expert

li Code A

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he conference for Friday is arranged for 10:30. I look forward to seeing you then.

egards

amsin

onsider the environment, think before you print!

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
/eb www.ffw.com **CDE**823

'rom: Code A
ent: 26 Oct 2007 08:21
'o: Tamsin Hall ffw (formerly Tomlinson) Code A
:c: Code A
ubject: FW: Dr Barton
lello,

'lease note below.

m not sure what we are telling patient's families and so we are consistent I would be grateful if you would ng Mr Stevens.

hanks Code A

---

rom: Paul Hylton Code A
ent: 24 Oct 2007 09:54
o: Code A
ubject: Dr Barton

Code A

Ir Stevens just called re an update on the case. He has received a letter from FFW to explain that they ave taken over the case, but he has not heard anything since. He does phone for updates from time to me, his wife was one of the patients who died, and he is always very pleasant and polite.

you have anything that you can tell him his number is Code A

'aul

rom: Code A
ent: 26 Oct 2007 18:50
o: Tamsin Hall ffw (formerly Tomlinson) Code A
c: Code A Peter Swain Code A
ubject: Dr Barton - expert

nportance: High
amsin,

s you are aware I met Professor Black our expert last week.

rofessor Black appeared to be putting forward a number of reasons why he should not be an expert for iis case ie.

e would have reservations about being the only expert.

e h previously sat on FTP Panels.

e has not given evidence as an expert before so this would be his first case.

is employer has questioned whether his reputation could be affected by him giving expert evidence.

expressed my reservations about Professor Black after he left the meeting and I am still concerned that e may not be an effective witness in a case that will attract a lot of publicity and put him under emendous pressure.

realise that Professor Black has already provided reports on many of the cases and you were going to ook whether it was feasible for us to use Dr Ford as an expert in addition to Professor Black.

s we have a very limited timescale in which to prepare this case, I would be grateful if you and Sarah ould review whether it is appropriate to use Professor Black as an expert.

s I will now be on leave until 7 November please include Peter in your reply.

Vith thanks
Code A

Re: Barton - Expert

'rom: Hall, Tamsin Code A
ent: 18 Oct 2007 10:41
'o: Code A
ubject: RE: Barton - Expert
li Code A

have just spoken to Tom Kark and I think that you will be able to leave earlier than 4 - probably abou .30/3.00. This will then give him and I a chance to discuss some of the practicalities of working ɔgether. I don't think you'll be interested in hearing that!

is Dr Richard Reid.

ee you tomorrow. I'm getting the train down in the morning, I did yesterday too and it was delayed s opefully it will be on time in the morning!

amsin

amsin Hall | Solicitor
ɔr Field Fisher Waterhouse LLP
Code A

Code A

---

rom: Code A
ent: Thursday, October 18, 2007 8:45 AM
o: Hall, Tamsin
ubject: RE: Barton - Expert

lello Tamsin,

is fine, I just need to let colleagues know what time it is likely to finish.

hanks for providing the christian names but I meant to ask you for Dr Reid's christian name instead of rofesssor Blacks, so I can do a check on Dr Reid.

note when you will provide the costs estimate.

look forward to seeing you too.

Code A

Re: Barton - Expert

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rom: Hall, Tamsin [mailto:tamsin.hall@ffw.com]
ent: 17 Oct 2007 07:36
o: Code A
ubject: Re: Barton - Expert

i Code A

think that the conference should finish by 4, however if you need to leave earlier that is fine.

will provide a new costs estimate after the conference, once Sarah returns from holiday.

agree that the con should give us a better idea if we need a second expert on palliative care.

is Professor David Black and Dr Althea Lord.

ook forward to seeing you on Friday

amsin
amsin Hall Solicitor Field Fisher Waterhouse sent by blackberry

Iobile: Code A

---Original Message-----
rom: Code A
o: Hall, Tamsin Code A
ent: Tue Oct 16 10:47:29 2007
ubject: RE: Barton - Expert

amsin,

hank for your email,

xpert

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Veb www.ffw.com <http://www.ffw.com/> CDE823

Re: Barton - Expert

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eneral Medical Council

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he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

egus House, Falcon Drive, Cardiff Bay. CF10 4RU

) Adelaide Street, Belfast. BT2 8GD

el: [redacted]5 357 8001
ax: 0845 357 9001

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Re: Barton - Expert

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.egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
ax: 0845 357 9001

rom: Hall, Tamsin [Code A
ent: 12 Oct 2007 16:59
o: Code A
ubject: Instructions to Counsel (Barton).DOC

ttachments: DOCS_6067584_1.DOC

i Code A

YI a copy of our instructions to counsel in advance of the hearing next week.

amsin

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP
Code A

lobile Code A

onsider the environment, think before you print!

eld Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
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/eb www.ffw.com **CDE**823

IN THE MATTER OF The General Medical Council

AND

IN THE MATTER OF Dr Jane Barton

Instructions to Counsel to advise and draft charges and Brief to Counsel to represent the General Medical Council at a Fitness to Practise Panel Hearing

Counsel will find enclosed copies of the following:

Master File

1. Medical Act 1983 (as amended).

2. The General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988.

3. Transitional provisions:-

   (a) Schedule 2 of the Medical Act 1983 (Amendment) Order 2002.

   (b) GMC Guidance "Main Provisions of the Transitional Arrangements".

4. Rule 6(3) letter dated 11 July 2002 and PPC papers

5. Summary documents:-

   (a) Table of cases

   (b) Professor Richard Baker's statistical review of mortality rates (to follow)

   (c) Summary prepared by Hampshire Police.

   (d) Analysis prepared by Eversheds Solicitors.

   (e) CHI report.

(f) Summary analysis prepared by Field Fisher Waterhouse including analysis of witness evidence and transcripts and summary of expert reports.

6. Minutes of protocol call 6 September 2007

7. Indicative Sanctions Guidance

8. R (Bevan) v GMC [2005] EWHC 174

9. Relevant copies of Good Medical Practise

Individually labelled folders in relation to each patient containing

- Medical records[1]
- Witness statements and interview transcripts
- Expert evidence

3 File(s) of expert evidence (all in one set of folders for ease of reference)

Introduction

1. Instructing Solicitors act for the General Medical Council with whose Act and Rules Counsel is familiar (enclosures 1-3). Counsel will be aware that the General Medical Council's new Fitness to Practise Rules took effect on 1 November 2004.

2. However, concerns in relation to Dr Barton were reported to the General Medical Council prior to this date and the Preliminary Proceedings Committee decided to refer the case for inquiry before a Professional Conduct Committee of the GMC on 11 July 2002 (enclosure 4). For reasons set out below the case is only now ready to proceed and will, under the transitional provisions, be considered by a Fitness to Practise Panel applying the "old" rules from 1988 (as amended).

---

[1] Instructing Solicitors have identified problems with the medical records. Some are illegible or poorly copied and further copies or originals may be required. At present Instructing Solicitors do not have any x-rays or similar documents. The experts refer to materials on CD-ROM which we do not have at present. In terms of pagination the documents received from the police were paginated but inconsistently (and apparently in a different way to those on CD-ROM) – Instructing solicitors have had the records repaginated for each patient but the previous pagination should still be evident. Some cross-referencing may be required as the case progresses.

3. The case has been listed for hearing in 2008 with a provisional start date of 6 October 2008 and a time estimate of eight weeks.

Background

4. Counsel is referred to a number of summary documents which are enclosed at enclosure 5. These outline the background to this matter in some detail which will not be repeated in these instructions.

5. In summary Dr Jane Barton was a clinical assistant in elderly medicine at the Gosport War Memorial Hospital, Community Hospital in the Gosport area. She was also a part-time partner in general practice.

6. The concerns about Dr Barton's practise all relate to her work at the Gosport War Memorial Hospital and relate to elderly patients who were admitted either to Dryad Ward or Daedalus Ward.

7. Some patients were admitted for palliative care; others were admitted for rehabilitation following hospital admission or for respite care – their conditions were not considered to be terminal. The circumstances in which patients were admitted are quite wide ranging and there appear to be significant variations as to their prognoses.

8. In some cases patients were only expected to stay for a relatively short period and it was anticipated that they would return to their own home or, more often, residential care or nursing homes. Some patients remained on the ward for a considerable period and in some cases deteriorated such that their prognosis for discharge became less likely.

9. However, family members became concerned following the deaths of their relatives at Gosport War Memorial Hospital. The allegations in this case largely relate to the administration of opiate based medication, very often provided in syringe-driver form to these elderly patients. It will be the appropriateness of the prescription and administration of these opiate medications which will be at the heart of the General Medical Council case, together with more wide-ranging concerns about record keeping, proper assessment and treatment and the combination and quantity and method of delivery of medication provided.

10. The first family to raise concerns were the family of Mrs Gladys Richards who died in 1998 aged 91. Further details of her case are set out in the PPC papers (enclosure 4) and attached analysis documents (enclosure 5). Her daughters Mrs Mackenzie and Mrs Lack complained to the Hampshire Police about the treatment given to their mother and allege that she had been unlawfully killed.

11. Hampshire Police (Gosport CID) conducted the first police investigation in 1998/99. In early 1999 the CPS determined that a prosecution could not be justified and the matter was closed.

12. Mrs Mackenzie then made a formal complaint which was upheld and resulted in a review of the first police investigation.

13. Further work was undertaken between 1999 and 2001, including obtaining expert evidence. However, in August 2001 the CPS advised that there remained insufficient evidence to sustain a realistic prospect of a conviction.

14. There was subsequent local publicity which resulted in other families raising their concerns and four more cases were selected for review (Cunningham, Wilkie, Wilson and Page).

15. Further expert evident was obtained in relation to these cases and material was forwarded to the General Medical Council (and the Nursing & Midwifery Council and the Commission for Health Improvement).

16. This resulted in a consideration by the Preliminary Proceedings Committee and the Rule 6(3) letter referred to above. Council will note that all five of the cases mentioned were included in the PPC referral (Richards, Cunningham, Wilkie, Wilson and Page).

17. Shortly after the referral by the Preliminary Proceedings Committee of the General Medical Council Hampshire Police contacted the General Medical Council to indicate that they would be undertaking a new and far more extensive inquiry into the deaths of elderly patients at Gosport War Memorial Hospital.

18. In the intervening period (2001/2) evidence had been obtained from Professor Richard Baker (a statistical review of mortality rates), the Commission for Healthcare Improvement had reported and there were ongoing concerns in the local media.

19. The General Medical Council agreed, in accordance with usual practice, to give the police investigation primacy and the General Medical Council's investigation was held in abeyance while the police undertook their further work.

20. A total of 92 cases were investigated by the police during this third investigation and a team of medical experts were involved. The investigation was titled Operation Rochester.

21. As a result the cases were divided into three categories: optimal care, sub-optimal care and negligent care. Ten cases were considered to raise the most significant issues and

detailed files of evidence were prepared and submitted to the Crown Prosecution between December 2004 and September 2006 for advice.

22. In late 2006 the CPS determined that no cases would proceed with criminal investigation or charges and the entirety of the information gathered by the Hampshire Police was passed to the General Medical Council.

Field Fisher Waterhouse Involvement

23. Field Fisher Waterhouse has prior involvement with this case on a number of occasions.

24. Judith Chrystie of Instructing Solicitors was instructed when the case was referred in 2002 and was involved in the IOP and the initial stages of the investigation. She met with the CHI and began work on the case before we were asked to cease work to give the police investigation primacy.

25. In an entirely separate capacity Field Fisher Waterhouse were approached in their role as Specialist Advisers to police investigations and Matthew Lohn of Instructing Solicitors was asked to assist Hampshire Police with Operation Rochester. Accordingly Matthew Lohn acted as an adviser to the investigation assisting with the instruction of experts and indeed with the categorisation and some screening of cases. At this stage it was not possible for Field Fisher Waterhouse to also act for the General Medical Council. The potential conflict arose because at that stage the police investigation included materials which they would not wish to disclose to the General Medical Council nor, via the GMC, to disclose to Dr Barton.

26. During this 2003/4 period Judith Chrystie was again briefly involved in the issue of principle of getting documents from police forces for GMC proceedings.

27. Accordingly, when the General Medical Council received the additional information from the police in 2006 they initially decided to instruct Eversheds Solicitors to prepare the case for hearing. Subsequently this decision has been revisited and the matter was passed to Field Fisher Waterhouse in April of this year. The papers were received from Eversheds Solicitors in May 2007.

Procedure

28. The General Medical Council have already determined that the five cases referred by the Preliminary Proceedings Committee ought to proceed to the Fitness to Practise Panel. As these matters were referred prior to 1 November 2004 they must proceed in accordance with the transitional provisions and the provisions of the 1988 Rules.

29. The additional material received in 2006 could be treated differently but would result in the General Medical Council having two different cases against Dr Barton, one alleging serious professional misconduct under the old Rules, the other alleging impairment of fitness of practise by reason of misconduct under the new Rules.

30. This was considered to be unsatisfactory and accordingly the proposed approach, which has been indicated to the Defence, is that additional cases will be added under the proviso to Rule 11(2). This states that "*provided that, where the Committee refer any case relating to conduct to the Professional Conduct Committee and the Solicitor later adduces grounds for further allegations of serious professional misconduct of a similar kind, such further allegations may be included in the charge or charges in the case, or the evidence of such grounds for further allegations may be introduced at the inquiry in support of that charge or those charges, notwithstanding that such allegations have not been referred to the Committee or formed part of the subject of a determination by the Committee.*"

31. Field Fisher Waterhouse has advised that the new matters are allegations of a similar kind that can properly be added to the five cases already referred.

32. Whilst the General Medical Council expects that some cases will be added to those already referred, the procedure for doing this is devoid of any formal procedural step. There is no point at which additional cases will be considered either by a Committee or Case Examiners. The expectation is that some of the ten additional cases (eight of which were not formally part of the GMC case) may be appropriately added to the charge.

33. However, the General Medical Council will seek Counsel's advice on this decision since it is a decision which will affect a number of families. For example some families both within the ten and outside the ten but within the 92 cases considered during the third police investigation, have asked that their case be included at the GMC's proceedings.

34. Counsel will understand the GMC's anxiety to find the appropriate balance of cases to be brought whilst keeping the case within manageable bounds.

35. The expectation given to the Defence is that a maximum of all eight additional cases will be added (totalling 13 examples) although it has been made clear that this is a matter for Counsel's advice.

36. Counsel will also be invited to consider whether all of the five cases currently referred ought to proceed. However, the General Medical Council consider it a sensitive decision were it to be decided not to proceed with any of the cases already referred.

This would require the cases to be cancelled on the basis that the matters ought not to be included.

37. The interpretation of the transitional provisions means that these cases would be considered by a member of the Investigating Committee under Rule 28 of the new Rules. A decision that any of these matters ought not to proceed would be susceptible to judicial review by the families involved.

38. It is recognised that the outcome might be that weak cases within the initial five may proceed but only a limited number of additional (strong) cases will be added under the proviso to Rule 11(2). Families not included may argue that their case could be stronger than ones already included by virtue of the Rule 6(3) decision.

Expert Evidence

39. Instructing Solicitors have carefully considered the expert evidence available in this case (and provided to Counsel in separate files). Both they and the General Medical Council have analysed the differing opinions expressed by the experts in this case.

40. Overall, having reviewed the quality of the reports and the suitability of the reports for the evidence required at a General Medical Council Instructing Solicitors' view was that Dr David Wilcock would be the most suitable expert for these proceedings.

41. Unfortunately, on contacting Dr Wilcock he has indicated that he would not make himself available for the work which would be required to proceed with this matter at a GMC hearing.

42. The second most suitable expert appeared to Professor Black. We believe that Professor Black has reported on 11 of the 13 cases which are most likely to form the charge at the Fitness to Practise Panel hearing (he also worked on a number of cases which later were classed as category 1 or 2 and did not proceed).

43. Additionally, Professor Black has indicated an initial willingness to assist with the GMC case subject to certain requirements being met in terms of his fees and also from his employer who will need to release him and provide suitable cover for his position (as a Post Graduate Dean) during September/October 2008 when he will be required to attend the hearing.

44. Professor Black's expert reports are contained within the file of expert material provided to Counsel in this matter. We understand his reports are based only on the medical records and that he did not see any witness statements. Counsel will note that his conclusions are such that we might not proceed in the following cases:-

(a) Cunningham - where Professor Black suggests that while he has questions the terminal care of this patient was managed appropriately

(b) Pittock – possibly as Professor Black indicates a symptomatic approach was appropriate

(c) Service – where Professor Black thinks that although the dose of diamorphine and midazolam was higher than necessary it would have made very little to difference to the prognosis.

(d) Gregory – where Professor Black criticised poor documentation and the lack of examination/assessment he says the overall management was adequate.

45. Counsel will need to consider and advise upon whether we proceed on this basis or whether, in the circumstances of there being other material (eg Dr Wilcock's reports), which do in fact criticise Dr Barton's conduct in those cases, further expert evidence ought to be obtained.

46. Professor Black has indicated that it might be appropriate to secure additional expert evidence from other experts including a palliative care expert (he is a geriatrician Dr Wilcock provided palliative expertise) but Counsel will be aware of the need to balance this issues with a sense of what is necessary and proportionate for this case. Professor Black appears to be a little reluctant to be the sole expert in this case – a better assessment may be possible after the conference.

Defence

47. Dr Barton is represented by Ian Barker of the Medical Defence Union. Mr Barker has been involved in the case for at least nine years although given the limitations of police disclosure he has only seen very limited materials to date. Instructing Solicitors are currently copying and disclosing police material to him and have already provided him with the expert reports obtained by the police.

48. Instructing Solicitors have a good working relationship with Mr Barker and have had constructive discussions to date about how the case is likely to proceed. The MDU have indicated that they are likely to require full disclosure including of unused materials since they believe there may be cases upon which they wish to rely in their defence.

49. Instructing Solicitors have some concerns that the approach should be kept narrow and only relate to the cases upon which the GMC decide to proceed but clearly for the purposes of disclosure must give access to the Defence as requested. They would

want to resist any defence attempt to discuss these cases in terms of statistics or by drawing irrelevant comparisons with other cases.

50. It is understood that the MDU will instruct Alan Jenkins and Tim Langdale to represent Dr Barton at the forthcoming Fitness to Practise Panel hearing.

51. It is not yet known whether the Defence will seek to make legal arguments at the outset of the case. Of course on the face of the charge it will be evident that the matters arose nine to ten years prior to the hearing date (1998/9). However, for the reasons set out above the progress of the case has been affected by ongoing police investigations and in terms of the listing of the hearing the Defence resisted the suggestion that the case should be listed earlier in 2008 indicating that they would not be ready.

52. If the issue of delay is raised Counsel will no doubt be assisted by detailed chronologies which can be prepared by Instructing Solicitors if required.

53. It is understood that Dr Barton's defence will be on the basis that she was working in a busy and demanding post and in the circumstances it was appropriate for her to delegate to nurses in the way she did. That her prescribing of these medications was appropriate and it was for nursing staff to administer them appropriately as required (and to certify death in some cases). She will say her treatment was adequate and appropriate.

Analysis

54. Counsel is referred to the bundles prepared in relation to each case which may form part of the charge in this matter. In each file he will find the medical evidence and witness statements relevant to the patients.

55. Instructing Solicitors have spent considerable time analysing the witness evidence and in the analysis document at enclosure 5(f) Counsel will find recommended reading which identifies the statements upon which Instructing Solicitors believe we will need to rely. In the limited time available Counsel may wish to leave to one side those statements not recommended although ultimately we will need to form a view as to whether any other witnesses need to be contacted.

56. Instructing Solicitors have included their analysis, and the analysis prepared by Eversheds Solicitors, in relation to the merits of these cases and invite Counsel's considered opinion on which cases should proceed.

Miscellaneous

57. During the course of their investigation Instructing Solicitors have learnt that local pressure has been brought to bear on the Coroner for East Hampshire. He has contacted the Home Office to discuss whether inquests should be reopened in relation to a number of deaths as Gosport War Memorial Hospital and the circumstances in which this would require the exhumation of bodies which were not cremated.

58. The Coroner has indicated that the General Medical Council should proceed with its investigation whilst continuing to remain in contact with the Coroner.

59. In addition the Nursing & Midwifery Council has contacted the General medical Council to discuss the ongoing investigation. It is proposed that representatives from both organisations, together with Instructing Solicitors, meet to discuss any overlap in the case. Instructing Solicitors will not act for the Nursing & Midwifery Council on this matter as this might create a conflict. However, Counsel should be aware that even so there may be difficulties obtaining evidence from nurses who may be required to answer to their own regulatory body in relation to their conduct in this matter.

60. A similar issue arises in relation to two of the other doctors mentioned in these papers, Dr Reid and Dr Lord (who we expect to require as witnesses). As yet the General Medical Council has not determined how to proceed in relation to these doctors and Instructing Solicitors have asked for clarification as to whether there are currently opened matters against them.

Investigation

61. Instructing Solicitors' approach to this case is that, insofar as possible, the extensive evidence, already obtained by the police, should be utilised.

62. In Instructing Solicitors' experience taking further witness statements at this late stage is unlikely to serve any useful purpose and significantly increases the possibility of inconsistency and related issues of credibility amongst witnesses.

63. In addition there has been ongoing and ever increasing publicity in relation to this matter and some witnesses have been given some information from the police which again might be said to influence their perception of events.

64. However, Instructing Solicitors recognise that it may be necessary, for the purposes of the General Medical Council's proceedings, to secure further evidence from some witnesses and/or to address with them specific issues relating to the expert evidence which may assist in clarifying areas where the expert has been unable to reach a conclusion.

65. Additionally Instructing Solicitors do not underestimate the need to establish a rapport with those upon whom it will seek to rely at the forthcoming hearing. Accordingly it is proposed that Instructing Solicitors should agree with Counsel a list of likely witnesses and Instructing Solicitors will contact those witnesses to explain the GMC's procedures and that they may be required to give evidence in accordance with their police statement (and/or additional statement).

66. Instructing Solicitors are also seeking to obtain any statements given to the CHI inquiry so that all evidence given by any particular witness is available for the parties at the GMC's proceedings.

67. Instructing Solicitors would also seek to use the expert evidence already prepared insofar as it is suitable. They anticipate that Counsel may advise that the expert should prepare a new consolidated report to deal with the GMC case (once the cases to be used have been identified). However, insofar as is possible Instructing Solicitors should like to rely upon reports previously prepared so that again consistency is achieved and appropriate material can be used at the GMC.

68. Instructing Solicitors believe that they have the medical records required for this hearing but will need to consider with Counsel whether there are additional documents which may be required for the GMC hearing.

69. This case, as an old rules case, falls outside the recent protocol used by the GMC to prepare for hearings (and will not fall under the case management provisions of Rule 16 of the 2004 Rules). However, as indicated above, Instructing Solicitors have a good working relationship with the MDU and do believe that a sensible timetable can be agreed.

70. Thus far a protocol call took place on 6 September 2007 and a copy of the minutes of this call are attached at enclosure 6.

Instructions

71. Counsel is asked to review the material provided and to indicate if there are further materials which he would wish to receive. In particular Instructing Solicitors have not copied materials from the other police cases (category 1 and 2 cases) which the defence have indicated they will wish to review.

72. Counsel is asked to advise in conference which has been arranged for Friday 19 October 2007 which will be attended by Tamsin Hall of Instructing Solicitors, Code A Code A (GMC caseworker) and Professor Black. If available Matthew Lohn will also attend this conference.

73. The purpose of the conference is to discuss a preliminary approach to the case and the work to be undertaken to progress matters over the remaining weeks of 2007.

74. Counsel will note from the protocol call minutes that the General Medical Council have agreed to serve evidence and to provide a finalised charge on or before 18 January 2008.

75. Counsel is instructed to consider which of the cases ought to proceed and be included within the General Medical Council's charge and he will be asked to provide written advice in relation to those (police category 3) cases which are not proceeding so that the General Medical Council have sufficient evidence of the rationale behind their decision not to add certain cases. Similarly Counsel will be asked to provide a separate advices in relation to any currently referred cases which he considers ought not to proceed.

76. Counsel is asked to advise on the witness evidence and documentary evidence to be secured and the expert report to be prepared for the GMC's hearing.

77. In due course (in December 2007) Counsel will be asked to finalise the charge to be served in this matter.

78. Counsel is briefed to attend to represent the General Medical Council at the Fitness to Practise Panel hearing currently listed to commence on 8 September 2008.

79. As Counsel knows, in due course the GMC will provide instructions regarding Counsel's submission on the appropriate sanctions. As a result of the Bevan case (enclosure 8) the GMC has agreed set wording which all Counsel must use when making a submission on sanction. The GMC have asked that Counsel do not deviate from the set wording which is as follows:-

"Pursuant to Paragraph 19 of the Indicative Sanctions Guidance the decision as to the appropriate sanction to be imposed in this case is, of course, a matter for the Panel exercising your own judgement. What I am about to say are the GMC's submissions, which are to assist you in making your decision and are made in relation to the determination you must reach under Rule 30."

80. Overarching responsibility for this case rests with Sarah Ellson (email: Code A telephone: Code A) who will be supervising Tamsin Hall who has day to day conduct of the matter. Should Counsel have any questions he should not hesitate to Tamsin Hall Code A telephone: Code A Code A Regrettably Sarah Ellson will be on annual leave from 6-28 October 2007 and is therefore unavailable to attend the conference. However, it was considered

important to progress matters in this way and Sarah Ellson will be fully appraised of the discussions held at the conference on her return.

Field Fisher Waterhouse
4 October 2007

IN THE MATTER OF The General Medical Council

AND

IN THE MATTER OF Dr Jane Barton

Instructions to Counsel to advise and draft charges and brief to Counsel to represent the General Medical Council

Mr Tom Kark
Hollis Whiteman Chambers
3rd Floor, Queen Elizabeth Buildings
Temple
London
EC47 9BS

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel: +44 (0)20 7861 4000 **Fax:** +44 (0)20 7488 0084
E-mail: info@ffwlaw.com **Website:** www.ffwlaw.com **CDE:** 823

rom: Code A
ent: 16 Nov 2007 12:01
o: Tamsin Hall ffw (formerly Tomlinson) Code A
c: Code A
ubject: FW: Dr Barton
amsin,

lease note below re Mr Stevens, I'm trying to find the witness statements and will revert to you.

Code A

---

rom: Ryder, Robert Code A
ent: 14 Feb 2007 16:58
o: Paul Hylton Code A
ubject: Dr Barton

*** Before acting on this email or opening any attachment you are advised to read the Evershed isclaimer at the end of this email. ****

ear Paul
spoke to a Mr. Earnest Stephens today, the husband of one of Dr Barton's patients. He mentioned that e had been in touch with you and that you, in turn, had suggested that he contact me. He is unhappy bout the way the police dealt with his wife's case, initially treating it as one of the strongest cases, but ubsequently "down grading " it. I explained that I couldn't really comment on this, which he accepted. le then wanted confirmation that I have received all the papers relating to his wife - medical records and itness statements taken by the police. Following the conversation with him, I have checked the position. Ve do have a set of medical records, which were sent to us by the GMC sometime ago, but we do not ave any other documents, including the witness statements. When I spoke to him he said that the itness statements had been sent to the GMC.
laving checked which documents we currently hold, I need to revert to him. Before doing so, I need to onsider with you how I should best deal with him. I assume that he believes that we, on behalf of the MC, will be looking at his wife's case, and that he has been in touch to make sure that I have all the elevant paperwork. Mrs Stephens's case is not included in the 13 cases which I am currently looking at, s her case was not included in the "top ten" catagory 3 cases and is not one of the cases which have lready been referred .
s mentioned when we last spoke there is a huge amount of material to consider with reference to the 10 atagory 3 cases - over 50 lever arch files, and the police are going to send me some more papers hortly relating to their investigation of 3 of the 5 patients who have already been referrred to the anel, but which do not feature in the "top Ten". I am making good progress in the reading in process and y the end of the week will be able to send you my initial views - at least with reference to the top ten ases, (pending receipt of the further documentation from the police relating to the other cases)
nd based on a selected reading of the files.
he point I need you to consider in the meantime is whether I am authorised to look at any other cases , ncluding the case relating to Mrs Stephens, or whether I explain to Mr Stephens and any other relatives who contact me with similar requests, that for present purposes we have been instructed to review only a

ertain number of cases.
egards
ob

irect Dial: Code A

iternational: Code A
ww.eversheds.com

******** This email is sent for and on behalf of Eversheds LLP *********

'versheds LLP is a limited liability partnership, registered in England and Wales, registered umber OC304065, registered office Senator House, 85 Queen Victoria Street, London EC4V JL. Regulated by the Law Society. A list of the members' names and their professional ualifications is available for inspection at the above office.

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********** [http://www.eversheds.com/] **********

'rom: Code A
ent: 16 Nov 2007 11:56
'o: 'Hall, Tamsin'
:c: Code A
ubject: RE: GMC v Dr Barton - Attendance note of con with counsel
lall,

hank for you for your thorough notes, my comments in respect of issues arising from the notes are:

rthur Cunningham

ust to clarify the PPC considered the expert reports of Dr Mundy and Professor Ford.

raft charges

'eter is of the view that Tom should provide charges where narrative is kept to a minimum and that he hould **not** provide a summary to accompany the charges as previously indicated by me. However, [redacted]er dvises that Tom could draft his opening speech in advance and let Panel members have a copy of it, if e considers that it would assist them.

lastening death allegations

om is of the view we should not include such charges. However, Peter is of the view that if expert vidence supports such
harges they should be included as if we leave them out we would be open to criticism from CHRE for nder prosecuting the case.

lsie Devine

'eter is of the view that we could proceed with this case on the basis that it adds to the pattern of Dr arton's behaviour but not because we would be criticised by the family if we did not proceed.

ther Doctors

om is due to provide advice concerning Dr Tandy and Dr Lord. He will also need to provide advice in espect of Dr Richard Reid who has also been criticised by Dr Wilcock.

Code C

---

rom: Hall, Tamsin Code A
ent: 08 Nov 2007 12:21
o: Code A
Code A

c: Ellson, Sarah
ubject: GMC v Dr Barton - Attendance note of con with counsel

lease find attached the note of our recent conference. If you would like me to make any mendments then please let me know.

hanks

amsin

onsider the environment, think before you print!

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'eb www.ffw.com **CDE**823

'rom: Hall, Tamsin Code A
ent: 08 Nov 2007 12:21
'o: Code A
Code A
:c: Ellson, Sarah
ubject: GMC v Dr Barton - Attendance note of con with counsel

ıttachments: DOCS_6237097_1.DOC

'lease find attached the note of our recent conference. If you would like me to make any mendments then please let me know.

'hanks

'amsin

:onsider the environment, think before you print!

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Field Fisher Waterhouse

attendance note

Name:	**Tamsin Hall**	Call type:	**Conference**
Att:	**Tom Kark ("TK"), Tamsin Hall ("TET"), Code A Professor David Black ("DB") (from 12 noon-2pm)**	From:	
Duration:		Date:	**30 October 2007**

General Medical Council – Dr J Barton
Conference with Counsel 19 October 2007

1. TK giving overview of the cases which he considers a reasonable prospect of success:-

   (a) Eva Page:-

      (i) Eversheds think this is a weak case and that it needs full investigation. TK agrees with this.

      (ii) Professor Ford's report seems to say there is a reasonable prospect of success but DB has not given a report in this case. Provided that DB agrees then we have got a case.

      (iii) If we are looking at this case individually then TK thinks there would be no case but this adds to the pattern of it happening time after time.

      (iv) TK observed that Dr Barton was prescribing opiates almost straightaway and using an excessive dose range and putting the patients onto a syringe driver very quickly.

   (b) Alice Wilkie:-

      (i) Eversheds comment that there was a detailed investigation.

      (ii) Professor Ford is critical and there will be a reasonable prospect if DB comes up with the same.

(c) Gladys Richards:-

(i) Eversheds say that there is a good prospect.

(ii) DB thinks that the dosage was excessive and the treatment was "highly suboptimal".

(iii) TET noted that the witnesses in this case are high maintenance.

(iv) TET and TK agreed that this was fortunately not a case where we would need to advise cancellation.

(d) Arthur Cunningham:-

(i) This case has been referred, JSB confirmed this.

(ii) TK asked what evidence did the GMC have to make the decision to refer? Code A confirmed that they would not have had any of the expert reports when they made the decision to refer.

(iii) DB, in his report, states that the treatment was "managed appropriately" and reasonable management decisions were made. His only concern is that on 25/26th the dose was too high but it only shortened his life by a few days/hours.

(iv) The excessive dosages were prescribed by Dr Barton but were not given. DB says that "other practitioners may have followed a similar course".

(v) TK thinks that on the face of it this is the weakest referral.

(vi) TK said we will need to go through this in detail with DB.

(e) Robert Wilson:-

(i) TK commented that this is a good report by DB.

(ii) DB is critical of the dose. Code A There is a negligent dose of oramorphine, Dr Barton also failed to obtain senior medical opinion.

(iii) The Defence will say that Dr Barton acted on her own and that there was no cover. TK has read that one consultant was off for ten months. However, in TK's opinion, this is considerable mitigation but does not justify the lack of notes and the prescribing regime.

(iv) TK querying if DB will say that if one is prescribing a major drug then you would need to give a legitimate reason.

(v) TK said that we will require some evidence about the set-up at the hospital.

(vi) TK thinks that this case has a reasonable prospect of success.

(vii) There are also reports from Mundy & Marshall.

(viii) We will need to proceed with caution here because if we go to the best report then we will be accused of cherry-picking and the Defence may decide to call the other experts who are not supportive.

(f) Elsie Devine:-

(i) TK thinks that we need to think carefully about this case.

(ii) DB is critical about the usual lack of documentation.

(iii) The starting dose is higher than conventional but the case is quite weak/thin.

(iv) TK thinks that we probably have not got a great case here.

(v) TK noting that the police were looking at criminal charges and essentially looking to see if drugs shortened life. This is not our concern. We need to look at the adequate nature or otherwise of the prescribing and we not need to prove if this did shorten life at all. The question here is was it right to prescribe these drugs in the first place. If we are effectively looking at manslaughter about the shortening of life issue then this is too high for GMC proceedings. Our case is that Dr Barton did not make notes, even though she was rushed off her feet she should have done so. Also that it was simply not appropriate for her to prescribe the drugs in this fashion or at that dose.

(g) Elsie Lavender:-

(i) DB thinks that there was an inadequate assessment and the prescription was excessive and there was a failure to get specialist opinion.

(ii) TK thinks that we stand a reasonable prospect of success.

(h) Sheila Gregory:-

(i) At the moment we have got difficulties here. TK remarked that DB and Dr Wilcock provided reports. TET confirmed that Dr Wilcock is not willing to give evidence. TK and TET agreeing that this is a shame as his reports are

very good. TK observed that Dr Wilcock's report was a lot better on this case but we cannot pick and choose. Dr Wilcock says that there was no justification for opiates.

(ii) DB says that this is poor management but was just about adequate. DB does express concerns about the prescription of opiates in anticipation.

(i) Enid Spurgin:-

(i) TK thinks that this case stands a reasonable prospect of success.

(ii) DB said that the medical assessment was inadequate and Dr Barton immediately started analgesia. DB then goes on to say that the use of a syringe driver was appropriate but that no medical note was made.

(iii) TK said that we will need to ask DB about this in more detail.

(iv) DB also said that the starting dose was inappropriate.

(v) TK's understanding is that opiates should only be used if the pain is not be controlled. The problem in using opiates is that some react differently or badly, for example, some may be confused or fall over so if a doctor starts a patient on opiates then they need a really good reason. Dr Barton's problem is that she does not record any reason. Also a question that TK would like an answer to is if a patient can take opiates orally then why use a syringe driver?

(j) Ruby Lake:-

(i) DB criticises the usual failure to record notes and poor prescribing. There was also a failure to investigate a potential heart attack and DB goes as far as to say that the decision to start the syringe driver was "negligent".

(ii) In TK's opinion this is quite a strong case.

(k) Leslie Pittock:-

(i) DB criticises the documentation/notes and says that this patient was started on three times the conventional dose of diamorphine. This dosage may have shortened life and certainly led to excessive sedation.

(ii) TK said this is another reasonable case.

(l) Helena Service:-

(i) DB's report is quite thin on the ground. TET noted that it is in a different format to the other reports.

(ii) The doses used were higher than necessary and may slightly have shortened life.

(iii) TK and TET discussed whether or not we need to prepare another report. The one we have is a bit thin.

(iv) Dr Petch prepared a report to the police and he says that the treatment was appropriate. TK commented that were we to proceed with this case then we can expect that the Defence will call a converse opinion.

(v) Dr Petch was a consultant cardiologist and has not written reports on any other patient.

(m) Geoffrey Packman:-

(i) TK thinks this is a strong case.

(ii) TK and TET discussed how much witness evidence would be right to call.

(iii) In the case of Packman DB is critical of the notes and the decision to offer symptomatic care. There was also too high a starting dose.

(iv) TET commented that there is family evidence and an interview from Dr Barton. TK says that we need to look very carefully at which evidence we call.

2. Witness evidence:-

(a) TK and TET discussed that nurses had raised concerns in the early 1990s and we wondered why nothing had been done at that time. Dr Barton apparently also had concerns which she raised.

(b) Tim Langdale is defending. TK said that he is a very serious player and certainly will not stand idly by whilst we call potentially prejudicial evidence to them.

(c) We will need to think very carefully about which witnesses we do call.

3. Hospital Visit:-

(a) TK thinks that it would be a good idea for TET and himself to visit Gosport War Memorial Hospital to get an idea of where everything is.

4. Timeframe:-

(a) TK has got concerns about the timeframe agreed. The hearing is listed for the start of September 2008 and the Defence will need time. TK is conscious that we do not want to impose unreasonable time constraints upon ourselves.

(b) Alan Jenkins had phoned TK and said that he had heard that we were putting the hearing date back. TK did not know where Alan Jenkins had got this information from. TET confirmed that she had spoken to Ian Barker and said that we were having a conference and one of the issues we would be discussing would be timeframes but that she had not said anything about changing those timeframes.

(c) TK thinks that we should be able to meet the hearing date if we stick to one expert. The amount of investigation we need to do is reasonably limited.

(d) TK is very concerned about the time limit of 18 January 2008 to disclose the final charges. TK has a large GMC case starting shortly and is fully booked until 22 December. Realistically he will not be able to do much work until the end of the year. TK has told his Clerks to keep January free. In his opinion 18 January 2008 is unrealistic and he thinks we are entitled to say a few more weeks.

(e) Code A agreed that we should propose Friday 1 February 2008 for us to disclose to the Defence.

(f) TK and TET agreed that we will need to do a lot of work before then and TK commented that even given the extension he will not have had time to read every document by then and he will concentrate on the medical records.

(g) The GMC will need to receive the charges by 21 January 2008. JSB confirmed.

5. Medical records:-

(a) As a matter of priority TK proposed that we will need to re-order the medical records. The copies we have at the moment have been repaginated by FFW but TK thinks they may be out of order and there is a lot illegible records.

(b) TET will try and obtain the originals.

(c) The records need to be put in chronological order.

(d) TK wants a paralegal to start working straightaway on the medical records and make sure that the nursing notes are in chronological order, the medical records are in

chronological order and the drug records are in chronological order.

(e) TK does not want the old pagination taken off but will want a new pagination put on in the bottom right-hand corner.

(f) TK thinks this is a matter of priority.

(g) TET will need to tell the Defence that we will re-order the records.

(h) Two sets of medical records will need to be sent to Counsel, one for him and one for the Junior.

(i) TK proposed that whilst he was in Manchester for his big case he will come into the office and see what the paralegal is doing with the records.

6. Junior:-

(a) Code A and Peter have discussed this already. TK regards it as crucial in a case this size and Code A agreed that this is preferable.

(b) All agreed that a Junior would be used in this case.

(c) TK/TET to discuss who would be appropriate to use.

(d) We will instruct a Junior immediately so that TK can split the tasks and we can meet the deadline.

(e) Another copy of the witness statements and expert reports will need to be sent to the Junior.

7. Disclosure:-

(a) Given the dates TK thinks that he will not have read all the statements by then.

(b) When we disclose in February this means we will need to send a provisional list of used and unused evidence only.

8. Dr Lord and Dr Tandy:-

(a) Dr Lord was off for a lot of the relevant time.

(b) TK says that we need to consider if we need to call Dr Lord and Dr Tandy as witnesses. Some of the expert reports are very critical of them.

(c) JSB asking if we should instigate an investigation against these doctors. She was

asking TK for advice. JSB's concern is that we will be criticised if we go ahead with only one doctor when we have got evidence against other doctors.

(d) Is there a case against these doctors? TK said that Dr Barton says that these consultants regularly reviewed the prescriptions.

(e) TK said we either prosecute the doctors, take statements or leave them alone.

(f) TK will prepare some advice on this at the same time as the draft charges.

(g) Code A confirmed that these will be under the new rules and to add new complaints against Dr Tandy and Dr Lord would be a major headache. We would only be able to criticise Drs Lord and Tandy for supervision. The cases would not be able to be joined to Barton and would be separate cases.

(h) TK needs to concentrate on the Dr Barton case but will provide advice on Drs Lord and Tandy in due course.

9. General Statements from the Trust:-

(a) TK says that we need evidence as to the set up at the Trust. TET confirmed this is something that we certainly have not got at the moment.

(b) We agreed that they would probably want to be involved to give their perspective.

(c) TK querying whether it would an idea for TET to go to the Trust and sit down with them and find out some more background information and also allow them to be involved.

10. Jean Stephens/Edna Purnell

(a) TK confirmed we need to get hold of the notes and send them over to DB.

(b) TET will go back and look at what happened in these cases and whether or not we are updating the relatives.

11. Survival Prognosis:-

(a) DB confirming that we are not seeking to prove that any treatment hastened death and he would strongly argue against including this as a charge. The main issue here is adequate prescribing.

12. Professor Black:-

(a) We will need to provide a list of questions to him to deal with the areas he has not

already dealt with.

(b) Dr Wilcock criticises some areas that DB does not comment on at all, eg. on Cunningham Wilcock says that the dosage was too high.

(c) We must not send reports of the other experts to DB.

(d) TK, or possibly the Junior, will draft additional questions for DB.

(e) We will need to discuss DB's time commitments with him.

(f) We will need to send over the notes on Eva Page and Alice Wilkie for him to prepare a report. In our instructions we will ask him to specifically look at:-

(i) previous documentation of pain;

(ii) in light of no appropriate history of pain was it appropriate to begin opioid analgesia?

(iii) was it appropriate to begin opioid analgesia by syringe driver?

(iv) was the dosage range prescribed acceptable?

(v) was the dosage given acceptable?

(vi) may the drugs have resulted in the shortening of life?

(vii) may the drugs have resulted in respiratory depression?

13. Draft Heads of Charge:-

(a) TK wanted to know what Eversheds did. TET confirmed that Eversheds had not instructed Counsel or an expert and had drafted these themselves. Code A noted that the charges as drafted contain way too much narrative and reminded TK that charges need to go directly to the allegations.

(b) TK confirmed that we want to change the draft heads of charge quite a lot.

(c) We discussed the recent decision by the GMC to make sure that argument is eliminated about factual matters and that the narrative will not be included in the charges. TK understood this and Code A suggested that we could possibly provide the Panel with a summary of the background separate to the charges. She has used this in other cases.

14. Expert reports:-

(a) TK noted that tabs 28-30 had the wrong reports in them. TET will just go back through the folders to make sure they have the right documents in them.

15. Professor Black in attendance at the meeting from 11.50 am:-

(a) DB says that he sat on Fitness to Practise Panels until 2005. This means that there is a possibility that he could know some of the Panel members. He sat on the Panels from 2002-2005. He was thinking that the Defence may want to look at reasons why he could be discredited. We would have to veto panel members if he knew them.

(b) DB was very keen to point out that he has not got much medico-legal experience. He had not done any prior to working on this case.

(c) TET will send DB a copy of the CPR rules on expert witnesses. This will ensure that he knows what his duties are. We will need him to write a declaration based on the rules. TK ran through the rules with DB very briefly, eg. if he changes his mind he must notify the Court, he needs to be objective/unbiased and also reveal information that may help the Defence.

(d) In 2002 DB wrote an editorial in a free journal on geriatric medicine on the Gosport War Memorial Hospital. This is a long time before he wrote the reports but he wanted to disclose it for completeness.

(e) Dr Barton will say that she was enormously overworked and there was no consultant cover and she had a GP practise. TK wanted to know does a part-time job excuse what happened? DB said no, if he was the Clinical Director then he would say that he had paid her to work half-time which is five sessions and he would expect her to do that. DB thinks that she was paid a half salary and the CHI report says that there was 200 patients on a 6-8 week stay. This is not a heavy patient load. A consultant geriatrician would see 1200 patients per year with support. The CHI said that there were 196 admissions per year.

(f) TK asked, as a lay observer, how long it would take to authorise prescription of major sedation, to make sure that the patient needs it and to note it DB said that the duty of care Dr Barton had was equal to this group as to her GP practise. TK commented that it is a worrying feature that she seemed to have put patients onto the syringe driver almost as soon as they came through the door. DB said it is hard to work out from inadequate notes what happened and any justification. Dr Barton does not seem to have used paracetamol or co-proxamol. There may have been a reason for this but it is certainly not recorded. TK said that sometimes there is no pain recorded and then Dr Barton has given opiates. We will need to examine the issue of how much support she did have. DB said that this is a bit tricky as he is not a GP working in that environment but when he was an SPR in Hastings about 20 years ago if the GP was away then DB would go down and run a similar hospital so he has some experience of that.

(g) DB said that currently he does not do any in-patient work. For the last three years he has only carried out one day per week. DB was a full-time consultant at Queen Mary's, Sidcup for eight years. From 2004 however he has only done one day a week clinical work. This clinical work was slow stream rehabilitation so the same patient base as in this case. DB is certain that Dr Barton will say that she did what a GP would do . This goes back to her point about pressure. She may say that this was standard practise for a clinical assistant GP, the same as in a nursing home. The trouble is that the care in nursing homes is often terrible. DB's answer to this will be that she was in an NHS hospital and that patients have a right to expect the same treatment.

(h) TK said that even if it were a nursing home then surely this prescribing was not right. DB said that in many nursing homes there is a culture of lack of note-keeping.

(i) TK said that we are obliged to tell the Defence if we find any information which underestimates our case and assists the doctor. So before giving an opinion then DB will need to make sure that he has seen everything first. DB said that he has tried to give a fair unbalanced view already.

(j) TK said that we want to instruct one expert and it would be logistically preferable for us to instruct DB. The only two patients that DB has not looked at are Eva Page and Alice Wilkie. We have got reports from a Professor Ford and Dr Mundy on those but TK advised DB that he should not see those reports to avoid criticism.

(k) We discussed whether or not an alternative would be to call Professor Ford just for those two patients. TET will contact him to see if he will help.

(l) TET will check the reports of Dr Ford against the reports of DB and highlight inconsistencies.

(m) DB had one day's witness training on expert witnesses in Manchester. TK said that we can disclose that in due course.

16. Discussion between DB and TK about individual patients:-

(a) Gladys Richards:-

(i) This patient had a fractured thigh bone and had dislocated her hip. There are bad medical and nursing records. The anticipatory prescribing is concerning.

(ii) Paragraph 5.6 "to" the GWMH on 11 August 1998 needs amending.

(iii) This patient was frail and demented but not obviously in pain. TK asked about the phrase "I am happy for nursing staff to certify death". DB said that this practically means that when a patient dies the death is expected so a nurse

can send the patient to the mortuary and the doctor can attend on the next morning to sign the certificate. This is a very normal practise. TK asked if DB had been surprised to see this in the note. DB said that it does show the culture if the phrase is used in every note. This means that they are expecting terminal care and there is no expectation of rehabilitation. This is normal practise only when expecting death. If Dr Barton was writing it routinely then it seems more of a self-protection thing. DB said that using it in all the notes would give the wrong impression to the nursing staff.

(iv) TK asked if these patients would be DNR anyway. DB said that the chances of resuscitation with patients with multiple pathology would give patients a potentially very unpleasant death so realistically resuscitation would not even be tried. DB confirmed that oromorph is an oral form of morphine.

(v) TK said that quite a lot of the patients are confused and can fall over and queried whether this was like a chicken and egg scenario that once the patients had started on morphine then the chances of them falling over are increased. DB confirmed that this is the case. Some patients find it very upsetting and they have got delirium. Delirium is very poorly managed and spotted in hospitals. The way to manage delirium is by managing the environment. This could include, for example, good lighting during the daytime and none at all at night. Big clocks, making sure patients' hearing aids work and that they are taken to the toilet. Also to minimise drugs usage and only use drugs as a last resort. In this case the patient needed no drugs in the acute hospital where they are exhibiting bigger behavioural problems.

(vi) TK asked if morphine can give bad reactions. DB confirmed that it can do. TK had noted that one of the patients had vomited afterwards. DB confirmed that he would normally give an antimetic to stop people from feeling sick after morphine.

(vii) DB said that there is a well-known effect of sundowning with delirium. This means that patients can get really confused at night and can go downhill then. Sometimes patients can give a good social façade and have superficial chats but if you go underneath then the patient is not really there. Some people with delirium will be hyperactive but some people will just sit there very quietly. It is very much a fluctuating condition.

(viii) Gladys Richards comes into GWMH on 11 August. The next note is that sedation and pain relief are not a problem. The nursing notes in this case are better than the medical notes.

(ix) DB noted that the notes were not in order and it had taken him a couple of weeks' work just to sort out the chronologies in this case.

(x) In paragraph 5.9 DB has noted 10mg in 5ml. PRN means "when you want". DB did not know what the Latin of this meant and TET will look this up.

(xi) PRN is written down and this is usually a nursing decision so they can give drugs without going to the doctor. It is commonly used for mild painkillers, for example if a patient had a heart attack. It is quite unusual if a patient is not already having pain.

(xii) From paragraph 5.4 DB has noted that she was receiving regular co-codamol but from 7 August at Gosport no painkillers had been used. No opiates had been used since the post-operative period on 1 August to 2 August. Unless the patient had done something nasty then DB would assume that no further painkillers would have been needed.

(xiii) TK suggested that TET send a copy of these notes to DB so that he can amend his report.

(xiv) It is unusual to prescribe oromorph as PRN if there had been no pain for the last nine days. DB said that there had been no pain in the Hasiar Hospital. On 14 August there is a note that sedation/pain relief has been a problem. Dr Barton made that comment on 14 August but we do not know what that problem was. In 5.9 Dr Barton has immediately given oromorph. At 5.7 pain. The nursing card index (5.8) mentions that the patient was agitated but it does not mention pain. We do not know why the patient was agitated.

(xv) TK asked if the patient could have been agitated as the oromorph was not agreeing with her. DB said that this could be a contributory cause to agitation. We have nothing at all in the notes to explain why she was given oromorph on 11 August.

(xvi) DB said that the dosages given by the nurses were always within the range prescribed. DB said there is no criticism of the nurses going beyond their powers.

(xvii) At 5.9 DB will need to go back and look at the notes as the dates are wrong. He will need to look at the drugs charts pages 62.

(xviii) TK and DB agreed that we need to get this report into a chronological order and clarify all the dates as at present the report is a little bit confusing.

(xix) Diamorphine was prescribed 20-200mg. DB confirmed that subcutaneously means by injection. This would only be a syringe if it was a one-off. The implication of what Dr Barton has written is to allow a syringe driver. The range on the PRN side is done so that the nurses can give a 20mg syringe driver on the first day and then increase.

(xx) DB cannot remember ever getting up to a dose of 200mg on a patient himself.

(xxi) We will need to go back and look at the records – did Dr Barton just write PRN all over 24 hours. TK said that we will need to look this up as it makes a significant difference.

(xxii) In paragraph 5.11 TK asked if the syringe driver was patient controlled. DB said no, none of these would be. The patient controlled syringe driver would be used to facilitate the nurse if the patient was crying out in pain. The syringe driver is filled and it runs for 24 hours. You put in an infusion and there is a pump mechanism which drives the medication into a fine bore tube in a 24 hour period.

(xxiii) Paragraph 6.6 refers back to paragraph 5.6 and we are talking about 11 August here.

(xxiv) TK asked what kind of clinical examination should be carried out. How full would DB expect? DB said that his practise would be that any new patient he would do a summary of the notes, record the notes having come across, a summary of the past medical history to get a picture of the patient. He would listen to the heart, chest and tummy and conduct a brief neurological examination, for example moving the arms and legs and a reflex test on the feet and he would look at eye movement and the vision field. It would literally take about five minutes to do all that and it gives a baseline for future treatment. DB said that a junior doctor would always do all of that and probably in more detail. If the patient was just moving wards then you would not need to. If a patient had been seen as a day patient by the consultant who had just done this for you then it would not be necessary for you to do it all again.

(xxv) In paragraph 6.6 the patient is not obviously not in pain so there does not seem to be any clinical justification. There is the old axiom that "if it is not written down then it did not happen". TK asked if this is proven here. DB said that if the results of an examination are not written down then there is no baseline to go back to.

(xxvi) DB said there is a gradation here. He has described it as "highly suboptimal prescribing". DB has trouble with the word negligent. TK made it clear that we are not interested in negligence. What we are looking at here is whether or not the treatment was below the standard that we would expect of a reasonably competent doctor. We do not have to prove that this doctor would deliberately or negligently shorten people's lives. We are looking at if a treatment was reasonable or not.

(xxvii) DB said that Dr Barton should have discussed the patient with the surgical

team at Hasiar or with her own consultant. Dr Barton will say that there was no consultant cover but DB said that there is a geriatric department at Plymouth and she would always be able to ring and speak to somebody there. This was not a pure GP bed. Under the NHS Act only a consultant or a GP can admit a patient to hospital. Some beds were GP beds in the GWMH where a GP could admit/discharge and was fully responsible for the patient. Dr Barton was working at the GWMH as a clinical assistant, not as a GP.

(xxviii) Clinical Assistant – TK wants a job description. TET will try and get this.

(xxix) DB said that a clinical assistant is a GP undertaking clinical work under supervision of a consultant. They are not working as a GP and they are using their skills in part of a managed hospital environment. The doctor is paid to provide a clinical service. Dr Barton is fully trained but not there to train. She was there to provide a clinical service and would be working to a consultant.

(xxx) TK querying if we should go to the Trust to ask what they were expecting Dr Barton to do? What cover was in place?

(xxxi) DB said that the clinical director of the geriatric service at the time would be best placed to say this. This would have been Dr Reid. The patient had to be the responsibility of the Trust so the Trust would have had to provide assistance, possibly over the phone.

(xxxii) In paragraph 7.1 anticipatory prescribing is dealt with. Anticipatory prescribing would be used for example when a patient had a heart attack or recurrent angina or if they were clearly coming across as dying.

(xxxiii) Gladys Richards did not come across to GWMH on 11 August to die even though the mortality rate is high for her symptoms. The mortality rate would be 50% in one year.

(xxxiv) TK said that we had a good case on this lady.

(b) Arthur Cunningham:-

(i) TK summarised that this was a 79-year old who had Parkinson's and an offensive ulcer. DB's opinion was that "managed appropriately including the decision for the syringe driver only concern was regarding doses on 25 and 26". DB said that this was poor care but not one of the very bad ones.

(ii) In paragraph 5.19 an offensive necrotic ulcer is mentioned. DB confirmed that offensive means that the ulcer smells and that the prognosis is poor is shorthand for "the patient will probably die".

(iii) TK asked who authorised the use of the syringe driver. DB said that this was written up by Dr Barton and the nurses would make the decision whether or not to start. We do not know from the notes who said to start the syringe driver.

(iv) We need to find out where the day hospital fits in.

(v) In paragraph 5.20 it is very appropriate what Dr Barton wrote. TK asked when does the syringe driver start. DB confirmed this was 2030 on 21 September. He arrived on that day and before midnight he was on the syringe driver. TK questioned whether or not he had been on morphine before that and whether or not there should have been a graded introduction? DB said that the patient could have been prescribed oral opiates. This man was dying and if he was in pain DB would not criticise a small regular dose of morphine. If the patient could not swallow then it would be very reasonable to use the syringe driver. There is no evidence that this patient was nauseous or could not swallow.

(vi) TK asked what the distinguishing features of this case are. DB said that he is more concerned about the increase in the dose of the drugs rather than starting them in the first place. Diamorphine is not a treatment for agitation per se but reasonable treatment for stress and other symptoms and it can be used not just for pain. The distinction with this case as opposed to the others are that this man was undoubtedly dying. Although the nurses did not write that this is clear from the "prognosis is poor" comment. However the notes do say that the bed should be kept open at the nursing home. This is what is called a belt and braces approach.

(vii) In paragraph 5.27 the jump in the dose is referred to. DB said that the dose from 20 to 40 is a big jump. Usually the increase would be 50% of the original dose. The dose is then increased to 60 and then to 80. Midazolam is a minor tranquiliser and it is not contra indicated with Diamorphine.

(viii) DB would use Diamorphine with or without an antiemetic drug. He has never found the combination of Diamorphine and Midazolam necessary to use. DB can find no reason in the notes to explain the increase in the amount of Diamorphine given.

(ix) In paragraph 6.27 and 6.28 DB would not necessarily expect to see a medical note as this could have been a nursing decision. He cannot tell from the notes which nurse or doctor made the decision. Dr Barton has written the prescription in such a way to allow that to happen. There is a huge range in the prescription.

(x) TK said if it is just this one decision then it would not be before the GMC but

if we look at it in the round then there is a pattern. In the last two days if Dr Barton was responsible then it is wrong if she prescribed the drugs in such a way as to allow the nurses to increase the dosage in this way.

(xi) DB said that the prescribing in this case is poor. Dr Barton has written 20-200mg so this is a very big range right at the start. It would have been appropriate to prescribe a smaller range at the start and then the review patient and then adjust the range. There is too much responsibility given to the nurses here. On the 25th Dr Brook comes in and sees the patient and allows this to continue. TET confirmed that Dr Brook was one of Dr Barton's GP partners who covered for her occasionally.

(xii) DB clarified that the criticism here is the original dosing range.

(xiii) TK says this is one of the weakest cases that we have got. This is a referred case so Code A confirmed that we would have to go through the cancellation procedure and TK will need to write a cancellation advice.

(xiv) **TK will write a cancellation advice on this case. Code A and TET both agree with this decision.**

(c) Robert Wilson:-

(i) TK and DB agreed that this is the worst case. Dr Barton was, in DB's view, negligent and contributed to death more than minimally.

(d) Elsie Devine:-

(i) TK questioned if this was a weak case? DB said that the drug management was suboptimal and there was no justification for PRN. Fentanyl is another opiode and is administered via a subcutaneous patch. It was muscle-relaxant properties too. There was good palliation of symptoms but the care was suboptimal. The major problem with this case is that by the time anyone did anything the patient was seriously ill. There is no real medical notes so we do not know what went wrong so suddenly with the patient.

(ii) In paragraph 6.11 there are no doctors' notes from 1-15 November. There are nursing records. Nurses would not do blood test unless the doctor asked them to.

(iii) This is a criticism in itself that Dr Barton has not made any notes between these periods. TK said this is important as there is no notes for a two week period as this is quite some length of time.

(iv) DB said that if the patient was in the ward for two months and waiting for a

nursing home then it is not a problem if the patient's situation does not change and there are no medical notes. However if the situation was changing then a note should always be made.

(v) DB will go back and look at paragraph 6.12 to see where he got that information (page 156).

(vi) In paragraph 6.5 it is clear that by 19 November the patient was terminally ill.

(vii) In paragraphs 6.17 and 5.19 we need to check that it was Dr Barton who wrote up the prescription for Diamorphine/Midazolam by syringe driver infusion and make this clear in the report.

(viii) DB said that there are regulations about how controlled drugs should be prescribed, for example, in writing and numbers.

(ix) We need to look up the regulations for prescribing controlled drugs in the BNF.

(x) The patient was started on twice the normal dose (6.20). We are presuming that Dr Barton prescribed this.

(xi) TK querying whether Dr Barton has been asked if she made the notes. If the interviews do not ask her this then we will need to ask, through her lawyers, if they are her entries. If she is not going to admit this then we will need a handwriting expert to be instructed to prove that they are.

(xii) In paragraph 5.17 and 5.18 DB says that there was good palliation of her symptoms. DB confirmed that the patient was seen by Pastor Mary and died peacefully.

(xiii) TET gave information about the family and in particular the daughters as witnesses.

(xiv) TK said that overall it was not our strongest case but there is a total lack of notes. If we look at this case in context with the other cases then TK would not be unhappy to continue. However the evidence is largely on the lack of notes.

(xv) Code A confirmed that to add cases she would need to do a letter to the registrar saying that the cases were sufficiently similar. She would include witness statements to support that.

(e) Elsie Lavender:-

(i) This is a good case. In paragraph 6.10 DB said that there was a failure to get a specialist opinion. Whose fault was this? Dr Barton should have been saying "This doesn't look right" and asking a consultant for advice. Dr Barton is providing day to day care on the ward. The consultants would say that they would expect to be notified by Dr Barton of any problems.

(f) Sheila Gregory:-

(i) TK thinks that this is a weak case. DB confirmed that the patient was managed appropriately. There is some weakness in the documentation but overall the care is "just adequate". The notes are dreadful. The main issue is that DB is not saying that any of the doses are wrong.

(ii) **TK, TET and Code A agreed that this case should not be added.**

(g) Ruby Lake:-

(i) All agreed that this case is fine. It is one of the worst cases.

(h) Leslie Pittock:-

(i) This case is fine.

(i) Geoffrey Packman:-

(i) This case is fine.

(j) Helena Service:-

(i) This patient was admitted on 3 June, the notes are poor. In paragraph 2.13 TK questioned if this was the first time that she had had diamorphine. DB said yes it is. She has had thyridazine which is a major tranquiliser every night. By 4 June at 0200 she was put on a syringe driver. The following day she was given diamorphine and she was dead by the next day. The problem with this case is that DB is not happy about the transfer. The patient was not stable on the transfer. Old patients are somewhat of a nuisance in hospitals and it is tempting to move them but consideration should be given to the fact that moving can cause additional stress and this is a good reason to carry out an additional examination to ensure if the patient has been sent to Gosport War Memorial Hospital in an unwell state.

(ii) If she was severely breathless then this is a good reason to give diamorphine. Diamorphine is a good treatment for breathlessness for reason of heart disease. 20mg for a little frail lady is definitely the upper limit. DB said that many would have started with a lower dosage.

(iii) TK questioned paragraph 2.19 which says "and that a reasonable body of practitioners would do the same". DB looked at text books for this.

(iv) We will need to append to the report copies of the text books that he looked at and also the Wessex Protocols 1995.

(v) DB said if he was pushed then he would say that this was within an acceptable amount. In this case the prescribing was probably acceptable as the patient had severe breathlessness and the starting dose was OK.

(vi) This is not our strongest case.

(vii) TK said that all of our cases could run on the basis of rubbish notes but in terms of the dosage regime then there is not much criticism here. TK's gut feeling is that we should leave this case and go with something stronger. Also we have a report from Dr Petch which says that the palliative care was appropriate in this case.

17. General Discussion DB/TK:-

(a) DB questioned whether or not his involvement in this case would potentially damage his reputation? He has discussed it with his employer and this is a point that they have raised.

(b) TK clarified that the evidence would have to be forthright and candid and that the defence will examine him on the evidence given. TET explained that his duty is to the Court and he would have to act as an impartial expert. As long as he is acting within his competency then there should not be an issue. DB did seem concerned about this issue.

18. Availability:-

(a) Between Christmas and New Year periods DB is very available. We would propose that we would circulate a list of questions to him on areas that need clarification or have been raised by the other experts. DB said that he would not be able to have all the papers at home or in his office as he simply has not got room and the proposal is that he would come to FFW London office to look at the records as he cannot have them at his office.

DB then left the meeting.

19. Discussion Code A TK/TET after DB had left the room:-

(a) Code A TK and TET have concerns about how DB will act on the stand. However this is not a hugely complicated case in terms of issues, it is volume that makes it hard.

(b) TET will check the Ford and Black reports and let TK know any points of dispute.

(c) Talking about Elsie Devine. JSB has concerns that Elsie Devine is a weak case and whether or not it adds anything. TK thinks that we have a reasonable prospect of success based on DB's evidence as there were no notes made for two weeks. TET said that perhaps the family evidence and involvement could tip the case in balance towards proceeding as they have already indicated they would make an awful lot of fuss if the case did not proceed. Code A will discuss the matter with Peter. TK said there is a pattern here. The drug management was suboptimal and there was a lack of documentation.

GENERAL MEDICAL COUNCIL – DR JANE BARTON

ACTION POINTS FROM CONFERENCE

1. Paralegal to reorder medical records:-

   (a) Get original records

   (b) Make the copies as dark as possible so that they are legible.

2. TK will draft advice and charges by 21 January 2008 for GMC approval. He will include cancellation advice. We will not let the Defence know at this stage which cases we are not going to proceed with.

3. We will run with:-

   (a) Eva Page (Ford)

   (b) Alice Wilkie (Ford)

   (c) Gladys Richards

   (d) Elsie Devine (Just)

   (e) Elsie Lavender

   (f) Enid Spurgin

   (g) Ruby Lake

   (h) Leslie Pittock

   (i) Geoffrey Packman

   (j) Robert Eilson

4. We will not run with:-

   (a) Arthur Cunningham

   (b) Sheila Gregory

   (c) Helena Service

5. TET will compare the Ford and Black reports and provide a list to TK flagging up any problems.

6. TET will provide a copy of the expert reports and witness statements to Counsel for the Junior.

7. Counsel's Clerk will call TET next week regarding a Junior. Probably a couple of names will be suggested and then TET will gain approval from Code A

8. TET will send to the CPR rules on experts to DB.

9. TET will do a note of the conference and circulate to TK and Code A (the relevant parts to do with DB can be taken out and forwarded to him).

10. Seek clarification from the Defence that Dr Barton admits to making entries in notes. If not, consider a handwriting expert.

11. DB will need to append text books and Wessex protocols 1995 to his reports.

12. TET to organise DB attending FFW offices in London to look at the expert reports.

13. TK will prepare list of further supplemental questions for DB.

14. Look up the regulations about controlled drugs in the BNF.

15. TET to contact the Trust and get a job description for the clinical assistant for TK.

16. PRN – look up the Latin of this phrase.

17. TET to contact Professor Ford again to see if he would be willing to assist.

18. TET to look at the expert reports folder, in particular tabs 28-30 have long reports in. TET to look into Jean Stevens/Edna Purnell and see what happened and identify the notes and send them to Professor Black to see if we have a case to proceed here.

19. TK would like to visit GWMH. TET to look into this.

20. TET to contact the Trust and organise potential visit and also any further documentation that they have.

21. Cases against Dr Lord and Dr Tandy – TK to provide advice to GMC in due course on whether there is potentially a case against them also.

'rom: Code A
ent: 19 Nov 2007 16:59
'o: Peter Swain Code A
ubject: FW: Barton - Junior Counsel
YI

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rom: Hall, Tamsin Code A
ent: 19 Nov 2007 16:53
'o: Code A
:c: Ellson, Sarah
ubject: RE: Barton - Junior Counsel

li Code A

understand that Rebecca Harris has quite a bit of GMC experience. She has been directly instructed by ıe GMC in about 40 cases. Over half of them were direct instructions from Toni Smerdon. Perhaps you ould speak to Toni for her input?

om said that she is very bright and has the right experience. Also, and possibly most importantly, she is ble to start work immediately which is a considerable bonus given the very tight time constraints.

hope that this helps.

would be grateful if you could let me have your thoughts as soon as possible as I am keen to get the ınior working as soon as possible in order that they get through the masses of evidence.

or clarification, the rates do not include VAT.

hanks

amsin

amsin Hall | Solicitor
ɔr Field Fisher Waterhouse LLP
Code A

lobile Code A

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rom: Code A
ent: Thursday, November 15, 2007 4:17 PM

o: Hall, Tamsin
ubject: RE: Barton - Junior Counsel

ello Tamsin,

either Peter or I have any prior knowledge of Rebecca, did Tom give any specific reasons for ecommending her.

lso are the figures provided exclusive of VAT?

hanks Code A

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rom: Hall, Tamsin Code A
ent: 14 Nov 2007 17:00
o: Code A
c: Elson, Sarah
ubject: Barton - Junior Counsel

i Code A

Ve have now had a discussion with Tom and his clerk regarding juniors for use in this matter.

om recommends Rebecca Harris. She is on maternity leave at the moment and can start work nmediately. She comes highly recommended and has GMC experience.

n terms of rates Counsel's clerk suggested going back to the fees that we used to have from ounsel before the current agreement.

- So Tom would be £150 ph and Rebecca £100 ph.
- Tom estimates the brief would be 250 hours each for him and for a junior.
- This comes to £37,500 for Tom and £25,000 for Rebecca.
- For hearing it would be £750 per day for Tom, £600 for Rebecca.
- This comes to £67,500 for Tom, £49,000 for Rebecca.

would be grateful for your comments on instructing Rebecca and the proposed fees.

Ve are in the process of revising our fee estimate and will forward that to you as soon as ossible.

'lease note that Sarah is going to e-mail you seperately regarding Professor Black.

'hanks

'amsin

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

1obile Code A

:onsider the environment, think before you print!

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0 Adelaide Street, Belfast. BT2 8GD

el: 0845 357 8001
ax: 0845 357 9001

'rom: Code A
ent: 21 Nov 2007 16:23
'o: 'Hall, Tamsin'
ubject: RE: Barton - Junior Counsel
orry yes the fees are approved.

Code A

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rom: Hall, Tamsin Code A
ent: 19 Nov 2007 17:31
o: Code A
ubject: RE: Barton - Junior Counsel

reat, I'll get the papers sent down to her.

re the fees also approved?

hanks for getting back so quickly.

amsin

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP
Code A

lobile Code A

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rom: Code A
ent: Monday, November 19, 2007 4:59 PM
o: Hall, Tamsin
c: Ellson, Sarah
ubject: RE: Barton - Junior Counsel

lello,

just spoken to Toni Smerdon and Juliet Oliver who both highly recommend Rebecca, in light of this she i pproved as the junior for this case.

Code A

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rom: Hall, Tamsin [mailto:tamsin.hall@ffw.com]
ent: 19 Nov 2007 16:53
o: Code A
c: Ellson, Sarah
ubject: RE: Barton - Junior Counsel

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Code A

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o: Hall, Tamsin
ubject: RE: Barton - Junior Counsel

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o: Code A
c: Ellson, Sarah
ubject: Barton - Junior Counsel

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hanks

amsin

amsin Hall | Solicitor

or Field Fisher Waterhouse LLP
Code A

Mobile Code A

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0 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001

'rom: Code A
ent: 22 Nov 2007 16:22
'o: Code A
:c: Tamsin Hall ffw (formerly Tomlinson) Code A
ubject: Dr Barton
lello,

have just spoken to Mark Mallison from the NMC and enquired whether there lawyers still required a ieeting with us.

lark advised that he has been unable to find any lawyers available for the meeting but he will get back to s if the position changes.

Code A

'rom: Code A
ent: 28 Nov 2007 16:13
'o: The Empanelment Team
ubject: Professor David Black - 2632917

mportance: High
lello,

Ve are considering using the above doctor as expert doctor in a forthcoming FTPP case.

'rofessor Black used to sit on FTP Panels until 2005.

Ve would be grateful if you could let us know the date his tenure began and ended what was the reason is tenure ended.

'his request is quite urgent as the information provided may determine whether we can use him as an xpert.

Vith thanks
Code A

'rom: Code A
ent: 29 Nov 2007 10:06
'o: Tamsin Hall ffw (formerly Tomlinson) Code A
:c: Code A
ubject: Professor David Black
lello Tamsin,

recall from our conference that Professor Black stated that he ceased being a FTP Panellist in 2005 but ur Committee Development Team has no record of him.

efore deciding whether or not to use Professor Black as an expert we require our Committee evelopment team to do some checks on him, therefore I would we grateful if you would urgently contact rofessor Black to ascertain the dates he began and ended his tenure.

nce the Committee Development Team have carried out any requisite checks we will respond to Code A s mail concerning choice of experts.

Code A

rom: Wendy Martin Code A
ent: 29 Nov 2007 09:05
o: Code A
c: Neil Allwood Code A
ubject: RE: Professor David Black - 2632917
Code A

he name Dr David Black does not ring any bells with me.
have certainly never used him as a Specialist Adviser.

Vendy

---

rom: Code A
ent: 29 Nov 2007 08:52
o: Wendy Martin Code A
ubject: FW: Professor David Black - 2632917
mportance: High

Vendy,

lease note below, is Professor Black on the list of past specialist advisers?

Code A

---

rom: Angela Gatt Code A
ent: 29 Nov 2007 08:49
o: The Empanelment Team; Panel Development Team
c: Code A
ubject: RE: Professor David Black - 2632917

Code A

have looked in our list of panellists in Siebel (which includes former panellists) and we have no listings for the bove. I have also looked under the contact list where there are quite a few David Black's. I have also looked on our cel spreadsheet where we keep a list of panellists who are no longer active and there is no mention of a David lack. I believe he may have been a specialist advisor. Your best bet would be to ask Code A or Wendy Martin o see if they recall using him as a specialist advisor.

---

rom: Tim Simpson Code A **On Behalf Of** The Empanelment Team
ent: 29 Nov 2007 08:34
o: Panel Development Team

c: Code A
ubject: FW: Professor David Black - 2632917
mportance: High

lello

think you may be able to assist Code A better than we can on this issue.

hanks

im

---

rom: Code A
ent: 28 November 2007 16:13
o: The Empanelment Team
ubject: Professor David Black - 2632917
mportance: High

lello,

Ve are considering using the above doctor as expert doctor in a forthcoming FTPP case.

rofessor Black used to sit on FTP Panels until 2005.

Ve would be grateful if you could let us know the date his tenure began and ended what was the reason is tenure ended.

his request is quite urgent as the information provided may determine whether we can use him as an xpert.

Vith thanks

Code A

'rom: Angela Gatt Code A
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'o: The Empanelment Team; Panel Development Team
:c: Code A
ubject: RE: Professor David Black - 2632917
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Vith thanks

Code A

'rom: Code A
ent: 19 Dec 2007 17:11
'o: 'Ellson, Sarah'
:c: Hall, Tamsin
ubject: RE: Dr Barton - choice of expert
:arah,

Code A has agreed in principle to use Professor Black as our expert.

)ur Committee Development Team has so far identified 11 previous cases which Professor Black sat on o the possibility of conflict of interest arises if there are Panellists on the case that know Professor Black.

'roposed solutions to this are:

)nly empanel Panellists who Professor Black has not sat with before. The only disadvantage of this is that ecause Professor Black stopped sitting in May 2005 he is more likely not to know Panellists recruited fter this date who will be less experienced.

,t an early stage empanel Panellists including those who have sat with Professor Black and quickly scertain from the defence whether they have any objections to this.

would be grateful for your thoughts.

Code A

---

rom: Ellson, Sarah Code A
ent: 23 Nov 2007 15:25
'o: Code A
:c: Peter Swain Code A ; Hall, Tamsin
ubject: Dr Barton - choice of expert

)ear Code A

ly apologies for the delay in getting back to you on this. I spoke to Peter about this on 5 lovember when he and I met and we agreed that I should speak to Tom Kark to ensure that ur choice of expert was the right one and could be justified. I was only able to discuss this with om last week and I am sorry not to have emailed sooner but I have been away from my desk nd fairly involved with Dr Southall's case amongst other things.

know that after the conference you had a number of concerns (as set out in your email of 26)ctober) and felt that Professor Black was himself expressing some reservations about being ıe only expert in this case. I note that he has not given evidence before which is obviously not leal but I actually think his having previously sat on FTP Panels may be of benefit (subject to voiding no conflicts arise) because he will know what is expected at the GMC.

Code A and I havediscussed our options in detail and the suggestion that we could have two xperts which might reduce Professor Black's concerns about being a lone voice in this ase. To this end I reviewed whether we might use Professor Ford (something you asked us to o after the conference). As you may recall Black has reported on 11 cases (Leslie Pittock, :lsie Lavender, Ruby Lake, Enid Spurgin, Elsie Devine, Sheila Gregory, Helena Service, ;eoffrey Packman + 3 that Ford has also done (see below)), Ford has reported on 5 cases Eva Page and Alice Wilkie + the 3 below).

ord & Black have both done reports in the cases of Gladys Richards, Arthur Cunningham which we are probably cancelling) and Robert Wilson. My brief comments on reviewing their eports in these cases were:

:ichards

lack is slightly more accepting that this patient might have died. Criticises poor record keeping nd concerned by "anticipatory" prescription of opioid analgesia and prescribing oramorph as rn. He however thinks it was ok to be treating as palliative by 17 August. Ford takes a stronger ne - that patient was for rehab. He also criticises records and in particular he too says opioid nalgesia not appropriate. He describes decision to administer subcutaneously as reckless, ıappropriate and extremely hazardous whereas I think this is stage at which Black is saying alliative approach is ok.

;unningham:

lack sees this as an admission for terminal care which it was right to admit. He thinks the case ras managed appropriately save for the lack of note/justification for syringe driver and the ıcreases of diamorphine on 25/26 Sept 60-80-100 which he says lack justification and appear xcessive. Ford sees this as an admission for healing and pain relief - he thought initial dmission was appropriate but comments on Barton entry re certifying death (no indication he ould die). He criticises the decision to prescribe and administer diamorphine, hyoscine and ıidazolam as highly inappropriate, very hazardous and poor practice. He too says increase is

ery poor and cannot see justification for subcutaneous (syringe) administration. He criticises ecords and denial of food and fluids.

Vilson:

lack describes the complex condition of this man. His criticisms are reserved for the dose of iamorph on 15/10 which he describes as negligent. He suggests management plan from QA hould have continued and says it would have been appropriate to first use weaker analgesia. le is okay about mixing diamorphine + hyosine + midazolam but cannot see rationale for ıcreasing. Ford is less critical of record keeping but more critical of the prescription of iamorphine + hyosine + midazolam - he would only support oramorph. As with Black cannot nderstand increase. Criticises Wilson for inadequate assessment of MI.

onclusion on comparing Black and Wilson:

verall I thought the reports were not incompatible on the key issues but generally Ford is tronger than Black is most areas. While Ford is generally a little harsher in his views he does nd to blame teams a bit more, rather than just Barton (this of course would have issues for our MC case which can only be against Barton and might in fact be a "get out" for her). The efence will of course have both sets of reports and no doubt will put points to whoever we call bout what others have said. I thought Black's written reports were good and are more detailed ıat Ford's.

Vhen we met with Tom last week we discussed the possibility of using both Black and Ford he as firmly against this approach. He thinks that having two experts giving evidence will just nable the defence to play them off against one another and whilst we might say this expert is nly dealing with these cases we could not stop them asking either expert about any of the ases we take forward - we would not know what they would say (or they would both have to do eports in all cases - a complex and costly exercise). In terms of finalising the charge if we have ıst one expert we know what to charge - based on their single view. Tom could see the easons why we wanted to consider the two expert approach but did not feel any of our oncerns outweighed the damage he felt would be caused.
he options are therefore
lack FRCP a geriatrician/physician now Dean/Director of Post Grad medicine (Surrey and ussex) (he was medical director at St Mary's Kent 1997-2003) - he has done 11 reports and een to a conference - Tom feels that his questions eg about his reputation were not nsurprising given the issues surrounding expert evidence that have made the news recently. om considered Black was a fair witness which would be better than one who was over bold in onference but crumbled in cross examination. Tamsin's view is that Black was fine and that is concerns were legitimate and that it is best that he raised them at the start. Black has ıdicated, despite your perception of his reservations at the conference that he is willing to ssist us with this case and is completely happy about proceeding (as you know our first choice itness Dr Wilcock has said he cannot spare the time to help the GMC). Black would need to eport on the 2/3 cases he has not seen and we think we will get him to do some form of upplementary statement to cover gaps in his police reports/statements.
ord FRCP Professor of Pharmacology of Old Age (Wolfson Unit Newcastle) on geriatric pecialist register - he has done 5 reports so would have to do a further 5-8 reports. We have

ot met [redacted] him although he has indicated his willingness to assist.
lundy Consultant Physician and Geriatrician Frimley Park (Surrey) - we have chased and hased to try and make contact with him to see if he might assist (he did some reports for the olice). We feel that whilst he might offer a third choice and has the benefit of being still active s a doctor in the field his failure to return any of our calls in the last 2 months means we cannot nagine working with him successfully.
lew expert - this would be by far the most expensive option and would be time consuming. We ave not as yet made any inquiries as to who might assist with this so we do not know whether 'e could find a suitable expert (Mrs McKenzie (daughter of Richards) has suggested a long list f international options we might try!) If you preferred to go this route I think we would have to ive a new expert considerable time to review the records and write reports - I would expect this) dramatically impact on the timetable and would be likely to provoke a defence application to djourn the hearing into 2009. Tom was also worried that we would be seen to be "shopping for n expert" if we were not content to proceed with one of the experts already involved in this ase. The choice of expert is difficult as we will not be able to compare like with like ie Barton 'as a GP doing sessions as a clinical assistant at the GWMH but none of us feel a GP is best laced to judge the case.
is [redacted] viously a matter for you. Tom, Tamsin and I feel we can justify the choice of Professor lack (and him alone) for the reasons set out above. Clearly that does not mean we can uarantee how he will perform in the witness box but obviously we would work with him to make ure we expected him to come up to proof on the matters in the charge - it may be that as a esult we do not charge everything that anyone has criticised in each case, but it is perhaps ght that where a significant number of witnesses have looked at a matter and cannot agree iat a certain action was wrong we should not charge it as part of our allegation of SPM. There re issues in this case - the most obvious vulnerability seems to be the extent of system failures nd team errors rather than the culpability resting on Dr Barton.
understand Peter wants to make a decision on this as soon as possible - please feel free to all me if you (or he) wants to discuss the matter further.
know that you and Tamsin are dealing with a number of other matters - we have asked that ounsel prioritise advising on the issues surrounding Lord, Reid and Tandy who may be crucial itnesses but are also potentially subject to criticism and undoubtedly their representatives are oing to want to know the GMC position before we can interview them or take statements.
ha[redacted]you also for following up with the NMC - an unusual response but I guess if it was a riority they would make the time to meet. It means that we do not know which nurses may ace disciplinary proceedings but I suggest we continue on the basis we approach those we iink we need and only deal with the issue if they raise it or once we know we may be relying on particular nurse for any part of the charge.

inally Peter Swain was making some enquiries about the Baker report into the hospital which ie police have told us we must get from the CMO - we simply do not know if this would be a seful part of the background to this case.

arah Ellson | Partner
or Field Fisher Waterhouse LLP
d: **Code A**

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/e use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with quivalent standing and qualifications.

'rom: Code A
ent: 19 Dec 2007 17:15
'o: Gillian Graves Code A
ubject: Dr Barton - FTPP 8 September 2008 - 40 days
;illian,

'his is a high profile case which is due begin on 8 September 2007. I understand you will be doing the mpanelment for this case.

, major problem is that our expert is Professor David Black who was an FTP Panellist from 2002 to May 005 and there maybe a conflict of interest if there are Panellists on this case that he knows.

;ould you advise whether it is common practice in high profile cases to only use very experienced 'anellists, as a way forward maybe to only empanel Panellists who began their tenure after May 2005. lowever, this would have to be balanced against the consequent lose in experience.

wo be grateful if you would liaise with me before commencing empanellement and let me know when ou are likely to start the process.

Vith thanks
Code A

From: Hall, Tamsin Code A
Sent: 11 Dec 2007 17:37
To: Code A
Subject: FW: Barton

This is all the information he has. I have asked him if he knows the names of any of the cases but he can't remember them.

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
Code A

Mobile Code A

-----Original Message-----
From: Black, David Code A
Sent: Tuesday, December 11, 2007 5:28 PM
To: Hall, Tamsin
Subject: Re: Barton

Two performance the rest misconduct
David

-----Original Message-----
From: Hall, Tamsin [Code A]
To: Black, David [Code A]
Sent: Tue Dec 11 16:20:20 2007
Subject: FW: Barton

Sorry to ask another query - please could you confirm the type of cases you sat on as Juliet has requested below.

Thanks

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
Code A

Code A

From: Code A
Sent: Tuesday, December 11, 2007 11:23 AM
To: Hall, Tamsin
Subject: RE: Barton

Hello Tamsin,

Unfortunately we don't have a master data base. I would be grateful if you would ask Professor Black if he can recall the type of cases that he sat on eg. was it health, performance or misconduct?

Thanks Code A

From: Hall, Tamsin Code A
Sent: 11 Dec 2007 11:14
To: Code A
Subject: FW: Barton

Hi Code A

Professor Black has now got back to me. I hope this information helps.

Thanks

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
Code A

Mobile Code A

From: Black, David Code A
Sent: Monday, December 10, 2007 9:17 AM
To: Hall, Tamsin
Subject: RE: Barton

I was appointed to the fitness to practice directorate in 2001 and resigned in early 2005. I must have sat on about 10 cases, the longest being three or four days. I do not have the exact dates. I would assume the GMC has a master database.

David

From: Hall, Tamsin Code A
Sent: 04 December 2007 17:22
To: Black, David
Subject: Barton

Hi Professor Black

The GMC are still making their final decision regarding how we prepare this case. As part of their decision they want some more information about when you sat as an FTP Panelist.

Please could you confirm the exact dates when you sat as a Panelist?

Thank you

Tamsin

Tamsin Hall | Solicitor
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Code A

Mobile Code A

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Regus House, Falcon Drive, Cardiff Bay. CF10 4RU

20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
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Code A

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20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001

'rom: Peter Swain Code A
ent: 13 Dec 2007 12:21
'o: Code A
ubject: RE: Dr Barton - Expert
Code A

'his is a bit of a nightmare!

Vhat we can't afford to do is to pitch up at the hearing and have our expert evidence excluded because of is knowledge of the other panellists.

lowever, of itself, knowing the other panellists doesn't mean he can't act. The question is whether that ;ads to prejudice, and that is by no means automatic.

Vhat I think this means is that we need to know fairly quickly who the panel is going to be so we can see 'hether this leads to a potential conflict. Can you find out what the timetable is to empanelment?

suspect we also need legal advice on whether if he has sat with one of the panellists or attended a 'aining course with them this makes his evidence susceptible to potential exclusion by the panel. I don't 1ink it should of itself, but it is not for me to say definitively.

he bottom line is we have to understand the risks here, and if necessary we have to flush this out with 1e defence. As I say we can't run the risk of hoping it doesn't prove to be a problem by the time we get in ont of the panel.

:an we have a further chat on Monday please.

'eter

---

rom: Code A
ent: 13 December 2007 11:15
o: Peter Swain Code A
ubject: Dr Barton - Expert

'eter,

.s you are aware FFW and Counsel have recommended that we use Professor David Black, a former TP Panellist as an expert in this case and they are awaiting our decision.

'ou are asked me to ascertain why Professor Black stopped being a Panellist and the reason is that he esigned because he did not have enough time to devote to the position.

:hall I now advise FFW that we can use Professor Black , although the Committee Development Team ave advised that a potential problem is that he is likely to know most of the current Panellist as they tend) put experienced Panellists on high profile cases?

Code A

'rom: Peter Swain Code A
ent: 15 Nov 2007 09:44
'o: Code A
ubject: RE: Barton - Junior Counsel
'he hourly rates sound quite reasonable so this sounds OK. I assume the figures are ex VAT but please an you check this.

don't know anything about Rebecca Harris, but I assume Tom has his reasons for wanting to use her. 'erhaps Tamsin might just enquire gently as to what those reasons are!! But since she is acting as a ınior I don't really have an issue one way or the other.

'eter

---

rom: Code A
ent: 15 November 2007 08:56
o: Peter Swain Code A
ubject: FW: Barton - Junior Counsel

'eter,

'lease note below.

.s you happy to use Rebecca Harris as a junior and content with the fees outlined below?

Code A

---

rom: Hall, Tamsin Code A
ent: 14 Nov 2007 17:00
o: Code A
c: Ellson, Sarah
ubject: Barton - Junior Counsel

i Code A

/e have now had a discussion with Tom and his clerk regarding juniors for use in this matter.

om recommends Rebecca Harris. She is on maternity leave at the moment and can start work mediately. She comes highly recommended and has GMC experience.

terms of rates Counsel's clerk suggested going back to the fees that we used to have from ounsel before the current agreement.

- So Tom would be £150 ph and Rebecca £100 ph.
- Tom estimates the brief would be 250 hours each for him and for a junior.
- This comes to £37,500 for Tom and £25,000 for Rebecca.
- For hearing it would be £750 per day for Tom, £600 for Rebecca.
- This comes to £67,500 for Tom, £49,000 for Rebecca.

would be grateful for your comments on instructing Rebecca and the proposed fees.

/e are in the process of revising our fee estimate and will forward that to you as soon as ossible.

lease note that Sarah is going to e-mail you seperately regarding Professor Black.

hanks

amsin

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP
Code A

lobile Code A

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ubject: Barton - Junior Counsel

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amsin Hall | Solicitor
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Code A

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'rom: Valerie Barr Code A
ent: 12 Dec 2007 14:51
'o: 'Watson, Adele'
:c: Code A
ubject: RE: GMC - Dr Jane Barton

ttachments: reg add.pdf
li Adele

he registered addresses are in the attached file.

egards

alerie

---

rom: Watson, Adele Code A
ent: 12 Dec 2007 11:41
o: Valerie Barr Code A
c: Code A
ubject: RE: GMC - Dr Jane Barton

hanks Valerie.

dele

---

rom: Valerie Barr Code A
ent: Wednesday, December 12, 2007 11:40 AM
o: Watson, Adele
c: Code A
ubject: RE: GMC - Dr Jane Barton

orry for the delay Adele, I will try and get them to you later today.

egards

alerie

---

rom: Watson, Adele Code A
ent: 12 Dec 2007 11:35
o: Code A; Valerie Barr Code A
ubject: RE: GMC - Dr Jane Barton

li

still have not received any further information regarding these registered addresses as requested.

lease could you let me know if this is being dealt with?

lany thanks

dele Watson

---

rom: Code A
ent: Tuesday, December 04, 2007 8:24 AM
o: Valerie Barr Code A
c: Watson, Adele
ubject: FW: GMC - Dr Jane Barton

al,

would be grateful if you would obtain the registered addresses for the doctors listed below and email ıem to Adele.

hanks Code A

---

rom: Watson, Adele Code A
ent: 03 Dec 2007 15:29
o: Code A
ubject: GMC - Dr Jane Barton

Code A

am assisting Tamsin on the above matter and I was hoping that you would be able to help ıe.

require the current registered addresses for the following doctors so that we are able to ontact them and take witness statements if necessary. I have included their speciality at the me where available and GMC number, but if you require further information then please let me now.

he doctors I need registered addresses for are the following:

Dr Rosie Lusznat (Psychiatrist) - Code A
Dr Ewenda Jay Peters - Code A

Dr Arumugam Ravindrane (Specialist Registrar) - Code A
Dr Victoria Banks (Psychiatrist) - Code A
Dr David Francis Barnett (Dermatologist) - Code A
Dr Ian Paul Reckless - Code A
Dr Joanna Taylor (Psychiatrist) - Code A
Dr Walter Kingsley Jayawardena (Locum Consultant) - Code A
Dr Judith May Stephens (Renal Consultant) - Code A
Dr Tanya Georgina Cranfield (Haematology) -
Dr Althea Everesta Geradette Lord - Code A
Dr Jane Tandy - Code A
Dr Richard Ian Reid - Code A

lany Thanks

ıdele Watson | Paralegal
ɔr Field Fisher Waterhouse LLP

d: Code A mob: Code A

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
/eb www.ffw.com **CDE**823

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eneral Medical Council

t James Building, 79 Oxford Street Manchester. M1 6FQ

egents Place, 350 Euston Road, London. NW1 3JN

he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

el: 0845 357 8001
ax: 0845 357 9001

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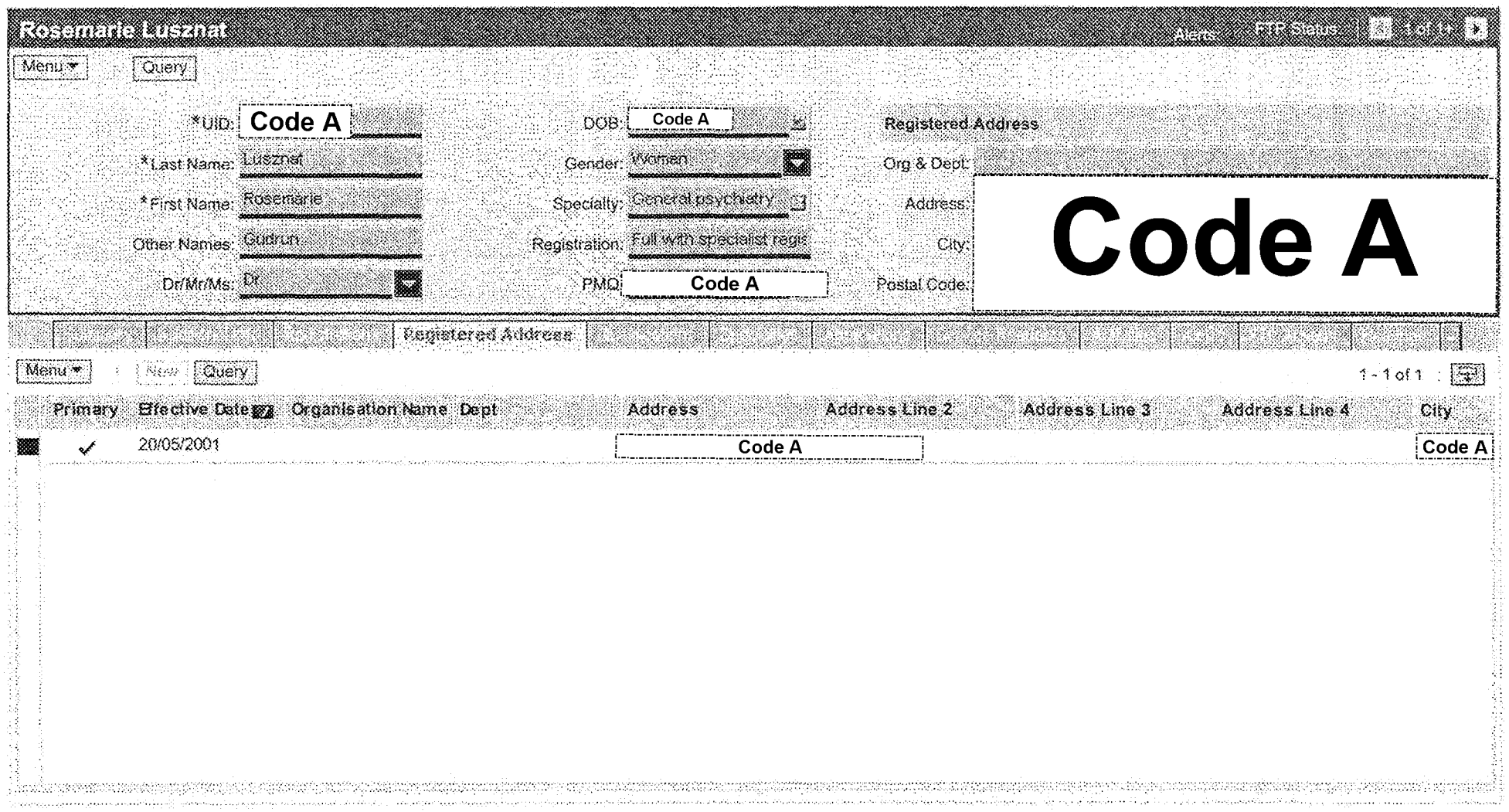
he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

el: 0845 357 8001
ax: 0845 357 9001


Rosemarie Luszniat
Alerts
FTP Status
1 of 1
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*First Name: Rosemarie
Other Names: Gudrun
Dr/Mr/Ms: Dr
DOB: Code A
Gender: Women
Specialty: General psychiatry
Registration: Full with specialist regis
PMQ: Code A
Registered Address
Org & Dept:
Address:
City:
Postal Code:
Code A
Registered Address
Menu
New
Query
1 - 1 of 1
Primary
Effective Date
Organisation Name
Dept
Address
Address Line 2
Address Line 3
Address Line 4
City
20/05/2001
Code A
Code A

All Doctors Across Organizations | Menu | Query | Query Results | 1 - 1 of 1

GMC	Alerts	FTP Indicator	UID	Last Name	First Name	Other Names	Dr/Mr/Ms	DOB	Registration	PMQ
	⚠		Code A	Peters	Ewenda	Jay	Dr	Code A	Full registration	Code A

Ewenda Peters — Alerts | FTP Status | 1 of 1

Menu | Query | Query Results

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*Last Name:	Peters	Gender:	Woman	Org & Dept:	
*First Name:	Ewenda	Specialty:		Address:	Code A
Other Names:	Jay	Registration:	Full registration	City:	
Dr/Mr/Ms:	Dr	PMQ:	Code A	Postal Code:	

All Doctors Across Organizations | Menu | Query | Query Results | 1 - 1 of 1

GMC	Alerts	FTP Indicator	UID	Last Name	First Name	Other Names	Dr/Mr/Ms	DOB	Registration	PMQ
			Code A	Ravindrane	Arumugam		Dr	Code A	Full with specialist registration	Code A

Arumugam Ravindrane — Alerts | FTP Status | 1 of 1

Menu | Query | Query Results

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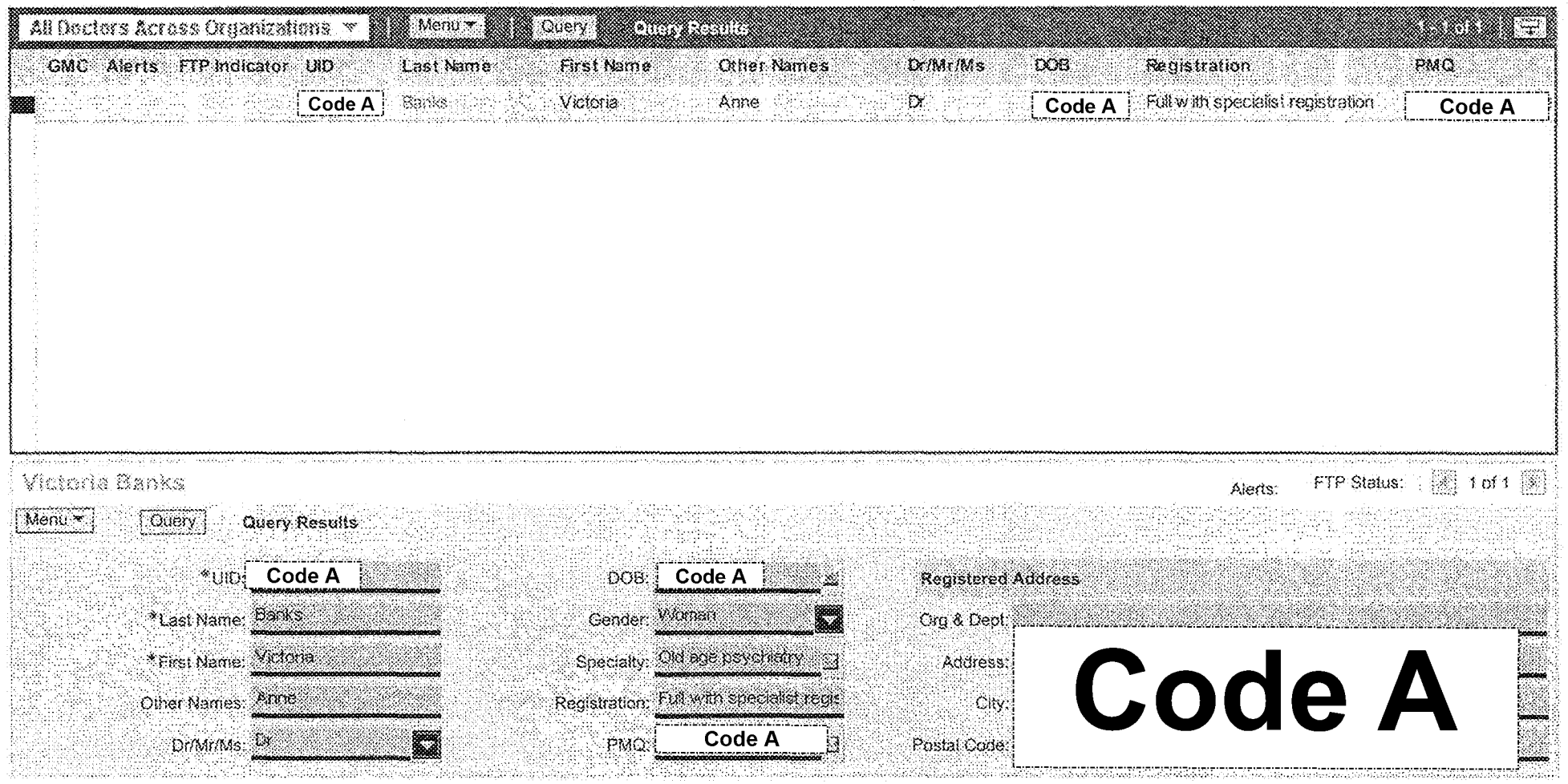
*First Name:	Arumugam	Specialty:	General (Internal) me	Address:	Code A
Other Names:		Registration:	Full with specialist regis	City:	
Dr/Mr/Ms:	Dr	PMQ:	Code A	Postal Code:	


All Doctors Across Organizations
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Query Results
1 - 1 of 1
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First Name
Other Names
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Dr
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Victoria Banks
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1 of 1
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Query Results
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*Last Name:
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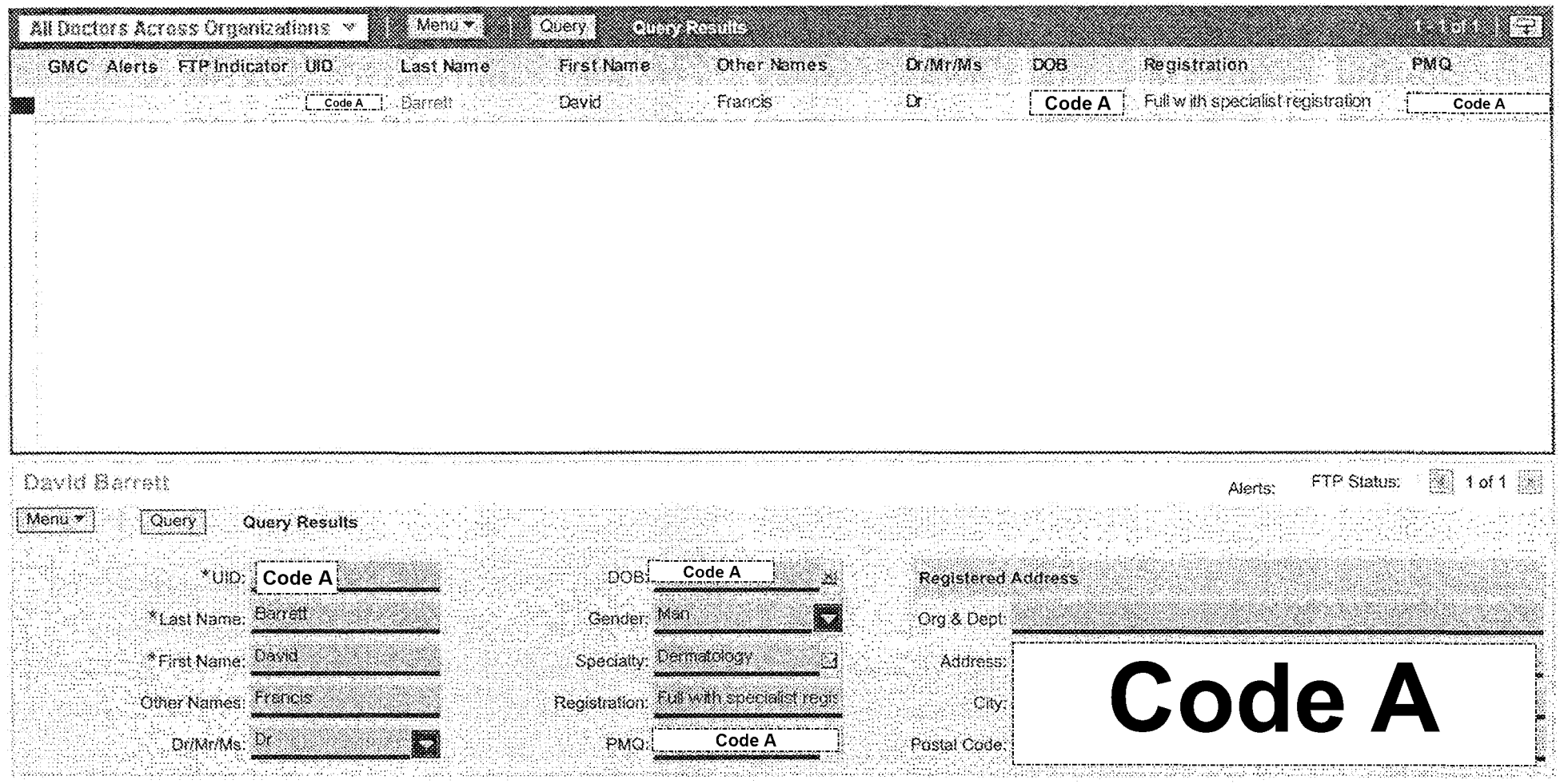
*First Name:
Victoria
Other Names:
Anne
Dr/Mr/Ms:
Dr
DOB:
Code A
Gender:
Woman
Specialty:
Old age psychiatry
Registration:
Full with specialist regis
PMQ:
Code A
Registered Address
Org & Dept:
Address:
City:
Postal Code:
Code A


All Doctors Across Organizations
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Query
Query Results
1 - 1 of 1
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Alerts
FTP Indicator
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First Name
Other Names
Dr/Mr/Ms
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Registration
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Dr
Code A
Full with specialist registration
Code A
David Barrett
Alerts:
FTP Status:
1 of 1
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Francis
Dr/Mr/Ms:
Dr
DOB:
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Org & Dept:
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City:
Postal Code:
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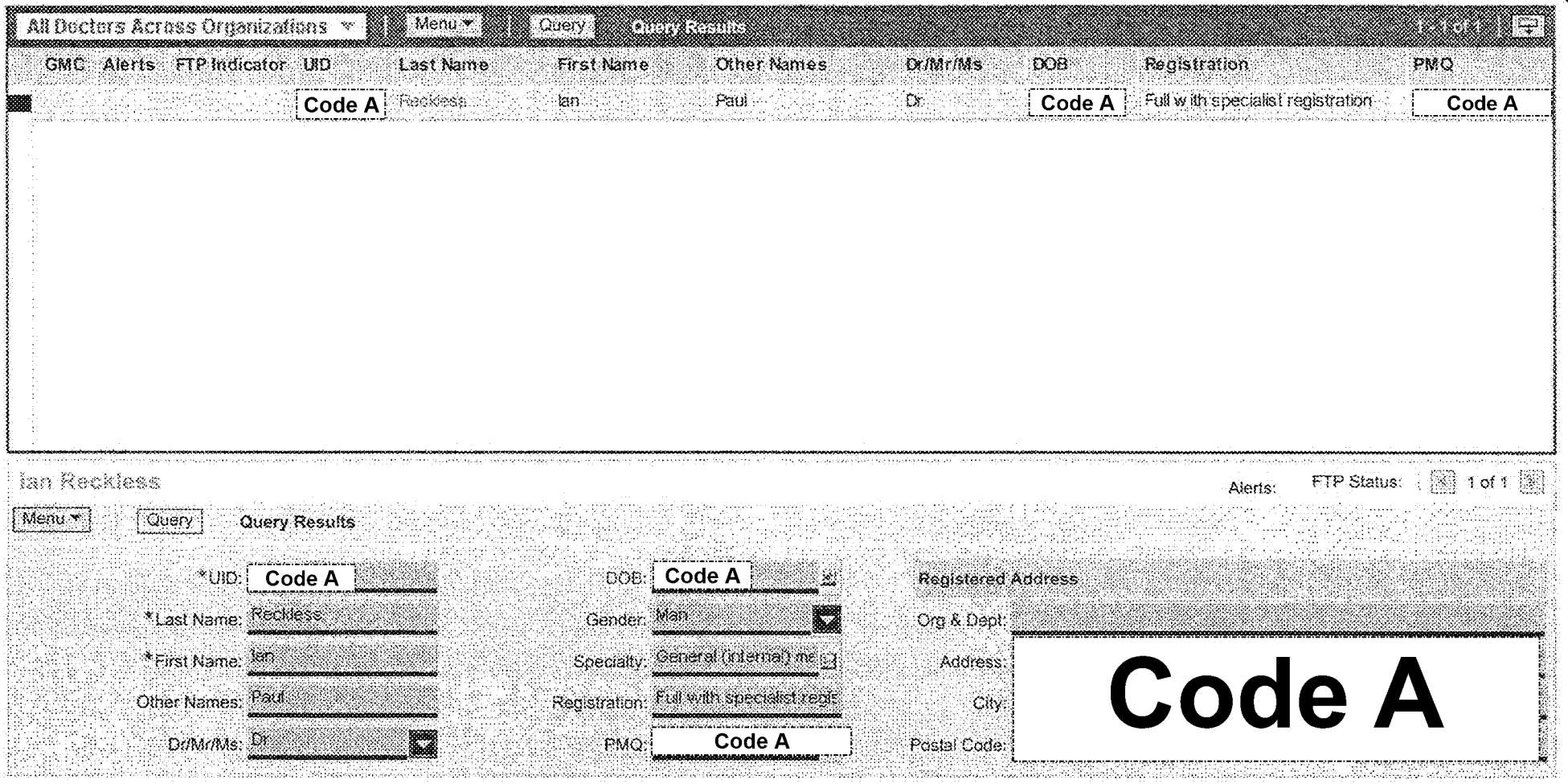
All Doctors Across Organizations
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Query Results
1 of 1
GMC
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FTP Indicator
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First Name
Other Names
Dr/Mr/Ms
DOB
Registration
PMQ
Code A
Reckless
Ian
Paul
Dr
Code A
Full with specialist registration
Code A
Ian Reckless
Alerts:
FTP Status:
1 of 1
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Query Results
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Other Names:
Paul
Dr/Mr/Ms:
Dr
DOB:
Code A
Gender:
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Specialty:
General (internal) me
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Full with specialist regis
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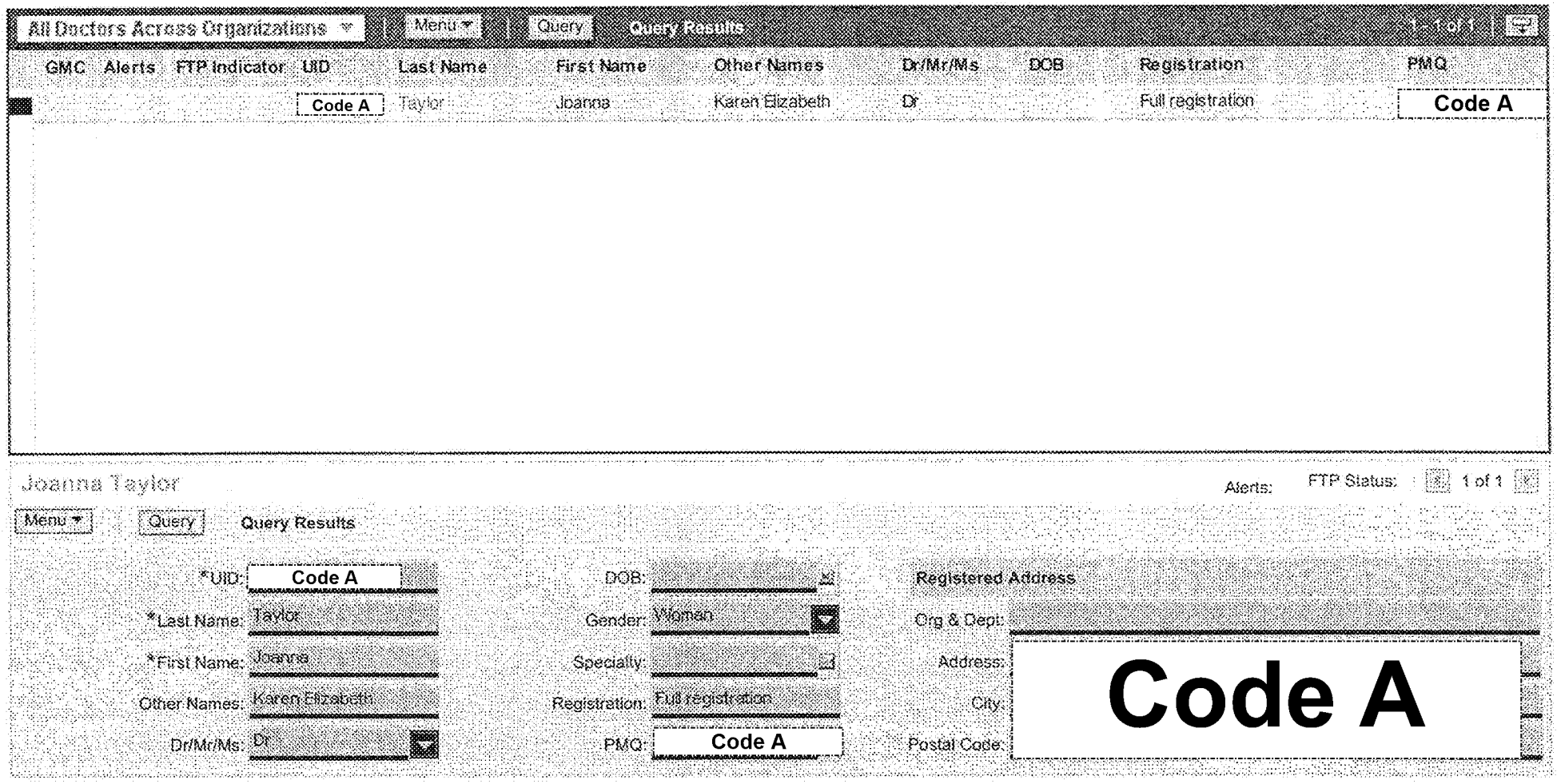
City:
Postal Code:
Code A


All Doctors Across Organizations
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Query Results
1 - 1 of 1
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FTP Indicator
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First Name
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Karen Elizabeth
Dr
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1 of 1
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Joanna
Other Names:
Karen Elizabeth
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Dr
DOB:
Gender:
Woman
Specialty:
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Registered Address
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Address:
City:
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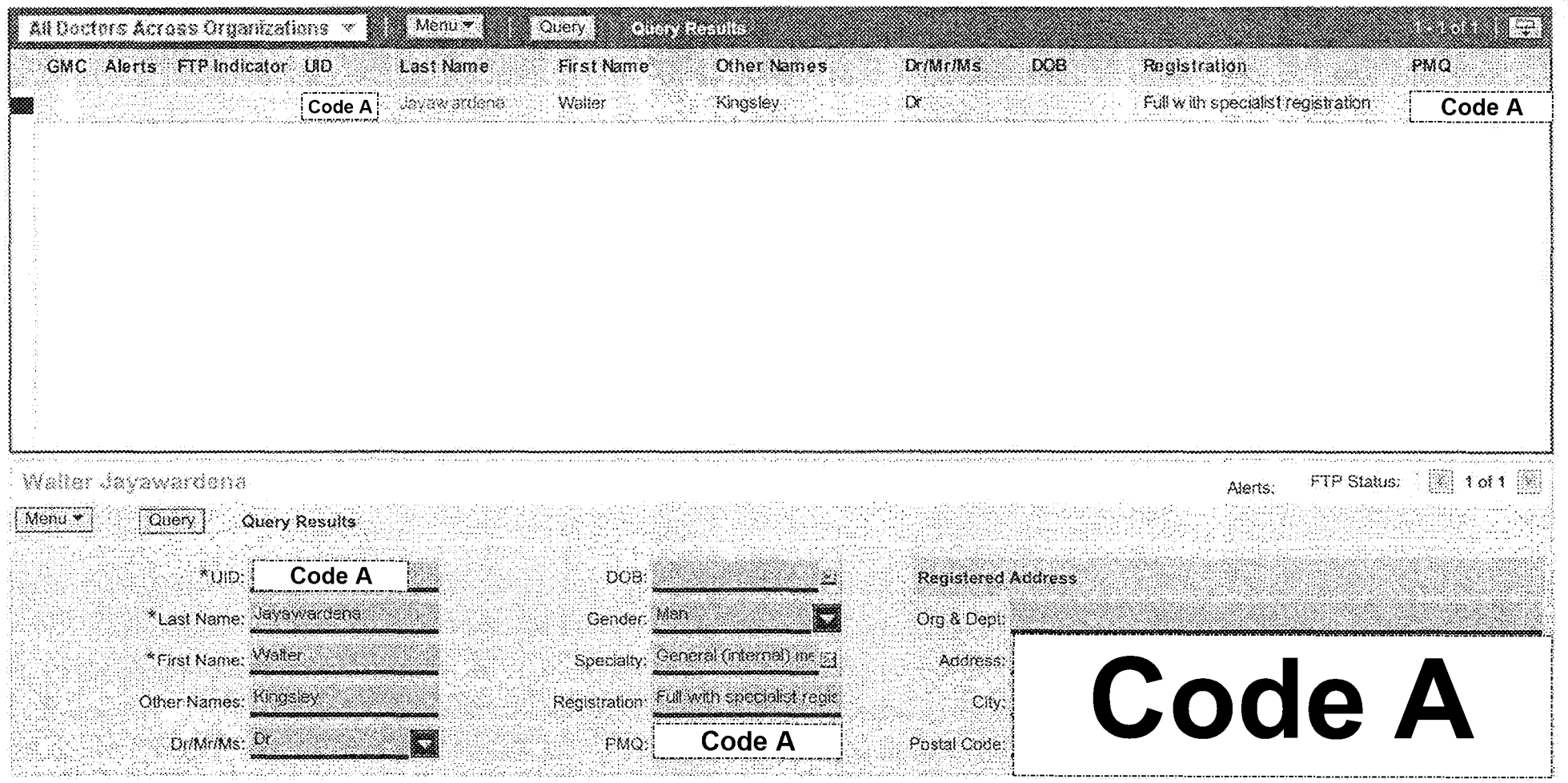
All Doctors Across Organizations
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Query Results
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First Name
Other Names
Dr/Mr/Ms
DOB
Registration
PMQ
Code A
Jayawardena
Walter
Kingsley
Dr
Full with specialist registration
Code A
Walter Jayawardena
Alerts:
FTP Status:
1 of 1
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Query Results
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*First Name:
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Other Names:
Kingsley
Dr/Mr/Ms:
Dr
DOB:
Gender:
Male
Specialty:
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Full with specialist regis
PMQ:
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Registered Address
Org & Dept:
Address:
City:
Postal Code:
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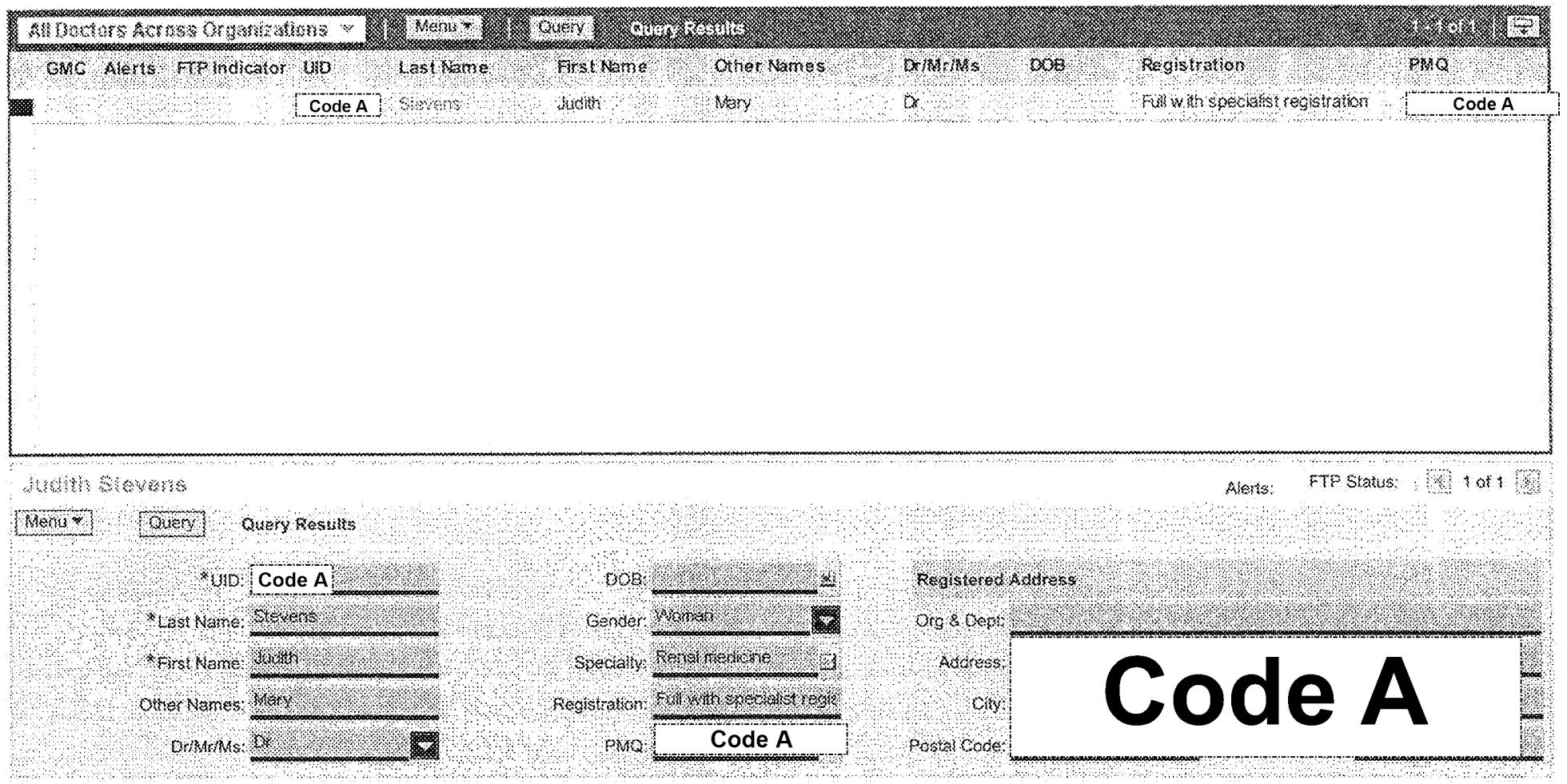
All Doctors Across Organizations
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Query Results
1 - 1 of 1
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Alerts
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DOB
Registration
PMQ
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Mary
Dr
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1 of 1
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Dr/Mr/Ms:
Dr
DOB:
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Full with specialist regis
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Code A
Registered Address
Org & Dept:
Address:
City:
Postal Code:
Code A

All Doctors Across Organizations | Menu | Query | Query Results

GMC	Alerts	FTP Indicator	UID	Last Name	First Name	Other Names	Dr/Mr/Ms	DOB	Registration	PMQ
			Code A	Cranfield	Tanya	Georgina	Dr	Code A	Full with specialist registration	Code A

Tanya Cranfield *** Doctor has closed Cases or Enquiries

Alerts: FTP Status: 1 of 1

Menu | Query | Query Results

*UID: Code A

*Last Name: Cranfield

*First Name: Tanya

Other Names: Georgina

Dr/Mr/Ms: Dr

DOB: Code A

Gender: Women

Specialty: Haematology

Registration: Full with specialist regis

PMQ: Code A

Registered Address

Org & Dept:

Address:

City:

Postal Code:

Code A

All Doctors Across Organizations | Menu | Query | Query Results | 1 - 1 of 1

GMC	Alerts	FTP Indicator	UID	Last Name	First Name	Other Names	Dr/Mr/Ms	DOB	Registration	PMQ
			Code A	Lord	Althea	Everesta Geradette	Dr	Code A	Full with specialist registration	Code A

Althea Lord *** Doctor has closed Cases or Enquiries

Alerts: FTP Status: 1 of 1

Menu | Query | Query Results

*UID: Code A

*Last Name: Lord

*First Name: Althea

Other Names: Everesta Geradette

Dr/Mr/Ms: Dr

DOB: Code A

Gender: Women

Specialty: Geriatrics

Registration: Full with specialist regis

PMQ: Code A

Registered Address

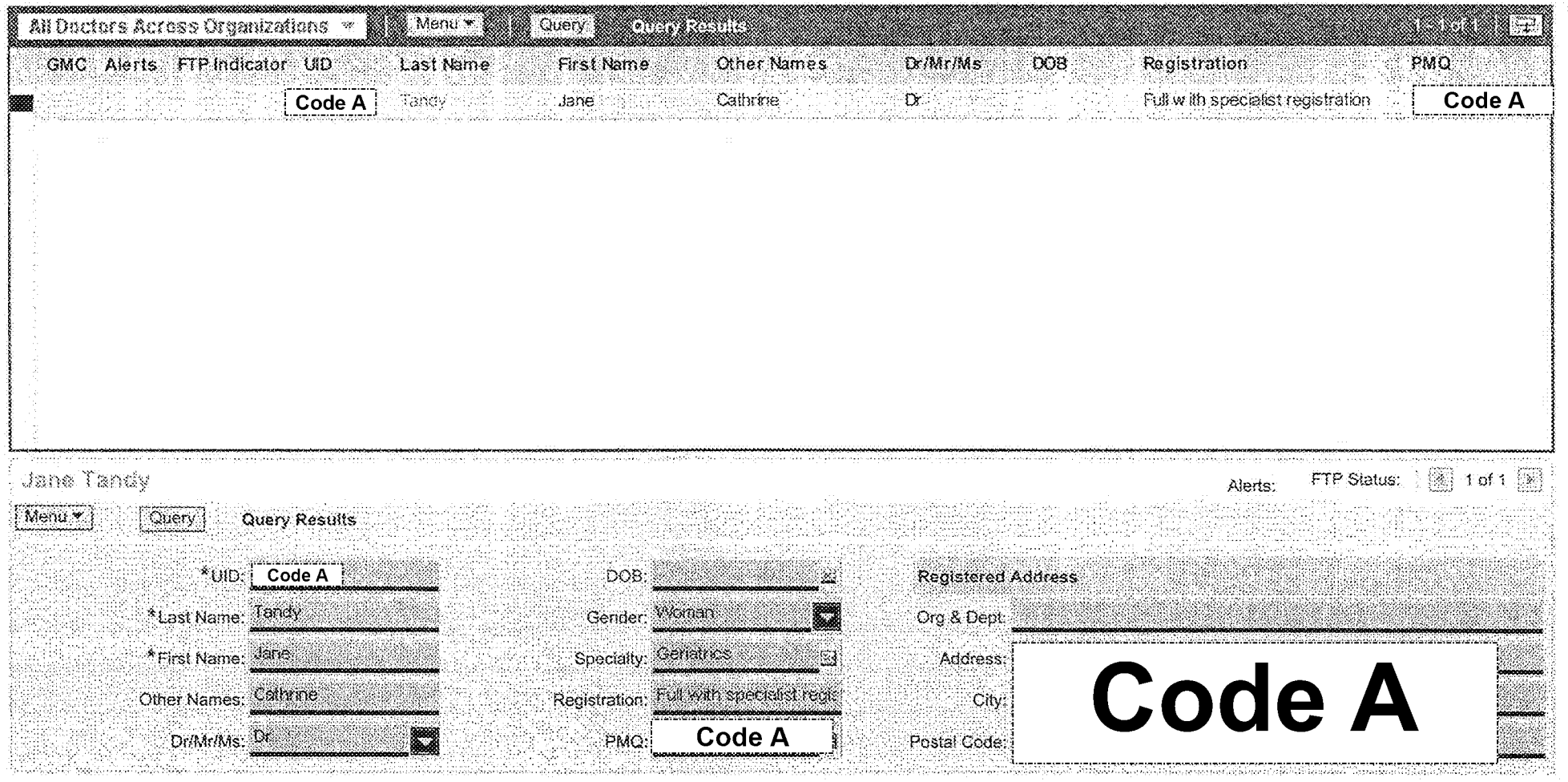
Org & Dept:

Address:

City:

Postal Code:

Code A


All Doctors Across Organizations
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Query Results
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GMC
Alerts
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First Name
Other Names
Dr/Mr/Ms
DOB
Registration
PMQ
Code A
Tandy
Jane
Cathrine
Dr
Full with specialist registration
Code A
Jane Tandy
Alerts:
FTP Status:
1 of 1
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Tandy
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Jane
Other Names:
Cathrine
Dr/Mr/Ms:
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Gender:
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City:
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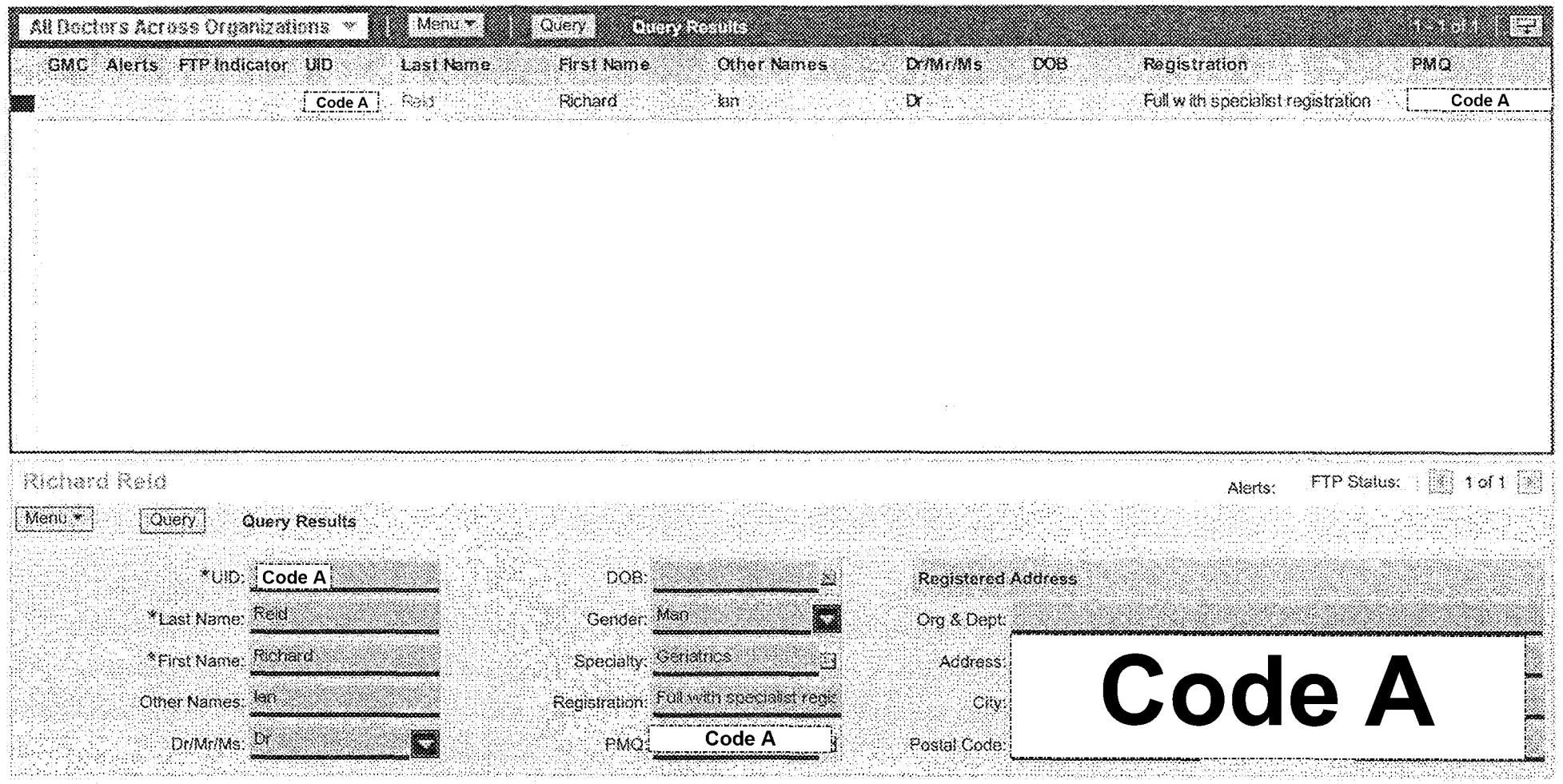
All Doctors Across Organizations
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Query Results
1 - 1 of 1
GMC
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DOB
Registration
PMQ
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Reid
Richard
Ian
Dr
Full with specialist registration
Code A
Richard Reid
Alerts:
FTP Status:
1 of 1
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Dr
DOB:
Gender:
Man
Specialty:
Geriatrics
Registration:
Full with specialist regis
PMQ:
Code A
Registered Address
Org & Dept:
Address:
City:
Postal Code:
Code A

'rom: Code A
ent: 09 Jan 2008 12:14
'o: Code A
:c: Hall, Tamsin
ubject: FW: Dr Barton - choice of expert
)ear Sarah,

write further to my email below.

further discussed this with Peter and we have decided to request that our Adjudication Team start mpanelling Panellists now who commenced after Professor Black ceased being a Panellist and that way 'e will know early on whether there are likely to be any problems.

Code A

---

ro Code A
ent: 19 Dec 2007 17:11
o: 'Ellson, Sarah'
c: Hall, Tamsin
ubject: RE: Dr Barton - choice of expert

arah,

'eter has agreed in principle to use Professor Black as our expert.

)ur Committee Development Team has so far identified 11 previous cases which Professor Black sat on o the possibility of conflict of interest arises if there are Panellists on the case that know Professor Black.

'roposed solutions to this are:

)nly mpanel Panellists who Professor Black has not sat with before. The only disadvantage of this is that ecause Professor Black stopped sitting in May 2005 he is more likely not to know Panellists recruited fter this date who will be less experienced.

t an early stage empanel Panellists including those who have sat with Professor Black and quickly scertain from the defence whether they have any objections to this.

would be grateful for your thoughts.

Code A

---

rom: Ellson, Sarah Code A

ent: 23 Nov 2007 15:25
o: Code A
c: Peter Swain Code A ; Hall, Tamsin
ubject: Dr Barton - choice of expert

lear Code A

ly apologies for the delay in getting back to you on this. I spoke to Peter about this on 5 lovember when he and I met and we agreed that I should speak to Tom Kark to ensure that ur choice of expert was the right one and could be justified. I was only able to discuss this with om last week and I am sorry not to have emailed sooner but I have been away from my desk nd fairly involved with Code A case amongst other things.

know that after the conference you had a number of concerns (as set out in your email of 26)ctober) and felt that Professor Black was himself expressing some reservations about being ıe only expert in this case. I note that he has not given evidence before which is obviously not leal but I actually think his having previously sat on FTP Panels may be of benefit (subject to voiding no conflicts arise) because he will know what is expected at the GMC.

amsin and I havediscussed our options in detail and the suggestion that we could have two xperts which might reduce Professor Black's concerns about being a lone voice in this ase. To this end I reviewed whether we might use Professor Ford (something you asked us to o after the conference). As you may recall Black has reported on 11 cases (Leslie Pittock, lsie Lavender, Ruby Lake, Enid Spurgin, Elsie Devine, Sheila Gregory, Helena Service, eoffrey Packman + 3 that Ford has also done (see below)), Ford has reported on 5 cases Eva Page and Alice Wilkie + the 3 below).

ord & Black have both done reports in the cases of Gladys Richards, Arthur Cunningham which we are probably cancelling) and Robert Wilson. My brief comments on reviewing their eports in these cases were:

ichards

lack is slightly more accepting that this patient might have died. Criticises poor record keeping nd concerned by "anticipatory" prescription of opioid analgesia and prescribing oramorph as rn. He however thinks it was ok to be treating as palliative by 17 August. Ford takes a stronger ne - that patient was for rehab. He also criticises records and in particular he too says opioid nalgesia not appropriate. He describes decision to administer subcutaneously as reckless, ıappropriate and extremely hazardous whereas I think this is stage at which Black is saying alliative approach is ok.

unningham:

lack sees this as an admission for terminal care which it was right to admit. He thinks the case as managed appropriately save for the lack of note/justification for syringe driver and the ncreases of diamorphine on 25/26 Sept 60-80-100 which he says lack justification and appear xcessive. Ford sees this as an admission for healing and pain relief - he thought initial dmission was appropriate but comments on Barton entry re certifying death (no indication he ould die). He criticises the decision to prescribe and administer diamorphine, hyoscine and nidazolam as highly inappropriate, very hazardous and poor practice. He too says increase is ery poor and cannot see justification for subcutaneous (syringe) administration. He criticises ecords and denial of food and fluids.

Wilson:

lack describes the complex condition of this man. His criticisms are reserved for the dose of)iamorph on 15/10 which he describes as negligent. He suggests management plan from QA hould have continued and says it would have been appropriate to first use weaker analgesia. le is okay about mixing diamorphine + hyosine + midazolam but cannot see rationale for ncr[redacted]ing. Ford is less critical of record keeping but more critical of the prescription of iamorphine + hyosine + midazolam - he would only support oramorph. As with Black cannot nderstand increase. Criticises Wilson for inadequate assessment of MI.

:onclusion on comparing Black and Wilson:

)verall I thought the reports were not incompatible on the key issues but generally Ford is tronger than Black is most areas. While Ford is generally a little harsher in his views he does end to blame teams a bit more, rather than just Barton (this of course would have issues for our ;MC case which can only be against Barton and might in fact be a "get out" for her). The efence will of course have both sets of reports and no doubt will put points to whoever we call bout what others have said. I thought Black's written reports were good and are more detailed nat Ford's.

Wh[redacted]we met with Tom last week we discussed the possibility of using both Black and Ford he as firmly against this approach. He thinks that having two experts giving evidence will just nable the defence to play them off against one another and whilst we might say this expert is nly dealing with these cases we could not stop them asking either expert about any of the ases we take forward - we would not know what they would say (or they would both have to do eports in all cases - a complex and costly exercise). In terms of finalising the charge if we have ist one expert we know what to charge - based on their single view. Tom could see the easons why we wanted to consider the two expert approach but did not feel any of our oncerns outweighed the damage he felt would be caused.
he options are therefore
lack FRCP a geriatrician/physician now Dean/Director of Post Grad medicine (Surrey and ussex) (he was medical director at St Mary's Kent 1997-2003) - he has done 11 reports and een to a conference - Tom feels that his questions eg about his reputation were not nsurprising given the issues surrounding expert evidence that have made the news recently. om considered Black was a fair witness which would be better than one who was over bold in onference but crumbled in cross examination. Tamsin's view is that Black was fine and that is concerns were legitimate and that it is best that he raised them at the start. Black has

ıdicated, despite your perception of his reservations at the conference that he is willing to ssist us with this case and is completely happy about proceeding (as you know our first choice ′itness Code A has said he cannot spare the time to help the GMC). Black would need to ɜport on the 2/3 cases he has not seen and we think we will get him to do some form of upplementary statement to cover gaps in his police reports/statements.
ord FRCP Professor of Pharmacology of Old Age (Wolfson Unit Newcastle) on geriatric pecialist register - he has done 5 reports so would have to do a further 5-8 reports. We have ot met him although he has indicated his willingness to assist.
lundy Consultant Physician and Geriatrician Frimley Park (Surrey) - we have chased and hased to try and make contact with him to see if he might assist (he did some reports for the olice). We feel that whilst he might offer a third choice and has the benefit of being still active s a doctor in the field his failure to return any of our calls in the last 2 months means we cannot nagine working with him successfully.
lew expert - this would be by far the most expensive option and would be time consuming. We ave not as yet made any inquiries as to who might assist with this so we do not know whether ′e could find a suitable expert (Mrs McKenzie (daughter of Richards) has suggested a long list f international options we might try!) If you preferred to go this route I think we would have to ive a new expert considerable time to review the records and write reports - I would expect this ɔ dramatically impact on the timetable and would be likely to provoke a defence application to djourn the hearing into 2009. Tom was also worried that we would be seen to be "shopping for n expert" if we were not content to proceed with one of the experts already involved in this ase. The choice of expert is difficult as we will not be able to compare like with like ie Barton ′as a GP doing sessions as a clinical assistant at the GWMH but none of us feel a GP is best laced to judge the case.
is obviously a matter for you. Tom, Tamsin and I feel we can justify the choice of Professor ılack (and him alone) for the reasons set out above. Clearly that does not mean we can uarantee how he will perform in the witness box but obviously we would work with him to make ure we expected him to come up to proof on the matters in the charge - it may be that as a ɜsult we do not charge everything that anyone has criticised in each case, but it is perhaps ght that where a significant number of witnesses have looked at a matter and cannot agree ıat a certain action was wrong we should not charge it as part of our allegation of SPM. There re issues in this case - the most obvious vulnerability seems to be the extent of system failures nd team errors rather than the culpability resting on Dr Barton.
understand Peter wants to make a decision on this as soon as possible - please feel free to all me if you (or he) wants to discuss the matter further.
know that you and Tamsin are dealing with a number of other matters - we have asked that ɔounsel prioritise advising on the issues surrounding Lord, Reid and Tandy who may be crucial ′itnesses but are also potentially subject to criticism and undoubtedly their representatives are oing to want to know the GMC position before we can interview them or take statements.
hank you also for following up with the NMC - an unusual response but I guess if it was a riority they would make the time to meet. It means that we do not know which nurses may ıce disciplinary proceedings but I suggest we continue on the basis we approach those we ıink we need and only deal with the issue if they raise it or once we know we may be relying on particular nurse for any part of the charge.

inally Peter Swain was making some enquiries about the Baker report into the hospital which ıe police have told us we must get from the CMO - we simply do not know if this would be a seful part of the background to this case.

arah Ellson | Partner
or Field Fisher Waterhouse LLP
d: **Code A**

onsider the environment, think before you print!

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/eb www.ffw.com **CDE**823

'rom: Code A
ent: 09 Jan 2008 12:28
'o: Gillian Graves Code A
ubject: FW: Dr Barton - FTPP 8 September 2008 - 40 days
;illian,

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Code A

rom: Gillian Graves Code A
ent: 09 Jan 2008 15:23
o: Code A
c: The Empanelment Team
ubject: RE: Dr Barton - FTPP 8 September 2008 - 40 days
hanks for this Code A, I probably won't get a chance to do anything this week but should be able to next eek. Hope that will be OK.

hanks

ill

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ent: 15 Jan 2008 17:24
'o: 'Ellson, Sarah'
:c: Hall, Tamsin; Watson, Adele; Timms, Mary
ubject: RE: Dr Barton
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:ent: 14 Jan 2008 08:32
'o: Code A
:c: Hall, Tamsin; Watson, Adele; Timms, Mary
:ubject: RE: Dr Barton

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;et feedback from Counsel about progress and rate limiting points

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Ve would welcome your comments and feedback on any of the above.

understand Mary and Peter will meet to discuss this case on 18 and I am seeing Peter on 22 anuary so I thought I should copy this to Mary also.

arah Ellson | Partner

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Code A

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/eb www.ffw.com **CDE**823

rom: **Code A**
ent: Friday, January 11, 2008 10:19 AM
o: Hall, Tamsin
c: Ellson, Sarah
ubject: Dr Barton

amsin,

lr Stevens

ou may recall that you previously enquired whether we had a received a witness statement Mr tevens, I have checked the files that we hold and I can only find the attached correspondence from lr Steven's daughter, June Bailey.

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:ounsel's advice is due on 21 January 2008, is Tom is still on schedule to provide it by that time, as I /ish book a meeting with Peter to discuss the advice so after it is received?

Code A

;eneral Medical Council

:t James Building, 79 Oxford Street Manchester. M1 6FQ

:eg[illegible]s Place, 350 Euston Road, London. NW1 3JN

'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
'ax: 0845 357 9001

'rom: Code A
ent: 17 Jan 2008 13:20
'o: 'Hall, Tamsin'
:c: Code A Peter Swain Code A
ubject: RE: Update Dr Barton
amsin,

hank your for your email.

'rofessor Black

is agreed to pay Professor Black £200.00 ph for proving his report, but before he begins we need to gree with him a time estimate in terms of hours for preparing the report or a capped fee. Also incidental xpenses will have to be approved as they arise. I will need to seek advice from our Finance Section oncerning the billing arrangements that Professor Black suggests.

ravel expenses – In accordance with our guidance mileage is reimbursed at 40p per mile, further o uidance provides that standard class train travel should be used. Our guidance does not provide for air avel so Professor Black will need to seek our approval if the need for this arises.

)r Barker

lichael Cotton chased the DOH about the report this week and I have spoken to him today and he will end a further chaser.

'eter – Tamsin has set out Mrs Reeves and Mrs Mackenzie's views on Professor Black below.

Code A

---

rom: Hall, Tamsin Code A
ent: 17 Jan 2008 12:32
'o: Code A
ubject: Update Dr Barton

li Code A

'rofessor Black

'lease could you confirm that you are happy with the following rates prior to me sending out a formal lette f instruction?

agree that the hourly rate for all work is £200 per hour, including incidental expenses such as secretarial xpenses.

lowever for the days of attending the hearing I would want £1200 per day. This will be in two parts. £600 illed directly by me and £600 billed by the deanery to be used for backfill in my absence.
ravel expenses should be direct reimbursement of public transport or taxi costs. I can not see how I ould need to travel outside London but if I did it would either be 45p per mile or first class train costs r business class air costs."

Irs Reeves' and Mrs McKenzie's views on Professor Black

oth Mrs R and Mrs MK are long time protagonists for the families of the patients. They are essentially nhappy with all of the experts used by the Police and feel that it was on the basis of the expert's reports at the CPS decided not to prosecute. Which is essentially true. However, they have not seen any of the eports but nonetheless have concluded that the reports must make erroneous conclusions. This is based n their supposition and the fact that the CPS read out extracts from the reports to them.

lso, they are unwilling to accept the severity of the conditions afflicting their relatives.

hey also have dug into Prof Black's background and have found out that he also has sat on a committee ith Alan Milburn. This has led them to conclude that because the Government said "there will never be nother Shipman" that there will be some kind of cover up conspiracy.

have assured them that Professor Black will act as an Independent expert and is appropriately qualified o do so. He will have the opportunity to read all of the witness statements and also we can address any oncerns which they may have regarding specifics about the treatment of their relatives which might not e accurately reflected in the medical records.

will instruct Professor Black to prepare a generic report covering, amongst other topics, dementia. Both Irs R and Mrs MK complain that their mothers were not suffering from dementia to the degree that the otes suggest. However, as Prof Black explained in Con, it is often the case that elderly patients are etter able to function in the company of their relatives.

Irs R has written to Professor Black directly to which he has not responded and I have written to her skin her to direct any queries to me. I know that she has also been bombarding the PCT and the oroner with her concerns and I have been unable to allay her fears. She also has a history of press nvolvement.

do not think that their fears are justified and feel that they would be raising the same issues whoever we ad instructed. Mrs R in particular cannot understand the role of an expert witness (she keeps repeating at no-one could be an expert if they have not examined her mother) despite me explaining this on umerous occasions.

r Baker report

Ve would like this as soon as possible as it may influence the drafting of the charges.

imetable

Ve are still discussing this with Counsel and Professor Black. For your information I am meeting with om and Rebecca next week to discuss how we will proceed administratively and to ensure that the metable is realistic. I will, of course, keeping you updated.

Ir Stevens

s discussed by e-mail yesterday, we are in the process of instructing Professor Black with regard to this.

orrespondence with the defence

will write to them to let them know about the instructed expert and also proposing the new timetable. As arah has explained, they will no doubt object!

isit to Portsmouth / witnesses

have arranged to visit Hampshire from 29 to 31 January and am meeting with the PCT and hopefully ome of the witnesses to take further statements and to allay any concerns they have.

ll witnesses have now been contacted except for Drs Lord, Tandy and Reid (the consultants) about hom Counsel is preparing advice currently.

egards

amsin

amsin Hall | Solicitor
r Field Fisher Waterhouse LLP
Code A

Code A

---

rom: Code A
ent: Tuesday, January 15, 2008 5:24 PM
o: Ellson, Sarah
c: Hall, Tamsin; Watson, Adele; Timms, Mary
ubject: RE: Dr Barton

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This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify gmc@gmc-uk.org

General Medical Council

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Legus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
'ax: 0845 357 9001

From: Michael Cotton Code A
Sent: 17 Jan 2008 15:21
To: Code A
Cc: Peter Swain Code A
Subject: FW: Gosport case

for info

-----Original Message-----
From: Code A
Sent: 17 Jan 2008 15:22
To: Michael Cotton Code A
Subject: Re: Gosport case

From: David O'Carroll, Deputy Branch Head, Professional Regulation + Room 2N11 Quarry House Code A ,
Code A

Michael

I understand that a colleague Agatha Ferrao will be replying to you direct..

David O'Carroll

P Help save paper - do you need to print this email?

'rom: Code A
ent: 11 Jan 2008 10:19
'o: Hall, Tamsin
:c: 'Ellson, Sarah'
ubject: Dr Barton

ıttachments: papers.pdf
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Code A

Ernest J Stevens

Code A

19 August 2005

Dear Mr Hinton,

Following my Fathers recent telephone conversation regarding the death of my Mother (Mrs Jean Irene Stevens), on 22nd May 1999 at the War Memorial hospital.

My Father and I are unhappy with the decision of my Mothers death being accidental, as we were originally told she had been categorised as a level 3, most serious case. There was also concern for possible negligence clinical abuse.

Thank you for agreeing to help my Father and I bring closure at this sad time.

Yours Sincerely

Code A

June Bailey.

HAMPSHIRE CONSTABULARY

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

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 ONA

Mr Stevens

Code A

21st July 2005

Dear Mr Stevens,

The purpose of this letter is to set out, in order, the investigation relating to your late wife's treatment at the Gosport War Memorial hospital (GWMH) prior to her death in May 1999.

Can I remind you of the sequence of events.

Operation Rochester was commenced in 2002 in order to investigate concerns raised by a number of families regarding the circumstances of relatives whilst patients at the GWMH. You reported your concerns to us on 16th September 2002.

As you may remember, on the 6th Jan 2003 the Police obtained the medical records relating to Mrs Stevens, from the Gosport War Memorial Hospital. These records were copied and distributed to a team of medical experts who specialised in the following fields, Toxicology (the study and effect of chemicals upon the body). Palliative (the care of the terminally ill), Geriatrics (Care of the elderly), General Medicine and Nursing.

Having studied the content of the medical records, the experts came to the joint conclusion that the care that your wife received gave them cause for grave concern. Their review paid particular attention to the medication that she was both prescribed and administered. Accordingly your wife's case was categorised as a level 3 (most serious).

The medical experts identified that there appeared to be a lack of initial detailed medical information and thus could not identify why she received the care that she did. As a direct result, the police investigation was centred on discovering further medical records that related to your wife's initial admission. These records were subsequently found at the Royal Naval Hospital Haslar.

The records were seized on the 16th October 2003, copied and re-distributed to the medical experts. The medical team performed a further detailed review of these notes. They reported their findings at a conference held last February.

Their conclusions were amended in the light of the Haslar records. They noted that your wife had been admitted to Haslar Hospital on 26th April 1999 having suffered a CVA (stroke). Her recovery was affected when she later suffered a Myocardial Infarction (heart attack) on 28th April 1999.
Mrs Stevens was transferred to the Gosport War memorial hospital on the 20th May 1999. She subsequently died two days later.

The medical experts all agreed that the treatment Mrs Stevens received had been the correct and appropriate treatment from the day of her admission to Haslar. Her treatment and the subsequent care plans were fully in line with what they would expect in light of her continuing illness.

Mrs Stevens had been prescribed and administered appropriate levels of analgesics (pain relief) to alleviate her pain and potential discomfort from the date of her admission. This care continued whilst she was a patient at GWMH.

In reviewing the medical records in their entirety, the experts are now of the opinion that the care and treatment of your wife was fully in accordance with standard medical practice. Accordingly they were able re-categorised your wife's case as level 1.These means that they had no cause for concern regarding the treatment provided by any healthcare professional and that your wife died of natural causes.

These findings have subsequently been ratified by an independent medical legal expert to ensure that all possible enquiries have been concluded.

Enquires of this nature are complex and detailed and inevitably take time. As new evidence emerges it can change significantly the way we need to we view each case. I know from my previous visit to you and from what Kate Robinson has reported to me, how distressing this matter has been for you and your family.

I would therefore like to take this opportunity to thank you for the patience, support and dignity you have displayed during our investigation.

Yours sincerely

Code A

Nigel Niven
Deputy SIO

Re: Dr Barton

'rom: Ellson, Sarah Code A
ent: 16 Jan 2008 17:22
'o: Code A
:c: Hall, Tamsin
ubject: Re: Dr Barton

'amsin is best placed to answer this. I spoke to him once early on - I am not sure if she has poken to him since. I am not back until Friday if you need me to check my note.

;arah Ellson | Partner

)r Field Fisher Waterhouse LLP
Code A

:onsider the environment, think before you print!

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
/eb www.ffw.com **CDE**823

Re: Dr Barton

●

From: Code A
To: Ellson, Sarah Code A
CC: Hall, Tamsin
Sent: Wed Jan 16 15:18:19 2008
Subject: FW: Dr Barton

Hello,

●

have to phone Mr Stevens, could you tell me briefly what you told him previously.

Code A

From: Valerie Barr Code A
Sent: 16 Jan 2008 11:18
To: Code A
Subject: Dr Barton

●

Hi Code A

Mr Stevens, would like to speak to you about the case – Gosport War Memorial Hospital? – on Code A Code A please.

Val

Re: Dr Barton

ieneral Medical Council

t James Building, 79 Oxford Street Manchester. M1 6FQ

.egents Place, 350 Euston Road, London. NW1 3JN

he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

.egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

el: 0845 357 8001
ax: 0845 357 9001

rom: Hall, Tamsin Code A
ent: 18 Jan 2008 15:36
o: Code A
ubject: Barton - FYI letter to defence

ttachments: DOCS_6636488_1.DOC

Code A

etter to the defence as promised.

amsin Hall | Solicitor
r Field Fisher Waterhouse LLP
Code A

Code A

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el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
Veb www.ffw.com **CDE**823

FAO Ian Barker
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Our ref: TET/00492-15579/6636488 v1
Your ref:

Also sent by e-mail to Code A

18 January 2008

Dear Sirs

General Medical Council - Dr J Barton

We write to update you with regard to the current position regarding our investigation.

We intend to rely upon Professor Black's expert evidence in this case. You already have the reports he has drafted for the Police investigation. We anticipate that he will also prepare reports on Eva Page, Alice Wilkie, Jean Stevens and Edna Purnell. We will disclose these to you as soon as we receive them.

We would like to inform you, at this early juncture, that Professor Black has previously acted as a Panel member on approximately 11 GMC Fitness to Practise Panels. He was appointed to the Fitness to Practise directorate in 2001 and resigned in early 2005. The GMC adjudication section have indicated that they will take steps to ensure that the Panel members empanelled for this case were appointed after May 2005. In the circumstances, we do not consider that this could give rise to any objection but would be grateful if you would confirm this.

For your information, Professor Black will be unavailable to attend the hearing until 23 September 2008 but we anticipate that this will broadly fit with the anticipated running order.

Unfortunately we are not in a position to serve the Draft Notice of Hearing upon you at the present time. We would propose to serve the Draft Notice of Hearing by 3 March 2008, over six months before the hearing is due to begin. In our view this should not affect the hearing date of 8 September 2008 as we have already disclosed to you the bulk of the evidence upon which we will seek to rely. We have sent you the witness statements and medical records in relation to each patient and a copy of all of the expert reports (including those prepared by Dr Black). On or before 3 March we will have sent you Professor Black's reports on Eva Page, Alice Wilkie, Jean Stevens and Edna Purnell. We

are in the process of drafting production statements or supplementary statements for those witnesses whom we will intend to call at the hearing and propose to serve these upon you by 3 March 2008 at the latest.

We may have further supplementary expert reports (by way of clarification) to serve upon you after 3 March 2008. We intend to do this by the beginning of April. We do not anticipate that any evidence served after 3 March will alter the Draft Notice of Hearing substantively.

We presume that the documents which you are already in receipt of will enable you to commence hearing preparation and to instruct an expert.

We also are in possession of a large amount of information, provided by Hampshire Constabulary, that will form the unused material. We would be grateful if you would contact us regarding how the material may best be provided to you.

There is a Stage 2 telephone conference scheduled for 24 January 2008. We propose that this be adjourned until after 3 March 2008. Please confirm if you agree to this and we will contact GMC adjudications and make the necessary arrangements.

We regret that we have been unable to provide you with draft charges today. We will, of course, keep you fully informed of developments. Please do contact us if you wish to discuss any matters raised in this matter further.

Yours faithfully

Field Fisher Waterhouse LLP

'rom: Code A
ent: 22 Jan 2008 15:59
'o: 'Hall, Tamsin'
:c: Ellson, Sarah
ubject: RE: Barton - update of arrangements re Professor Black
amsin,

hanks for email.

eter advised that when Professor Black returns from holiday he should be brought up speed on any vidence that he wasn't aware that has come out from the cross examination of witnesses.

Code A

---

rom: Hall, Tamsin [mailto:tamsin.hall@ffw.com]
ent: 18 Jan 2008 14:49
'o: Code A
:c: Ellson, Sarah
ubject: Barton - update of arrangements re Professor Black

)ear Code A

write to confirm details of our conversations today re Professor Black.

informed Professor Black of the hearing dates when I initially spoke to him in October 2007 nd have recorded this in my attendance note. However, it transpired this week that Professor lack had erroneously understood that the hearing was to commence in October and has made lans to be abroad in early September and cannot alter these.

rofessor Black will be abroad from 5 September 2008 until Sunday 21 September 2008. He ould be available to read into transcripts on 22 September 2008 (directed to the appropriate nd relevant parts by us) and the he would give evidence from 23 September.

Ve discussed alternative options of either adjourning the hearing by a couple of weeks so that rofessor Black could attend the whole hearing or instructing another expert, which would ssentially jeopardise the current hearing schedule.

ou have discussed the matter with Peter and have confirmed to me that your preferred option ; to formally instruct Professor Black and for him to attend the hearing from 23 September 2008.

will proceed upon that basis and formally instruct him. He has already been sent some

apers and will also receive more on Monday to enable him to start preparation of the upplementary and additional reports.

am about to send a letter to the Defence confirming that we are not in a position at present to erve the Draft Notice of Hearing upon them and proposing the new timetable as agreed with ou previously. I will copy the letter to you for your information as agreed.

Ve had scheduled a Stage 2 telecon for 11:00 on 24 January 2008. This will now need to be acated. I have included this within the letter to the defence and will e-mail adjudications.

hanks - Have a good weekend.

amsin

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP
Code A

lobile Code A

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/eb www.ffw.com **CDE**823

'rom: Code A
ent: 17 Jan 2008 13:20
'o: 'Hall, Tamsin'
'c: Code A Peter Swain Code A
ubject: RE: Update Dr Barton
amsin,

hank your for your email.

'rofessor Black

is agreed to pay Professor Black [redacted] for proving his report, but before he begins we need to gree with him a time estimate in terms of hours for preparing the report or a capped fee. Also incidental xpenses will have to be approved as they arise. I will need to seek advice from our Finance Section oncerning the billing arrangements that Professor Black suggests.

rav expenses – In accordance with our guidance mileage is reimbursed at [redacted], further our uidance provides that standard class train travel should be used. Our guidance does not provide for air avel so Professor Black will need to seek our approval if the need for this arises.

)r Barker

lichael Cotton chased the DOH about the report this week and I have spoken to him today and he will end a further chaser.

'eter – Tamsin has set out Mrs Reeves and Mrs Mackenzie's views on Professor Black below.

Code A

---

rom: Hall, Tamsin Code A
ent: 17 Jan 2008 12:32
'o: Code A
ubject: Update Dr Barton

li Code A

'rofessor Black

'lease could you confirm that you are happy with the following rates prior to me sending out a formal lette f instruction?

[redacted]

3rd Party
Informatio

[redacted]

lrs Reeves' and Mrs McKenzie's views on Professor Black

oth Mrs R and Mrs MK are long time protagonists for the families of the patients. They are essentially nhappy with all of the experts used by the Police and feel that it was on the basis of the expert's reports iat the CPS decided not to prosecute. Which is essentially true. However, they have not seen any of the eports but nonetheless have concluded that the reports must make erroneous conclusions. This is based n their supposition and the fact that the CPS read out extracts from the reports to them.

lso, they are unwilling to accept the severity of the conditions afflicting their relatives.

hey also have dug into Prof Black's background and have found out that he also has sat on a comm[redacted]ee ith Alan Milburn. This has led them to conclude that because the Government said "there will never be nother Shipman" that there will be some kind of cover up conspiracy.

have assured them that Professor Black will act as an Independent expert and is appropriately qualified o do so. He will have the opportunity to read all of the witness statements and also we can address any oncerns which they may have regarding specifics about the treatment of their relatives which might not e accurately reflected in the medical records.

will instruct Professor Black to prepare a generic report covering, amongst other topics, dementia. Both lrs R and Mrs MK complain that their mothers were not suffering from dementia to the degree that the otes suggest. However, as Prof Black explained in Con, it is often the case that elderly patients are etter able to function in the company of their relatives.

lrs R has written to Professor Black directly to which he has not responded and I have written to her sking her to direct any queries to me. I know that she has also been bombarding the PCT and the oroner with her concerns and I have been unable to allay her fears. She also has a history of press ivolvement.

do not think that their fears are justified and feel that they would be raising the same issues whoever we ad instructed. Mrs R in particular cannot understand the role of an expert witness (she keeps repeating iat no-one could be an expert if they have not examined her mother) despite me explaining this on umerous occasions.

r Baker report

Ve would like this as soon as possible as it may influence the drafting of the charges.

imetable

Ve are still discussing this with Counsel and Professor Black. For your information I am meeting with om and Rebecca next week to discuss how we will proceed administratively and to ensure that the metable is realistic. I will, of course, keeping you updated.

Ir Stevens

s discussed by e-mail yesterday, we are in the process of instructing Professor Black with regard to this.

orrespondence with the defence

will write to them to let them know about the instructed expert and also proposing the new timetable. As arah has explained, they will no doubt object!

isit to Portsmouth / witnesses

have arranged to visit Hampshire from 29 to 31 January and am meeting with the PCT and hopefully ome of the witnesses to take further statements and to allay any concerns they have.

ll witnesses have now been contacted except for Drs Lord, Tandy and Reid (the consultants) about hom Counsel is preparing advice currently.

egards

amsin

am Hall | Solicitor
r Field Fisher Waterhouse LLP
d Code A

lobile Code A

---

rom: Code A
ent: Tuesday, January 15, 2008 5:24 PM
o: Ellson, Sarah
c: Hall, Tamsin; Watson, Adele; Timms, Mary
ubject: RE: Dr Barton

arah,

hank for your email which I have discussed with Peter.

eter would like to know what Mrs Reeves and Mrs Mckenize's views on Professor Black are.

/e note your proposed timetable, which is subject to your discussions with Counsel and Professor Black. eter is of the view that if this new timetable is feasible after your discussions we must stick to it to avoid opardising the hearing date and we must let the defence know at an early stage of any changes to the metable. Please confirm the timetable after your discussions.

/e note that you will inform the defence about our choice of expert and I will keep you informed about evelopments with empanelment.

eter has asked Michael Cotton to make enquiries with the Department of Health about the report from Dr arker, when would you ideally require the report by?

lease note that I will on leave from 11-22 February 2008 and Code A **will cover my wo n ny absence.**

Code A

---

rom: Ellson, Sarah Code A
ent: 14 Jan 2008 08:32
o: Code A
c: Hall, Tamsin; Watson, Adele; Timms, Mary
ubject: RE: Dr Barton

)ear Code A

'amsin and I met to discuss progress on this matter on Friday.

'ou have asked about Counsel's advice which is due on 21 January. Counsel wrote on hursday in the following terms "*We are of course under pressure of time for the draft charges ut I am still aiming for the 21st though that may need a little bit of flexibility. Can you let me now how Dr Black is getting on with the reports on Page and Wilkie and also what his time stimate is on the report for Purnell and Stevens now that he has their records? I am having a ıinor operation tomorrow but it does require a General and so I may be out of action for a few 'ays. Depending on recovery I am hoping to be back working by Tuesday/Wednesday next 'eek.*"

his suggests that there is some doubt about our being ready with a draft charge by 21 anuary. There are some problems with the matters Counsel asks about and I have just written) him to make the following points:

to reiterate the pressures of the timetable and the risk of defence objections to the listing if we et behind (although I think these can be resisted for some time yet)

to explain that we were waiting for Counsel to advise on matters to be raised with Black (and 'hether a further con was required). That said there have of course been some other issues onfirming the decision to use Black (this was only confirmed by the GMC on 19 December) - 'e are just confirming formalities with him and will get the papers on Wilkie/Page/Stevens/ 'urnell to him next week

to ask whether Counsel considers a draft charge can be prepared yet? I suspect as a ıinimum he will need a report from Black for each case so in my opinion 21 Jan is unrealistic see may thoughts on a new timetable below). We have also been hoping for some guidance 'om Counsel as to whether there are other pieces of information he needs to do the charge. Ve have identified for ourselves witnesses of fact we believe will be relevant and have either 'ritten to them to ask for production statements or are hoping to see them at the end of anuary. If Counsel does need additional information we hope we have at least set in train ıquiries that may help us to have this by early Feb. (The Trust are helping us trace/contact staff 'itnesses but this has taken several weeks and has only been resolved today).

the advice we sought urgently from Counsel, to which he refers, relates to the other key octors Lord/Tandy/Reid who we need to rule out if we are to have any prospect of asking them) co-operate with this case. The letters to these potentially important witnesses have not gone ntil we know what to say when they or their lawyers get in touch.

)n other matters:

. Thank you for checking about the Stevens statement. He may mean the daughter's orrespondence. Tamsin will check this and about the GMC files you mention although they do ot ring a bell.

. Mrs Reeves and Mrs Mckenzie have strong views about Professor Black and have been ombarding Tamsin with these. We are satisfied we can justify the use of Professor Black and f course this is not a complainant case but I thought you should be aware.

. Thank you for keeping us informed about empanelment it is our view we should disclose our hoice of expert and the steps being taken by the GMC in our next letter to the defence.

. I understand from the last case review that the GMC are pursuing getting the CMO ommissioned report from Baker

ı summary I think we should next write to the defence to explain progress and our proposed evised timetable. One thing to have in mind is how robust the GMC will wish to be about the earing date. We can expect the defence to start complaining immediately. If everything is isclosed by mid March they still have nearly 6 months to prepare. My view is that the defence ave plenty they can be getting on with and we should resist any adjournment requests owever I appreciate we must then aim to stick to the timetable and further delays will worsen ıe position and an adjournment late in the day would be highly undesirable.

hope the following may be realistic but does have to be checked with Black and Counsel:

nmediately instruct Black on 4 further cases

ecide approach to Lord/Tandy/Reid

et feedback from Counsel about progress and rate limiting points

9-31 Jan see outstanding witnesses

ıid Feb reports (on 4 unreported cases) from Black (subject to this being possible for him)

5 Feb draft charges from Counsel

nd Feb draft charges approved and disclosed + disclosure of new reports

nd of Feb complete disclosure of production statements and new evidence save for final Black eports

lid/late March - supplementary/GMC style reports from Black for all cases.

Ve would welcome your comments and feedback on any of the above.

understand Mary and Peter will meet to discuss this case on 18 and I am seeing Peter on 22 anuary so I thought I should copy this to Mary also.

arah Ellson | Partner

r Field Fisher Waterhouse LLP
d: Code A

onsider the environment, think before you print!

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/eb www.ffw.com **CDE**823

rom: Code A
en Friday, January 11, 2008 10:19 AM
o: Hall, Tamsin
c: Ellson, Sarah
ubject: Dr Barton

amsin,

Ir Stevens

ou may recall that you previously enquired whether we had a received a witness statement Mr tevens, I have checked the files that we hold and I can only find the attached correspondence from Ir Steven's daughter, June Bailey.

lowever, we cannot locate two of our files: 2002/2340/01 and 2002/0941/01, by any chance did versheds pass them to you?

:ounsel's Advice

:ounsel's advice is due on 21 January 2008, is Tom is still on schedule to provide it by that time, as I ish book a meeting with Peter to discuss the advice so after it is received?

Code A

;eneral Medical Council

:t James Building, 79 Oxford Street Manchester. M1 6FQ

:egents Place, 350 Euston Road, London. NW1 3JN

'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
'ax: 0845 357 9001

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:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
'ax: 0845 357 9001

Re: Dr Barton

'rom: Hall, Tamsin Code A
ent: 16 Jan 2008 18:14
'o: Code A
ubject: Re: Dr Barton

[e will be preparing a report along the same lines as his others. I will send him detailan of the family's concerns)o.

'amsin Hall Solicitor Field Fisher Waterhouse sent by blackberry

1obile. Code A

----Original Message-----
rom: Code A
'o: Hall, Tamsin <tamsin.hall@ffw.com>
ent: Wed Jan 16 17:37:16 2008
ubject: RE: Dr Barton

'hanks Tamsin,

ıst to clarify are you specially instructing Professor Black on oncerns raised by Mr Stevens and his daughter.

Code A

----Original Message-----
rom: Hall, Tamsin Code A
ent: 16 Jan 2008 17:23
'o: Ellson, Sarah; Code A
ubject: RE: Dr Barton

[i Code A

'es, I have spoken to him. The latest position is that I have obtained ıformation from the Police and am about to instruct Black on the case. will then hope to be in a position to update him further.

'hanks

'amsin

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

1obile Code A

Re: Dr Barton

[redacted]

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rom: Ellson, Sarah
ent: Wednesday, January 16, 2008 5:22 PM
'o: Code A
'c: Hall, Tamsin
ubject: Re: Dr Barton

'amsin is best placed to answer this. I spoke to him once early on - I m not sure if she has spoken to him since. I am not back until Friday

Re: Dr Barton

you need me to check my note.

arah Ellson | Partner

or Field Fisher Waterhouse LLP
d: Code A

----Original Message-----
rom: Code A
o: Ellson, Sarah
C: Hall, Tamsin Code A
ent: Wed Jan 16 15:18:19 2008
ubject: FW: Dr Barton

[ello,

have to phone Mr Stevens, could you tell me briefly what you told him reviously.

Code A

---

rom: Valerie Barr Code A
ent: 16 Jan 2008 11:18
o: Code A
ubject: Dr Barton

[i Code A

Mr Stevens, would like to speak to you about the case - Gosport War Memorial Hospital? - on Code A please.

al

his email and any files transmitted with it are confidential and ntended solely for the use of the individual or entity to whom they are

Re: Dr Barton

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0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
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'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

.egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
ax: 0845 357 9001

'rom: Hall, Tamsin Code A
ent: 30 Oct 2007 12:15
'o: Code A
:c: Ellson, Sarah
ubject: RE: Dr Barton

li Code A

have spoken to Mr Stevens this morning and explained that currently his case is not one /hich we have all the evidence for and that I am in the process of assessing what we do ave with regard to his wife's treatment. He is very unhappy with the way the police dealt /ith the case. He said that initially they were most sympathetic and that they told him that ıey viewed his case as very serious and then they seemed to 'lose interest'. He is very een for his wife to be included as one of the patients that are investigated by the GMC.

Code A and his daughter gave statements to the police. He thinks he sent Paul Hylton copies of ıese. We do not appear to have any that the police have sent us. Could you see if Paul oes have any / there are any on your system?

ıs agreed at the con, I will look into exactly what we have got for this case and for that of :dna Purnell so that we can decide how to proceed with these cases in terms of whether we hould ask Professor Black/another expert to advise on the prospects of success.

have dictated a note of the con and will circulate this to you once it has been typed up. I oped to do this last week but was unfortunately out of the office so I apologise for the delay.

have received your comments about Professor Black and am meeting with Sarah this fternoon to discuss your concerns in more depth and we will then get back to you with our iews.

have not received suggestions for a junior as yet but will chase counsel's clerk again and et back to you with some names as soon as possible.

'hanks

'amsin

'amsin Hall | Solicitor
ɔr Field Fisher Waterhouse LLP
Code A

1obile Code A

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/eb www.ffw.com **CDE**823

rom: Code A
ent: Friday, October 26, 2007 8:21 AM
o: Hall, Tamsin
c: Ellson, Sarah
ubject: FW: Dr Barton

lello,
lease note below.
m not sure what we are telling patient's families and so we are consistent I would be grateful if you ould ring Mr Stevens.
hanks Code A

---

rom: Paul Hylton Code A
ent: 24 Oct 2007 09:54
o: Code A
ubject: Dr Barton
Code A

Ir Stevens just called re an update on the case. He has received a letter from FFW to explain that ney have taken over the case, but he has not heard anything since. He does phone for updates from me to time, his wife was one of the patients who died, and he is always very pleasant and polite. you have anything that you can tell him his number is Code A
aul

otify gmc@gmc-uk.org

ieneral Medical Council

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'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
ax: 0845 357 9001

From: Michael Cotton Code A
Sent: 17 Jan 2008 15:21
To: Code A
Cc: Peter Swain Code A
Subject: FW: Gosport case

for info

-----Original Message-----
From: Code A
Sent: 17 Jan 2008 15:22
To: Michael Cotton Code A
Subject: Re: Gosport case

From: David O'Carroll, Deputy Branch Head, Professional Regulation + Room Code A , Code A

Michael

I understand that a colleague Agatha Ferrao will be replying to you direct..

David O'Carroll

P Help save paper - do you need to print this email?

From: Michael Cotton Code A
Sent: 17 Jan 2008 15:21
To: Code A
Cc: Peter Swain Code A
Subject: FW: Gosport case

for info

-----Original Message-----
From: Code A
Sent: 17 Jan 2008 15:22
To: Michael Cotton Code A
Subject: Re: Gosport case

From: David O'Carroll, Deputy Branch Head, Professional Regulation + Room
Code A

Michael

I understand that a colleague Agatha Ferrao will be replying to you direct..

David O'Carroll

P Help save paper - do you need to print this email?

'rom: Claire Riley [Code A]
ent: 24 Jan 2008 09:33
'o: 'Hall, Tamsin'; Barker, Ian
:c: Ellson, Sarah; [Code A] Claire Riley [Code A]
ubject: RE: Barton - Stage 2 telecon 24 Jan 2008

mportance: High
)ear All

urther to Tamsin's email I confirm that the stage 2 telecon will not take place today at 11:00.
Ve would like to re-schedule this for week commencing 3 March and I would therefore appreciate you
)rwarding me dates that you are all available to take part in the stage 2 that week.

look forward to hearing from you.

:ind regards

:laire Riley
.djudication Listings
[Code A]

---

rom: Hall, Tamsin [Code A]
ent: 23 Jan 2008 15:25
'o: Claire Riley [Code A]
:c: Ellson, Sarah; Barker, Ian; [Code A]
ubject: Barton - Stage 2 telecon 24 Jan 2008

'lease can this be vacated - we need to relist for some time after 3 March 2008.

he defence have agreed this course of action.

amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
d [Code A]

lobile [Code A]

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

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rom: Claire Riley [Code A]
ent: 24 Jan 2008 11:21
o: 'Hall, Tamsin'; Barker, Ian
c: Ellson, Sarah; [Code A]
ubject: RE: Barton - Stage 2 telecon 24 Jan 2008
ear All

lany thanks for your replies. The stage 5 (old rules) has been re-scheduled to take place on 4 March 08 @ 1:00.
look forward to speaking with you then.

ind regards

laire

---

rom: Hall, Tamsin [Code A]
ent: 24 Jan 2008 09:55
o: Barker, Ian; Claire Riley [Code A]
c: Ellson, Sarah; [Code A]
ubject: RE: Barton - Stage 2 telecon 24 Jan 2008

lello all

am also free any day that week.

hanks

amsin

am Hall | Solicitor
or Field Fisher Waterhouse LLP
[Code A]

lobile [Code A]

---

rom: Barker, Ian [Code A]
ent: Thursday, January 24, 2008 9:54 AM
o: Claire Riley [Code A] Hall, Tamsin
c: Ellson, Sarah; [Code A]
ubject: RE: Barton - Stage 2 telecon 24 Jan 2008

ear Claire

lany thanks for the message. I am free any day in that week.

est wishes

an

-----Original Message-----
From: Claire Riley Code A
Sent: 24 January 2008 09:33
To: Hall, Tamsin; Barker, Ian
Cc: Ellson, Sarah; Code A
Subject: RE: Barton - Stage 2 telecon 24 Jan 2008
Importance: High

Dear All

Further to Tamsin's email I confirm that the stage 2 telecon will not take place today at 11:00. We would like to re-schedule this for week commencing 3 March and I would therefore appreciate you forwarding me dates that you are all available to take part in the stage 2 that week.

I look forward to hearing from you.

Kind regards

Claire Riley
Adjudication Listings
Code A

From: Hall, Tamsin Code A
Sent: 23 Jan 2008 15:25
To: Claire Riley Code A
Cc: Ellson, Sarah; Barker, Ian; Code A
Subject: Barton - Stage 2 telecon 24 Jan 2008

Please can this be vacated - we need to relist for some time after 3 March 2008.

The defence have agreed this course of action.

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
Code A

Code A

Consider the environment, think before you print!

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'rom: Hall, Tamsin Code A
ent: 24 Jan 2008 17:48
'o: Code A
:c: Ellson, Sarah
ubject: RE: Barton - update of arrangements re Professor Black

li Code A

just thought that I'd let you know that the defence have confirmed that they have no bjection to Prof Black being used with regard to him having been a Panellist previously.

'hey have asked for written confirmation about why we have not been able to serve the)NOH on them by 18 Jan 2008. I will send you a copy of my response prior to sending it to ıe defence for your comment. I will send this over to you on Monday as I am out of the ffice on leave tomorrow.

)ur basic position is that we have disclosed the majority of the used evidence on them and ıey should be able to commence hearing preparation now and therefore the delay will not ause them any prejudice.

'hanks

'amsin

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

Code A

:onsider the environment, think before you print!

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
/eb www.ffw.com **CDE**823

rom: Code A
ent: Tuesday, January 22, 2008 3:59 PM
o: Hall, Tamsin
c: Ellson, Sarah
ubject: RE: Barton - update of arrangements re Professor Black

amsin,
hanks for email.
eter advised that when Professor Black returns from holiday he should be brought up speed on any
vidence that he wasn't aware that has come out from the cross examination of witnesses.

Code A

'rom: Code A
ent: 31 Jan 2008 15:00
'o: Gillian Graves Code A
ubject: Dr Barton
lello Gill,

m on leave for nearly 2 weeks from 13 February 2008.

;ould you let me know before then the names of the Panellist that you have empanelled and their iographical details so that we can forward this information to the defence to see if they have any bjections.

'hanks
Code A

From: Code A
Sent: 31 Jan 2008 15:04
To: Michael Cotton Code A
Subject: RE: Gosport case

Hi Michael,

Have you heard anything further Agatha Ferrao, the reason that I ask is that I'm on leave from 13- 22 February and our Counsel has to finalise the charges by 25 February?

Code A

-----Original Message-----
From: Michael Cotton Code A
Sent: 17 Jan 2008 15:21
To: Code A
Cc: Peter Swain Code A
Subject: FW: Gosport case

for info

-----Original Message-----
From: Code A
Sent: 17 Jan 2008 15:22
To: Michael Cotton (020 7189 5168)
Subject: Re: Gosport case

From: David O'Carroll, Deputy Branch Head, Professional Regulation + Room
Code A ,

Michael

I understand that a colleague Agatha Ferrao will be replying to you direct..

David O'Carroll

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'rom: Code A
ent: 31 Jan 2008 15:24
'o: The Empanelment Team
ubject: RE: Dr Barton
'hanks, we'll disclose on that basis and let me know if there any change.

---

rom: Gillian Graves Code A **On Behalf Of** The Empanelment Team
ent: 31 Jan 2008 15:23
'o: Code A
c: The Empanelment Team
ubject: RE: Dr Barton

'es, as long as they know that it is subject to change and obviously do not attempt to contact any of the 'anellists, but I'm sure this goes with out saying.

'hanks

;ill

---

rom: Code A
ent: 31 January 2008 15:16
'o: The Empanelment Team
ubject: RE: Dr Barton

'hanks Gill, is it ok to disclose to the defence at this stage?

---

rom: Gillian Graves Code A **On Behalf Of** The Empanelment Team
ent: 31 Jan 2008 15:15
'o: Code A
c: The Empanelment Team
ubject: RE: Dr Barton

li Code A

'lease see the details of the Panel we have secured at the moment, this is subject to change as with all 1ese things so I would be grateful if the information didn't get spread too widely about. Let me know if you eed any other info.

'hanks

;ill

Mr Andrew Reid, LLB JP
Director, Pecksniff's Ltd. Member: Prescription Medicine Code of Practice Authority Appeal Board. Justice of the Peace. Member, Magistrates' Association Executive Committee, West Sussex Branch. Formerly: Criminal Defence Barrister; British Council Country Director, Taiwan; CEO Powco, Vietnam.

Mrs Pamela Mansell, CQSN AMDP MA
Management Consultant in Org Development Social Care and Child Care (inc Health Authorities). Previous employment : C/E of Charity: Director of Children and Family Services - L/A. Member: CIPD : Past President - Inner Wheel Club (Partner Org of Rotary).

Mr Toyin Okitikpi, FRSA BA Socia
Mental Health Review Tribunal. Member of Asylum & Immigration Tribunal. Member of Adventure - social work/social welfare consultancy. Member of monitoring committee - Bar Council. Researcher - Social work/Social welfare.

Dr Anthony Isaacs, MA MSc BM BCh
Senior Medical Assessor, MHRA. Emeritus Consultant Endocrinologist, Chelsea & Westminster Hospital. Honorary visiting Professor, Middlesex University. Member: Society for Endocrinology; BMA, MDDUS. Fellow RCP (London); RSM. Member of Council and Honorary Vice President, Section of Endocrinology and Diabetes, RSM. Chair of Governors, Hendon School.

Dr Alex McFarlane, MB BS FRCS
Member: British Medical Association; Scottish Catholic Medical Association. Medical Protection Society; Conservative and Unionist Party. Fellow: Royal College of Surgeons of England. Senior Medically Qualified Panel Member (The Appeals Service) : Department of Constitutional Affairs.

From: Code A
Sent: 31 January 2008 15:00
To: Gillian Graves Code A
Subject: Dr Barton

Hello Gill,

I'm on leave for nearly 2 weeks from 13 February 2008.

Could you let me know before then the names of the Panellist that you have empanelled and their biographical details so that we can forward this information to the defence to see if they have any objections.

Thanks
Code A

'rom: Code A
ent: 31 Jan 2008 15:31
'o: Code A ; Tamsin Hall ffw (formerly Tomlinson) Code A
ubject: Dr Barton
)ear All,

,elow are the proposed Panellists for the hearing.

)ur Adjudication Section has advised that this information can be disclosed to the defence, but they hould be made aware that it is subject to change and they should not contact any of the Panellists.

1r Andrew Reid, LLB JP
)irector, Pecksniff's Ltd. Member: Prescription Medicine Code of Practice Authority Appeal Board. Justice f the Peace. Member, Magistrates' Association Executive Committee, West Sussex Branch. Formerly: ;riminal Defence Barrister; British Council Country Director, Taiwan; CEO Powco, Vietnam.

1rs Pamela Mansell, CQSN AMDP MA
1anagement Consultant in Org Development Social Care and Child Care (inc Health Authorities). 'revious employment : C/E of Charity: Director of Children and Family Services - L/A. Member: CIPD : 'ast President - Inner Wheel Club (Partner Org of Rotary).

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1ental Health Review Tribunal. Member of Asylum & Immigration Tribunal. Member of Adventure - social /ork/social welfare consultancy. Member of monitoring committee - Bar Council. Researcher - Social /ork/Social welfare.

)r Anthony Isaacs, MA MSc BM BCh
;enior Medical Assessor, MHRA. Emeritus Consultant Endocrinologist, Chelsea & Westminster Hospital. lonorary visiting Professor, Middlesex University. Member: Society for Endocrinology; BMA, MDDUS. ellow RCP (London); RSM. Member of Council and Honorary Vice President, Section of Endocrinology nd Diabetes, RSM. Chair of Governors, Hendon School.

)r Alex McFarlane, MB BS FRCS
1ember: British Medical Association; Scottish Catholic Medical Association. Medical Protection Society; ;onservative and Unionist Party. Fellow: Royal College of Surgeons of England. Senior Medically lualified Panel Member (The Appeals Service) : Department of Constitutional Affairs.

Code A

FAO Ian Barker
MDU
230 Blackfriars Road
London
SE1 8PJ

Our ref: TET/00492-15579/6670173 v1
Your ref: ispb/990079

24 January 2008

Dear Sirs

General Medical Council - Dr J Barton

Thank you for your letter of 23 January 2008.

We are grateful for your confirmation that you do not raise any objection to Professor Black acting as our expert in this case.

As you correctly identify in your letter, we hoped to be in a position to serve the Draft Notice of Hearing upon you by 18 January 2008. As we informed you by letter of 18 January 2008 this will no longer be possible and we now propose to serve the Draft Notice of Hearing by 3 March 2008.

It may be helpful for us to explain why our investigation has taken longer than anticipated.

To date we have disclosed to you:

1. 30 August 2007 – 2 folders of medical reports

   (a) Elsie Devine – reports of Dr Wilcock, Prof Black, Dr Dudley

   (b) Gladys Richards – reports of Prof Ford, Prof Livesley, Prof Black

   (c) Helena Service – reports of Prof Black, Dr Petch, Dr Wilcock

   (d) Sheila Gregory – reports of Prof Black, Dr Wilcock

   (e) Arthur Cunningham – reports of Prof Black, Dr Wilcock

(f) Geoffrey Packman – reports of Dr Marshall, Prof Black, Dr Wilcock

(g) Alice Wilkie – reports of Dr Mundy, Prof Ford

(h) Eva Page – reports of Dr Mundy, Prof Ford

(i) Ruby Lake – reports of Dr Wilcock (x2), Prof Black

(j) Leslie Pittock – reports of Dr Wilcock (x2), Prof Black

(k) Robert Wilson – reports of Prof Baker, Prof Black, Dr Marshall

(l) Elsie Lavender – reports of Prof Black, Dr Wilcock

(m) Enid Spurgin – reports of Dr Redfearn, Prof Black, Dr Wilcock

(n) Generic report of Professor McQuay (sent on 5 December 2007 to be inserted into the folders)

2. 10 October 2007

(a) Medical records for 14 patients; Alice Wilkie, Arthur Cunningham, Sheila Gregory, Robert Wilson, Helena Service, Ruby Lake, Elsie Devine, Enid Spurgin, Geoffrey Packman, Elsie Lavender, Gladys Richard, Jean Stevens, Leslie Pittock, Eva Page

(b) Patient files (witness statements and interviews) for 13 patients; Arthur Cunningham, Sheila Gregory, Robert Wilson, Leslie Pittock, Ruby Lake, Enid Spurgin, Helena Service, Alice Wilkie, Eva Page, Geoffrey Packman, Elsie Lavender, Gladys Richards, Elsie Devine

(c) Copy of CHI investigation report

3. 11 October 2007 - Statements/interviews of Drs Lord and Tandy in relation to Elsie Lavender, Robert Wilson, Ruby Lake, Gladys Richards, Arthur Cunningham and Leslie Pittock.

4. 5 December 2007 – Summary of medical records (prepared by Field Fisher Waterhouse)

5. 14 December 2007

(a) Medical records of Jean Stevens (also disclosed on 10 October 2007 – additional set, these are in an alternative order), Edna Purnell

(b) Generic case files – 2,3,4,5,6,7 (number 1 does not exist)

6. Enclosed with this letter, by way of disclosure, is:

   (a) Witness folder Edna Purnell

   (b) Witness folder Jean Stevens

   (c) Colour copy of photographs of Room 3 Gosport War Memorial Hospital

7. Also enclosed with this letter, by way of disclosure, is a list of witnesses whom we anticipate that we will need to call. (More detail about this is included below)

We are currently making arrangements for the copying of the material supplied to us by the Police which does not relate to any of the patients whom we anticipate will form part of the charges. We will forward this to you as soon as we are able.

As detailed above, we have now disclosed to you the majority of the evidence upon which we anticipate that we will seek to rely. We would anticipate that you are able to commence hearing preparation to a large extent from the documents that you already have prior to the service of the Draft Notice of Hearing.

We have unfortunately encountered some delays in our investigation. We do not, however, anticipate that these will have any effect upon your hearing preparation. You have asked that we explain the reasons for the delays. You will note that these have been peculiar to our investigation as the "prosecutors" and, now the information has been obtained and preparation is underway, we do not foresee that you will suffer any similar setbacks to your preparation.

We have had to spend some considerable time in liaison with the experts who prepared reports for the Police. It has taken some time to ascertain availability from a number of potential experts and then issue formal instructions to Professor Black.

As we are sure you understand we have had to identify which witnesses, out of the large number interviewed by the Police we regard as acting as potential witnesses at the Fitness to Practise hearing. Getting in contact with them has taken some considerable amount of time caused in large part through liaison with the Primary Care Trust and the Police to ascertain current contact details and employment status and to obtain all of the relevant information.

For your information the witnesses we anticipate that we will call are listed on the attached sheet headed 'summary of witnesses (24.01.08)'. This lists all of the witnesses whom we have currently identified as having relevant statements. We have included the initials of the patients whom they have made statements with regard to for your ease of reference. Please note that this is a provisional list and we reserve the right to call additional witnesses. We anticipate that the majority of these witnesses will not have any substantial new evidence to that which is contained within the statements which they have made to the Police, which you already have. We are in the process of obtaining production statements and taking additional statements where necessary.

We confirmed to you, by letter of 14 December 2007 that we considered it likely that we proceed with charges in relation to Gladys Richards, Elsie Lavender, Robert Wilson, Eva Page, Elsie Devine, Alice Wilkie, Ruby Lake, Geoffrey Packman, Leslie Pittock and Enid Spurgin. We reserved our position, in order to carry out further investigation, with regard to Sheila Gregory, Arthur Cunningham, Helena Service, Jean Stevens and Edna Purnell. We maintain this position.

You are in possession of Professor Black's reports in relation to all of those patients listed above except for Alice Wilkie, Eva Page, Jean Stevens and Edna Purnell. Professor Black is in the process of preparing reports in relation to these patients and we will disclose this to you as soon as we are able.

The GMC have informed you that the Stage 2 telephone conference has been rescheduled for 11:00 on 4 March 2008.

We hope that this clarifies the current position, please contact Tamsin Hall if you have any additional queries.

Yours faithfully

Field Fisher Waterhouse LLP

GMC

v

Dr Jane Barton

Advice

Re: Charges in respect of patients Cunningham, Service and Gregory

---

1. I have been asked specifically to consider whether there is sufficient evidence to justify including charges against Dr Barton in respect of the following three patients: Arthur Cunningham, Helena Service and Sheila Gregory.

2. Of those three I understand that only the case of Arthur Cunningham has already been referred by the Preliminary Proceedings Committee (under the old rules) but in my view the same consideration should be applied to each. That is, whether or not Dr Barton's conduct in relation to each of those patients, when looked at together with the other evidence of her conduct towards other patients is such as to justify the inclusion of charges.

3. Each case does not have to amount to an allegation that would justify a finding of serious professional misconduct but, if it does not, then the misconduct would have to be sufficiently serious so as to add to the wider picture going to support an allegation of serious professional misconduct. If it does not do so then it would not be appropriate to add that case. If those instructing me consider this approach to be wrong then the conclusions of this advice may have to be revisited.

Arthur Cunningham

4. In July 1998 this patient had been admitted to GWMH suffering from Parkinson's disease and Dementia. He was discharged briefly to a nursing home. On Monday 21st September 1998 this patient was admitted to Dryad Ward by Dr Lord who had been the Consultant responsible for his care. He was in considerable pain from a large, necrotic sacral ulcer. Dr Lord noted that his prognosis was poor. In a second statement to the police (dated 12.10.05) Dr Lord states that she does not recollect any conversation with Dr Barton regarding this patient's continuing care.

5. On Dryad Ward Dr Barton became responsible for his care. She prescribed Oramorphine which the patient received on the 21st, and also Dr Barton prescribed Midazolam with a range of 20-80mgs and Diamorphine with a range of 20-200 mgs which is described elsewhere by Professor Black as an unacceptable range but in this case is described as within an acceptable starting range. Dr Barton wrote in the notes that she was 'happy for nursing staff to confirm death'.

6. The patient was very agitated and aggressive according to nursing notes and became calmer once the syringe driver had been started on the 21st September.

7. The nursing notes reveal that on the 24th the night and day staff reported that the patient was in pain and his analgesia being Midazolam and Diamorphine was increased.

8. On Friday 25th September he was seen by Dr Barton's partner Dr Brook who did not change his medication and who noted – 'remains very poorly on syringe driver for TLC'. 'TLC' means of course 'tender loving care' but it is also an indication that the prognosis was very poor and the patient was dying. On Saturday the 26th September 1998 the patient died.

9. I will summarise below Professor Black's report –

   i) AC was managed appropriately including an appropriate decision to start a syringe driver for managing his symptoms;

ii) Professor Black was concerned about an increased dose of both Diamorphine and Midazolam in the syringe driver on the 25th and 26th September for which he could find no justification in the notes.

iii) In Professor Black's view those doses may have slightly shortened life.

10. There are two complaints in reality in relation to this patient's management. The first is the lack of notes which seems to pertain throughout Dr Barton's practice at this hospital and which she will defend by saying that she was too busy. The second issue is the dosage of the analgesics in the last two days of the patient's life.

11. Dr Wilcock in his report suggests that Dr Barton's standard of care fell short of a good standard but concludes that other doctors may have followed a similar course. He is critical of prescribing analgesics via a syringe driver as 'PRN' or 'as required'. He is also critical of the wide range of the Diamorphine prescription.

12. However Dr Wilcock also makes clear that the large doses were not in fact administered and Dr Barton could be seen simply as a doctor who was trying to allow her patient a peaceful death.

13. I make reference to Dr Wilcock's report only to establish that he is no more critical of Dr Barton's actions that Professor Black.

14. Although the criticism are much more limited in this case than with other patients the themes of criticism are still common - a lack of note making which falls below an acceptable standard; an unacceptably wide range for a prescription of diamorphine (depending on which view of Professor Black's opinion one takes); higher than justified dosage of analgesia in the few days leading up to the patient's death.

15. In conference I indicated that in my view this was one of the weaker cases and one that could be considered for cancellation. I do not depart from the view that the criticisms of Dr Barton's practice, in so far as it affected this patient,

are more limited than in relation to other patients. However, the theme of the criticism are the same and, on reflection, the evidence of bad clinical practice pertaining to this patient's treatment is sufficient in the context of the wider issues in this case to support a charge of serious professional misconduct.

16. I would like a further opportunity of discussing this case with Professor Black to try to ascertain what he is actually saying about the wide dosage regime in this case.

Helena Service

17. This patient was admitted to the Queen Alexandra Hospital on 17th May 1997 at the age of 99. She was suffering from a chest infection and likely cardiac failure.

18. On the 2nd June the Queen Alexandra nursing notes record that she was very demanding overnight and Professor Black opines that it appears that she was then deteriorating and entering the terminal phase of her illness.

19. She was transferred to GWMH Dryad Ward on Tuesday 3rd June 1997. Dr Barton conducted the admission assessment and concluded that the patient was suffering from heart failure. Professor Black is critical of the notes made on the patient's admission.

20. Dr Barton prescribed opiate analgesia of Midazolam and Diamorphine. The diamoprhine was prescribed within a range of 20-60 mgs subcutaneously. On Wednesday 4th June administration of the same opiates was commenced via syringe driver. Professor Black's view is that although 20 mgs as a starting dose is at the top end for elderly patients it is nevertheless within current guidelines. There was good reason according to Professor Black to give this patient Diamorphine.

21. Friends (Jean Kennedy and Delia Keene) noted a significant change in her condition after her arrival at GWMH.

22. In the early morning of Thursday 5th June this patient died. Professor Black's criticisms in relation to Dr Barton's treatment are limited to the lack of notes on her admission and a higher than necessary dose of opiates in the combination of 20 mgs of Diamorphine and 40 mgs of Midazolam. This dosage may have 'slightly shortened life although this opinion does not reach the standard of proof of beyond reasonable doubt' according to Professor Black.

23. Dr Wilcock is also critical of the starting dose but only goes so far as to say that it was likely to be excessive to her requirements.

24. Looking at this case individually and also considering it in the wider context of the case as a whole, I do not think that there is sufficient evidence to support an allegation of misconduct in respect of the care offered to Mrs Service. I advise therefore that no charges should be based upon Dr Barton's care of this patient.

Sheila Gregory

25. On 15th August 1999 this patient was admitted to Haslar Hospital having sustained a fractured neck of femur following a fall. On Friday 3rd September 1999 at Dr Tandy's direction she was transferred to GWMH Dryad Ward. She was seen by Dr Barton.

26. Thereafter she was seen by Dr Barton regularly and by Dr Reid once a week. Dr Barton was away on leave between 12th and 16th November and the patient was seen by Dr Reid on the 15th of that month when she was noted to be less well and suffering from a chest infection.

27. From 18th November she was administered Oramorph until she died on the 22nd November 1999. Diamorphine with a range of 20 – 80 mgs subcutaneously was also written up. The prescription of oral opiates was according to Professor Black an appropriate response to the deterioration in her general condition. She also received appropriate doses of Oramorphine.

28. Professor Black has no substantial criticism of this patient's treatment apart from the lack of clinical examination on admission. His conclusion in respect of the care provided to this patient is – 'Despite the above (criticism re: documentation on admission and examination) I am satisfied that Mrs Gregory's death was of natural causes and that her overall clinical management in Gosport was just adequate'.

29. Looking at this case individually and also considering it in the wider context of the case as a whole, I do not think that there is sufficient evidence to support an allegation of misconduct in respect of the care offered to Mrs Gregory. I advise therefore that no charges should be based upon Dr Barton's care of this patient.

Conclusion

30. I advise that no charges are laid based upon the care provided to Mrs Service or Mrs Gregory. I will however draft charges in respect of the standard of care afforded to Mr Cunningham unless I am instructed that my approach is somehow misconceived.

Tom Kark

QEB Hollis Whiteman

Temple

London EC4Y 9BS

17th January 2008

GMC

v

Dr Jane Barton

Advice

re: Doctors Reid, Lord and Tandy

---

1. I am asked to advise on the question of whether or not there is sufficient evidence to prosecute any of the three above-named doctors before a Fitness to Practice Panel of the GMC.

2. This case concerns the treatment of a number of elderly patients who were admitted to the Gosport War Memorial Hospital (GWMH) and came under the direct medical care of Dr Barton on Dryad and Daedalus Wards. The three above-named doctors were all consultants who were employed by the PCT and had responsibility at various times in relation to the two relevant wards at GWMH.

3. Although the case of Dr Barton will be heard under the old rules, any allegation against any of the three above-named doctors would be heard under the new rules and so, throughout this advice, I have referred to the issue of impaired fitness to practice as opposed to serious professional misconduct.

4. According to her police statements **Dr Lord** was employed between 1992 and 2004 as a Consultant Geriatrician for the Department of Medicine in Portsmouth. She worked during that time at the Queen Alexandra, St Mary's and at Gosport War Memorial Hospitals (GWMH). As the consultant, she acquired 24 hour responsibility for the patients at GWMH (see her statement *inter alia* re: Ruby Lake p.7 of 9) and was the consultant geriatrician for

Daedalus Ward. She did a weekly round on Daedalus Ward on Thursday afternoon for stroke rehabilitation patients. On alternate Monday afternoons she would do a ward round for the non-stroke patients on Daedalus and Dryad wards. In other words, she would do a ward round on each of the relevant wards once a fortnight. On those ward rounds she would review each patient.

5. The day-to-day management of the patients was left to Dr Barton and the regular nursing staff. Dr Lord states that she would expect Dr Barton to address the day-to-day needs of the patients and consult with her if it was necessary.

6. In her interview with police dated 27th September 2000 she described how she would discuss the medication regime with Dr Barton. She also said that she had every confidence in her.

7. **Dr Tandy** states that she was first employed as a consultant Geriatrician in Elderly Medicine in 1994 by East Hampshire PCT. That role included working at St Mary Hospital and the Queen Alexandra Hospital. Her responsibilities also included a once fortnightly ward round on Dryad Ward at the GWMH.

8. Dr Tandy states that on her ward rounds she would review the drug regimes of the patients and review the prescriptions of dugs. She describes it as being very infrequent that the doctor with day-to-day care of the patients on those wards for which she had responsibility would contact her.

9. According to the November 2004 statement of Dr Barton, Dr Tandy took a period of leave between April 1998 and February 1999.

10. **Dr Reid** (Statement in File 2 of Elsie Devine papers and see interview file) was first appointed to a consultant position in 1982 at Southampton General Hospital and began his role as Consultant in Geriatric Medicine and Medical Director of East Hampshire PCT in April 1998. At the relevant time he was working at the Queen Alexandra Hospital. From February 1999 until March 2000 he had consultant responsibility for Dryad Ward at GWMH. He was

extensively interviewed under caution during the police investigation during June and July 2006. Much of the following summary of his role comes from those interviews and the statement that he made.

11. He had consultant responsibility for Dryad Ward, on which there were normally twenty patients, supervising Dr Barton. He conducted a once weekly ward round on Monday afternoons. Every two weeks Dr Barton would attend the ward round with him alternating weekly with Dr Lord's ward round on Daedalus. He describes Dr Barton as being very experienced and how it would have to require a very serious clinical problem for her to seek his advice.

12. Daedalus Ward received patients for rehabilitation. Dr Reid had no recollection of ever doing a ward round on Daedalus. The patients admitted to Dryad Ward were generally for continuing care whose prognosis for recovery was not optimistic.

13. He described how Dr Barton had day-to-day medical management of the patients on both wards and that it was she who supported the nurses in their management of patients. He would have expected a change in the patient's medical condition to be recorded on the notes. He said he had no concerns about either the nursing care or the medical care on Dryad Ward.

14. There was, according to his police interviews, considerable pressure for beds at GWMH.

15. He said in interview that on his ward rounds he would read the patient's clinical notes and examine their prescription sheets and make a decision about their management. He commented that in general he would expect the implementation of a syringe driver to be recorded in the medical notes. He did not think it good practice to prescribe a variable amount of opiate as Dr Barton appeared to do. He had spoken on one occasion to Dr Barton about the dosage range.

16. Dr Reid said in interview that he could not remember Dr Barton writing up prescriptions for Morphine or Diamorphine for patients who were not in pain (i/v 4.7.06 at 14.02). He described pro-active prescribing of opiates for patients not in pain as 'not acceptable practice'. He said he had not been aware that Dr Barton had been doing so.

17. He said that a variable dose of opiates between 20 and 200 mgs was not acceptable.

18. The comment – 'Happy for nurses to confirm death' was appropriate if the patient was clearly dying. He would not have expected it to be written if the patient was not expected to die.

19. Dr Reid said that he had not discussed Dr Barton's note keeping with her as she was a senior and responsible GP. He agreed that there were deficiencies in her notes.

20. He could not remember ever having been called by Dr Barton as a consultant for advice or assistance.

The Patients

21. I now turn to deal with the role of the above named doctors in respect of each of the relevant patients with whom this case is concerned. I have dealt with the patients in the chronological order in which they were admitted to GWMH

22. **Leslie Pittock.** On 4 January 1996 Dr Lord undertook an assessment of this patient and recommended a transfer to a long term bed at GWMH. Dr Lord does not appear to have taken any further role in the treatment of this patient.

23. The patient was then admitted to Dryad Ward on Friday 5th January where he came under the care of Dr Barton and the Consultant Dr Tandy. Dr Barton admits in her statement seeing this patient on a daily basis. Dr Barton saw the patient on Tuesday the 9th January and raised the question of issuing opiates. The patient was seen again the following morning by both Dr Barton and Dr Tandy.

24. On the Wednesday 10th January 1996 Dr Barton prescribed opiates which she says she did in consequence of liaison with Dr Tandy. Professor Black is not critical of the decision to commence this patient on opiate pain relief.

25. The following day, Thursday, Dr Barton increased the drug regime apparently without recourse to Dr Tandy. On Monday 15th she increased the dose again adding Diamorphone and Midazalam and the drugs were then administered by a syringe driver. Dr Barton increased the doses again in the following few days again without recourse to the Consultant.

26. On Saturday 20th January when Dr Barton was on leave, the patient's GP Dr Brigg was consulted and increased the dose of Nozinan. Dr Brigg also the saw the patient the following day (21st January) and did not then interfere with the drug regime.

27. Dr Barton then took over the care of the patient again on Monday the 22nd and Tuesday 23rd. On Wednesday 24th January the patient died.

28. Dr Tandy states that she was involved in the initial review of this patient on 10th January 1996 with Dr Barton. She recorded that the patient was for TLC

in other words that his prognosis was very poor. Dr Barton accepted in her interview with the police that she had prescribed Oramorph to this patient. The 10th January appears to be the only time when Dr Tandy saw this patient after his admission to Dryad Ward.

29. Dr Tandy is critical of the dosage of Diamorphine and Midazolam.

30. In relation to her role with regard to this patient, although Dr Tandy did review the patient with Dr Barton, she did not prescribe him the relevant drugs nor did she have direct responsibility for his care after the 10th January 1996.

31. There does not appear to be anything in the conduct of Dr Tandy in relation to this patient which would justify an allegation that her fitness to practice was impaired. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

32. **Elsie Lavender**. In February 1996 the patient suffered a fall at home. She was admitted to Haslar Hospital and on 13th February was examined by Dr Lord who was thereafter on annual leave from 23rd February. She was also examined by Dr Tandy who by letter dated 16th February had suggested she was transferred to GWMH. On Thursday 22nd February she was transferred to Daedalus Ward at GWMH where she came under the care of Dr Barton.

33. On Saturday 24th February Dr Barton prescribed Morphine Sulphate.

34. By Tuesday 5th March the patient was started on analgesia via a syringe driver. She died on 6th March.

35. There does not appear to be any suggestion that once this patient was transferred to Daedalus Ward she was administered to by anyone other than Dr Barton.

36. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence

upon the basis of which an allegation of impairment could appropriately be made.

37. **Helena Service**. This patient was admitted to the Queen Alexandra Hospital on 17th May 1997 at the age of 99. She was suffering from a chest infection and likely cardiac failure.

38. She was transferred to GWMH Dryad Ward on Tuesday 3rd June 1997. Dr Barton conducted the admission assessment and concluded that the patient was suffering from heart failure. Dr Barton prescribed opiate analgesia of Midazolam and Diamorphine. On Wednesday 4th June administration of the same opiates was commenced via syringe driver.

39. Friends (Jean Kennedy and Delia Keene) noted a significant change in the patient's condition after her arrival at GWMH.

40. In the early morning of Thursday 5th June this patient died. Professor Black's criticisms in relation to Dr Barton's treatment are limited to the lack of notes on her admission and a higher than necessary dose of opiates.

41. None of the three above-named doctors had any direct dealings with this patient. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

42. **Eva Page**. In respect of this patient I have, for the time being, had to rely on the expert reports provided by Dr Mundy and Professor Ford. Professor Black has not yet prepared a report with regard to her.

43. On Friday 27th February 1998 this patient was 87 years old when transferred to Dryad Ward of GWMH for palliative care. She was suffering from lung cancer. She was prescribed Oramorph, however the notes (if accurate) reveal that the patient received no relief from Oramorph and on Monday 2nd March Dr Barton prescribed a Fentanyl patch which prescription appears to have been countersigned by Dr Lord.

44. A further entry on 2nd March reveals that the patient was seen by Dr Lord and diamorphine was prescribed to be given via syringe driver. On Tuesday 3rd March a syringe driver was commenced by Dr Barton and the patient died the same evening. Dr Mundy comments that in his view commencing this patient on opioid analgesia was inappropriate but he fails to give any reasons for his view. He does however comment that a dose range of 20mgs to 200 mgs as was prescribed by Dr Barton is unacceptable. Professor Ford is of the view that that prescription by Dr Barton was poor practice and potentially very hazardous.

45. There is no evidence that Dr Lord was involved in prescribing or agreeing to Dr Barton prescribing the unacceptable syringe driver dose. Professor Ford comments that his review of the medical notes and Dr Lord's own statement leads him to conclude that she was a competent thoughtful geriatrician who had a considerable clinical workload during the relevant period.

46. Depending on confirmation of the above by Professor Black once he has reviewed the records it appears that the offending prescription was one issued by Dr Barton.

47. At this stage therefore on the evidence available there is nothing in the care of this patient which justifies criticism of any of the above-named doctors amounting to an allegation of impairment although this view may change if it becomes apparent that Dr Lord was responsible for prescribing or agreeing to Dr Barton prescribing the offensive dose.

48. **Alice Wilkie**. The details of the complaints about this patient's treatment have been taken from the letters of complaint written by Mrs. M Jackson, the patient's daughter, together with a police report written by DC Robinson dated 29th April 2004. Professor Black has not yet reported upon this patient although reports were obtained from Dr Mundy and Professor Ford which I have read.

49. This patient was admitted to Queen Alexandra Hospital on 31st July 1998 suffering from dehydration and a UTI. On Thursday 6th August 1998 she was transferred to Daedalus Ward at GWMH for rehabilitation for 4-6 weeks only.

50. On Thursday 20th August she was prescribed 20 – 200 mgs Diamorphine and also Midazolam by Dr Barton. The patient does not appear to have been prescribed analgesic drugs previously. The patient died on Friday 21st August. The dose range of 20-200mgs is described by Dr Mundy as unusually large and the initial dose of 30mgs Diamorphine was excessive.

51. Professor Ford in his report comments – there is a significant gap in the medical notes between admission and the date of death being 21st August 1998. There are no entries in the medical notes in the days leading up to the patient's death indicating that she was in pain.

52. Dr Lord, the consultant responsible for this patient's care, saw her on Monday 10th August and should have seen her on the Monday following, which would have been the 17th August, but there is no note that she did see her on that date nor thereafter. The assessment by Dr Lord on 10th August is described by Professor Ford as reasonable but there is no note of any assessment made thereafter.

53. Professor Ford described Dr Barton's diamorphine and Midazolam prescription to be poor practice and potentially very hazardous.

54. In addition, the note made of Dr Lord's assessment on the 10th August is the only satisfactory medical note made during the patient's fifteen day stay on Daedalus Ward.

55. Dr Barton's offending prescription was made after Dr Lord had seen her on the 10th but also after Dr Lord may have done a ward round on the 17th albeit there is no note of it. There is no evidence therefore that Dr Lord either prescribed or tacitly approved the offending prescription. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the

above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

56. **Gladys Richards**. This 91 year old lady suffered a fractured thigh and was admitted to Haslar Hospital on 29th July 1998. She received opiate pain killers in the first two days of her admission but thereafter was given co-codamol. According to his statement Dr Reid saw this patient on 3rd August when she was well enough for transfer to GWMH for attempted rehabilitation. On Tuesday 11th August she was admitted on the advice of Dr Reid to GWMH on Daedalus Ward for rehabilitation.

57. She came under the care of Dr Barton who assessed her and the patient was prescribed Oramorph. She then suffered a dislocation of her hip having fallen out of her chair. She was taken back to the Haslar Hospital where she was treated and then readmitted to GWMH on Monday 17th August. On Tuesday 18th August the decision was taken to start her on a syringe driver with Diamorphine amongst other drugs.

58. Dr Lord was interviewed in 2000 and was asked about this patient. She did not see the patient but when asked about the drug regime prescribed by Dr Barton she described it as a palliative care regime.

59. This patient died on Friday 21st August 1998.

60. Once admitted to Daedalus ward none of the above three named doctors played any direct role in this patient's care. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

61. A complaint was made in relation to the death of this patient in response to which Dr Reid (according to his police interview in July 2006) developed a written policy for the management of patients by subcutaneous infusion (police exhibit – GFQ/HF/39).

62. **Ruby Lake.** In August 1998 this patient fractured a hip at home and was admitted to the Royal Hospital Haslar. Dr Lord agreed to transfer this patient to the GWMH on 14 August 1998. The patient was transferred on Tuesday 18th August and thereafter the patient was under the direct care of Dr Barton who prescribed Oramorph for the first time to this patient. The patient died on Friday 21st August. All of the drugs prescribed to this patient whilst at GWMH were prescribed by Dr Barton.

63. Apart from Dr Lord transferring this patient to GWMH none of the three above-named doctors played any direct role in this patient's care nor would they have had an opportunity of seeing her on one of the Monday ward rounds. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

64. **Arthur Cunningham**. In July 1998 this patient had been admitted to GWMH suffering from Parkinson's disease and Dementia. He was discharged briefly to a nursing home. On Monday 21st September 1998 this patient was admitted to Dryad Ward by Dr Lord who had been the Consultant responsible for his care. He was in considerable pain from a sacral ulcer. Dr Lord noted that his prognosis was poor. In a second statement to the police (dated 12.10.05) Dr Lord states that she does not recollect any conversation with Dr Barton regarding this patient's continuing care.

65. On Dryad Ward Dr Barton became responsible for his care. She prescribed Oramorph and Diamorphine with a range of 20-200 mgs via syringe driver.

66. The patient was very agitated and aggressive according to nursing notes and became calmer once the syringe driver had been started.

67. On Friday 25th September he was seen by Dr Barton's partner Dr Brook who did not change his medication. On Saturday the 26th September 1998 the patient died.

68. None of the above three doctors took any direct or indirect role in this patient's care once he had been admitted to Dryad Ward and the criticism of Dr Barton's care of this patient is in any event very limited. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

69. **Robert Wilson.** This patient was admitted to the Queen Alexandra Hospital on the 21st September 1998 following a collapse at home. Code A Code A On Wednesday 14th October 1998 he was transferred to Dryad Ward at GWMH. He was admitted by Dr Barton and prescribed Oramorph. This patient died on Sunday 18th October.

70. Doctor Peters appears to have seen the patient over the weekend before he died and authorized an increase in the dosage. That is a matter which no doubt will be raised by the defence should this matter go to trial in relation to this patient.

71. None of the above named three doctors played any direct role in this patient's care. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

72. **Enid Spurgin**. On 19th March 1999 this 92 year old lady fractured her right hip in a fall and was admitted to the Haslar Hospital. Complications followed surgery. She required pain relief in the form of Paracetamol.

73. On Friday 26th March she was transferred to Dryad Ward at GWMH. She was prescribed Oramorph on her first night's admission. The patient vomited her Oramorph and she was given Metoclopramide (an anti-emetic) and co-dydramol. On Wednesday 31st March she was prescribed morphine slow release tablets.

74. According to Dr Barton's interview, Dr Reid saw the patient on Wednesday 7th April and confirmed the analgesic dose, however this would have been before the patient was placed on the syringe driver on the following Monday.

75. On 11/12th April (Sunday/Monday) the patient was started on a syringe driver at a substantially increased dose. Dr Barton says in interview that she would have discussed the starting dose with the nurse.

76. The patient was seen on 11/12th April by Dr Reid who directed that the level of diamorphine should be reduced. On Tuesday 13th April the patient died.

77. Dr Wilcock is critical of the care provided both by Dr Barton and by Dr Reid. The patient was not adequately assessed and no action was taken to cure her of a potentially reversible septicemia. He criticises Dr Reid who halved the Diamorphine dose but doubled the Midazolam.

78. Professor Black's report is insufficiently focused to identify any specific criticism of Dr Reid and he may need to be asked to provide further assistance.

79. On the basis of the evidence at the moment, bearing in mind that Dr Reid actively intervened to reduce the dosage of diamorphine, there is insufficient evidence to demonstrate that Dr Reid's actions in respect of this patient amount to misconduct or deficient professional performance such as would justify an allegation of impaired fitness to practice. Quite apart from the specific considerations of this patient's case there are other general factors, which I will deal with below, which would make such a prosecution unfeasible.

80. **Geoffrey Packman**. This patient was 67 years old and weighed in excess of 23 Stone when, on 6th August 1999, he fell at home and was admitted to the Queen Alexandra Hospital where he was seen on a number of occasions by Dr Tandy. On Monday 23rd August he was transferred to Dryad Ward at GWMH.

81. He was admitted by Dr Ravindrane and was prescribed Paracetomol for pain relief. The patient was suffering from complex pressure sores, obesity and arthritis. He was seen by Dr Barton on the Tuesday 24th August when she prescribed Temazepam and on Thursday the 26th she prescribed Diamorphine 40-200 mgs and Oramorphine. A syringe driver was commenced on Monday 30th August. 40 mgs Diamorphine was given to the patient on the 30th, 31st and 1st September and then 60 mgs on the 1st and 90 mgs on the 2nd. Midazolam also appears to have been given to the patient over the same period.

82. On Wednesday 1st September this patient was reviewed by Dr Reid. Who noted that the patient required 'TLC' only. The patient died on Friday 3rd September.

83. Dr Wilcock is critical of both Dr Reid and Dr Barton alleging that both could be seen as doctors who breached their duty of care to this patient in failing adequately to asses his condition and failing to provide adequate treatment. Professor Black upon whom the GMC are relying for expert evidence in this case is also critical of the care provided by both doctors in terms of assessment and the adequacy of his treatment. The standard of medical prescribing is poor and there are significant failings in the way that the drug chart is written up. Both doctors are open to allegations of gross negligence. However Professor Black is of the view that the opiate analgesia provided to this patient was required in order to control his pain although the starting dose was higher than conventional.

84. The police interviewed Dr Barton on 17.11.05 when she produced a prepared statement and read it into the record. In further interviews she made no comment.

85. No statement was taken from Dr Reid in respect of this patient nor was an interview conducted with him which dealt specifically with this patient.

86. Although both experts are critical of the part played by Dr Reid, in fact he only reviewed the patient on one occasion at the GWMH two days before the

patient's death. The major criticisms of Dr Barton are the failure to assess him properly on 26th August and a failure to consult those senior to her when making her decision to treat the patient symptomatically only at GWMH (see para 6.8 of Professor Black's report). That significant failure can not be laid at Dr Reid's door.

87. Although Dr Reid ought to have taken more active steps to intervene when he saw the patient on the 1st his failure to do so would not of itself justify a charge of misconduct or deficient professional performance amounting to an allegation of impaired fitness to practice. The other two above-named doctors did not play any direct part in the treatment of this patient.

88. **Sheila Gregory**. On 15th August 1999 this patient was admitted to Haslar Hospital having sustained a fractured neck of femur following a fall. On Friday 3rd September 1999 at Dr Tandy's direction she was transferred to GWMH Dryad Ward. She was seen by Dr Barton.

89. Thereafter she was seen by Dr Barton regularly and by Dr Reid once a week. From 18th November she was administered Oramorph until she died on the 22nd November 1999. Dr Barton was away on leave between 12th and 16th November and the patient was seen by Dr Reid on the 15th of that month.

90. Professor Black has no substantial criticism of this patient's treatment apart from the lack of clinical examination on admission. The case is very unlikely to be added to the charges against Dr Barton.

91. There is no significant criticism of the role played by Dr Reid or Dr Tandy and Dr Lord played no direct role in the treatment of this patient. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

92. **Elsie Devine**. This patient was admitted to Queen Alexandra Hospital on 9th October 1999 and on Thursday the 21st October was admitted to the GWMH

Dryad Ward and she was assessed by Dr Barton. She was apparently prescribed Morphine solution.

93. Dr Reid appears to have seen this patient once she was on Dryad Ward on 25th October, 1st November 1999 and on 15th November when he recorded that she was very aggressive at times. She was seen on the 18th November by Dr Taylor who did not change her medication regime which then included anti-psychotic drugs but the patient was given a Fentanyl patch later that day.

94. On Friday the 19th November there was a marked deterioration in her health and she was again behaving very aggressively according to Dr Barton. Dr Barton started her on Diamorphine via a syringe driver. The patient died on Sunday 21st November.

95. An independent review panel examined the circumstances of Mrs Devine's treatment and death. At the hearing Dr Barton gave evidence and I note that she was supported by Dr Lord who also gave brief evidence.

96. Dr Lord made a statement to the police in relation to this patient. She was on sick leave during the period of the patient's admission until 15 November 1999. She says in her statement that she had no contact direct or indirect with this patient.

97. Dr Reid also made a statement to the police in relation to this patient. He saw the patient on three occasions between 21st October and 21st November 1999 as set out above.

98. Professor Black criticises Dr Barton's care of this patient in relation to the following aspects:

i) the lack of notes in relation to the investigation of a urinary tract infection and the prescribing of the drugs Amiloride, Trimethoprim, Thioridazine, Chlorpromazine and Fentanyl;

ii) the early prescription of Oramorph which he describes as having been inappropriate at that early stage of her treatment. In fact the drug does not appear to have been administered to the patient;

iii) the starting dose of Diamorphine of 40 mgs bearing in mind that the patient was at that time still under the influence of the Fentanyl patch;

iv) the starting dose of 40 mgs of Midazolam (although this may have been the responsibility of the administering nurse rather than Dr Barton).

99. When Dr Reid was interviewed in June 2006 (15:42-16:00) he indicated that he had had concerns at the time about the change from Fentanyl to diamorphine when he had, in March 2000, seen the prescription written by Dr Barton.

100. The last occasion on which Dr Reid had seen the patient during the course of her stay at GWMH was on the 15th November when there appear to have been no medical notes made for two weeks. The opiate drug regime appears to have been started on the 19th November.

101. In these circumstances, although Dr Reid can be criticised for his failure to raise the lack of note keeping with Dr Barton, there is insufficient material to mount a serious criticism of his care of this patient.

102. Accordingly, there is nothing in the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

Conclusion

103. Although there are some criticisms to be made of the conduct of Dr Reid in respect of the role he played in the treatment of patients Spurgin, Packman and Devine, looking at the evidence both individually and globally there is insufficient evidence to mount a successful prosecution of him before a Fitness to Practice Panel.

104. Although all three doctors played a supervisory role given their positions as consultant they had a very limited role in the care of the patients named

above. They were each reliant upon what was told to them about the degree of pain suffered by each patient justifying the use of opiate pain relief and on many occasions the use of opiates was adopted after their weekly ward round had taken place. All three could probably have been more proactive in questioning the drug regime on the ward rounds and in drawing the lack of notes to Dr Barton's attention. However such criticisms do not in my view amount to sufficient evidence in order to support an allegation of impairment.

105. An additional but marginal factor to take into consideration is that in order to justify mounting any case against any of the above-named three doctors the Registrar would have to consider whether exceptional circumstances applied so as to allow cases to proceed more than five years after complaints were made.

106. On the basis of the material that I have read in the case of Dr Barton, there is insufficient evidence in respect of any of the three named doctors to establish impairment by reason either of misconduct or deficient professional performance. In my view it would not be appropriate to mount a prosecution before an FTP against any of the three named doctors.

Tom Kark 17th January 2008

QEB Hollis Whiteman Chambers,

Queen Elizabeth Building,

Temple, London EC4Y 9BS

rom: Paul Hylton Code A
ent: 09 Nov 2007 12:18
o: Code A
ubject: RE: Dr Barton
don't but if we did they would probably be in the case files and/or IOP bundles

---

rom: Code A
ent: 09 November 2007 10:58
o: Paul Hylton Code A
ubject: FW: Dr Barton

i Paul,

o you recall receiving any statements from Mr Stevens?

Code A

---

rom: Hall, Tamsin Code A
ent: 30 Oct 2007 12:15
o: Code A
c: Ellson, Sarah
ubject: RE: Dr Barton

i Code A

have spoken to Mr Stevens this morning and explained that currently his case is not one which e have all the evidence for and that I am in the process of assessing what we do have with egard to his wife's treatment. He is very unhappy with the way the police dealt with the case. e said that initially they were most sympathetic and that they told him that they viewed his ase as very serious and then they seemed to 'lose interest'. He is very keen for his wife to be ıcluded as one of the patients that are investigated by the GMC.

e and his daughter gave statements to the police. He thinks he sent Paul Hylton copies of ıese. We do not appear to have any that the police have sent us. Could you see if Paul does ave any / there are any on your system?

s agreed at the con, I will look into exactly what we have got for this case and for that of Edna urnell so that we can decide how to proceed with these cases in terms of whether we should sk Professor Black/another expert to advise on the prospects of success.

have dictated a note of the con and will circulate this to you once it has been typed up. I hoped

› do this last week but was unfortunately out of the office so I apologise for the delay.

have received your comments about Professor Black and am meeting with Sarah this fternoon to discuss your concerns in more depth and we will then get back to you with our iews.

have not received suggestions for a junior as yet but will chase counsel's clerk again and get ack to you with some names as soon as possible.

hanks

amsin

amsin Hall | Solicitor
›r Field Fisher Waterhouse LLP
d Code A

lobile Code A

rom: Code A
ent: Friday, October 26, 2007 8:21 AM
o: Hall, Tamsin
c: Ellson, Sarah
ubject: FW: Dr Barton

ello,

lease note below.

n not sure what we are telling patient's families and so we are consistent I would be grateful if you ould ring Mr Stevens.

hanks Code A

---

ron Paul Hylton Code A
ent: 24 Oct 2007 09:54
o: Code A
ubject: Dr Barton

Code A

lr Stevens just called re an update on the case. He has received a letter from FFW to explain that ıey have taken over the case, but he has not heard anything since. He does phone for updates from ne to time, his wife was one of the patients who died, and he is always very pleasant and polite.

you have anything that you can tell him his number is Code A

aul

'el: 0845 357 8001
'ax: 0845 357 9001

rom: Valerie Barr Code A
ent: 16 Jan 2008 11:18
'o: Code A
ubject: Dr Barton
i Code A

lr Stevens, would like to speak to you about the case – Gosport War Memorial Hospital? – on Code A Code A please.

al

From: Michael Cotton Code A
Sent: 17 Jan 2008 15:21
To: Code A
Cc: Peter Swain Code A
Subject: FW: Gosport case

for info

-----Original Message-----
From: Code A
Sent: 17 Jan 2008 15:22
To: Michael Cotton Code A
Subject: Re: Gosport case

From: David O'Carroll, Deputy Branch Head, Professional Regulation + Room
Code A ,

Michael

I understand that a colleague Agatha Ferrao will be replying to you direct..

David O'Carroll

P Help save paper - do you need to print this email?

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David O'Carroll

P Help save paper - do you need to print this email?

Dr Barton

I returned Mr Stevens call from yesterday.

Mr Stevens wanted to know what the current position with the case was as it had been going on for 8 years.

I advised Mr Stevens that our Solicitors, FFW had obtained information from the Police which our expert would comment on and our Counsel would then provide legal advice as to which cases should proceed to a hearing.

Mrs Stevens advised that Eversheds had difficulties obtaining information from the Police and that he has lots of information.

I advised Mr Stevens that we would keep him updated with the progress of the investigation.

Code A
17 January 2008.

From: Code A
Sent: 31 Jan 2008 15:16
To: Michael Cotton Code A
Cc: Code A
Subject: Re: FW: Gosport case - contact details

Michael Code A

Agatha's details are:

Patient Safety & Investigations Manager
Wellington House (WEL) Room 422
Code A

Thanks
Alex

Alexandra Mortimer
Deputy Project Manager
Regulation Projects: Bill Team & White Paper Implementation Workforce Directorate
+ 2N12 Quarry House
Code A

From: Michael Cotton Code A
Sent: 31 Jan 2008 15:09
To: Code A
Cc:
Subject: FW: Gosport case - contact details

Importance: High

Alex
Could you please let me have the contact details for your colleague Agatha Ferrao. My colleague Code A is keen to contact her re the Gosport case. Thanks Michael

-----Original Message-----
From: Code A
Sent: 31 Jan 2008 15:04
To: Michael Cotton Code A
Subject: RE: Gosport case

Hi Michael,

Have you heard anything further Agatha Ferrao, the reason that I ask is that I'm on leave from 13- 22 February and our Counsel has to finalise the charges by 25 February?

Code A

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To: Code A
Cc: Peter Swain Code A
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for info

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Code A ,

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David O'Carroll

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Sent: 31 Jan 2008 15:09
To: Code A
Cc:
Subject: FW: Gosport case - contact details

Importance: High

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To: Michael Cotton Code A
Subject: Re: Gosport case

From: David O'Carroll, Deputy Branch Head, Professional Regulation + Room
Code A

Michael

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David O'Carroll

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'rom: Hall, Tamsin [tamsin.hall@ffw.com]
ent: 01 Feb 2008 12:20
'o: Code A
ubject: Barton - advice from counsel and letter to MDU

ıttachments: DOCS_6670173_1 (2).DOC; DOCS_6637140_1 (2).DOC; DOCS_6637078_1 (2).DOC

li Code A

'hanks for your e-mail regarding the panellists for the hearing, sorry for the late reply. Sarah ; on holiday and I have been off sick this week.

'lease find attached:

1. Counsel's advice regarding Dr's Lord/Reid/Tandy
2. Counsel's advice regarding cancellation
3. Draft letter from FFW to MDU confirming investigation timetable

would be grateful if you would confirm if you are happy for the letter to the MDU to be sent s drafted or if you would like any amendments. Would you like me to include information ıat we will not be proceeding regarding Service/Gregory or would you prefer for this to wait ntil service of the DNOH?

Ve now urgently need to contact Drs Lord/Reid and Tandy with regard to the hearing in ;eptember. I would be grateful if you could confirm the stance we should take when they or ıeir legal representatives inevitably telephone and ask if they are likely to be subject to riticism.

Vould it be alright to explain something along the lines of: "The GMC have looked at all the vailable evidence relating to the Dr Barton case and have taken advice, they have no rounds to suggest there are concerns about Dr x (Tandy/Lord/Reid)'s fitness to ractise. However, the GMC cannot give anyone immunity from someone making a omplaint or raising a concern but thought it would be helpful to clarify the position. Of ourse if Dr x is asked to attend to give evidence they may be asked questions by Dr ;arton's representatives and by the Panel, any questions would have to be relevant to the ubject matter of the hearing which will be whether Dr Barton is guilty of serious professional ıisconduct."

'lease could you check for me if any of them have any FTP issues also?

look forward to hearing from you.

!egards

'amsin

amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

lobile Code A

onsider the environment, think before you print!

eld Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
'eb www.ffw.com **CDE**823

'rom: Code A
ent: 05 Feb 2008 12:41
'o: 'Hall, Tamsin'
:c: Code A
ubject: RE: Barton - advice from counsel and letter to MDU
'amsin,

'hank you for your email and attachments which I have discussed with Peter.

)rs Lord, Reid and Tandy

Ve note Counsel's advice that there is insufficient evidence in respect of any of the three named doctors) establish impairment by reason of either misconduct or deficient professional performance.

'eter's view is that you should respond to any queries as follows;

Ve have looked at the available evidence relating to Dr Barton's case and we have advised the GMC that ıere do no appear to be grounds for engaging the GMC's fitness to practise procedures.

ınd then carry on with your paragraph ie. However, the GMC cannot give anyone immunity from omeone making a complaint or raising a concern but we thought it would be helpful to clarify the osition. Of course if Dr x is asked to attend to give evidence they may be asked questions by Dr arton's representatives and by the Panel, any questions would have to be relevant to the subject matter f the hearing which will be whether Dr Barton is guilty of serious professional misconduct."

TP issues –

cannot find any open complaints against the following:

)r Jane Catherine Tandy – Code A

)r Althea Everesta Geradette Lord - Code A

)r Richard Reid (there is more than one)

)nce you have contacted these doctors, I would be grateful if you ask them to confirm their ɛgistration numbers and I will then do a further check as necessary.

Ir Cunningham, Mrs Service and Mrs Gregory

Ve note and agree with Counsel's advice that charges should be drafted in respect of the allegations oncerning Mr Cunningham.

Ve note and accept Counsel's advice that there is insufficient to support allegations in respect of the care ffered to Mrs Service and Mr Gregory.

he relatives of Mrs Service and Mrs Gregory should be informed that we do not intend to take any actior

respect of these cases before we inform the defence.

Code A

---

rom: Hall, Tamsin Code A
ent: 01 Feb 2008 12:20
o: Code A
ubj t: Barton - advice from counsel and letter to MDU

i Code A

hanks for your e-mail regarding the panellists for the hearing, sorry for the late reply. Sarah is n holiday and I have been off sick this week.

lease find attached:

1. Counsel's advice regarding Dr's Lord/Reid/Tandy
2. Counsel's advice regarding cancellation
3. Draft letter from FFW to MDU confirming investigation timetable

would be grateful if you would confirm if you are happy for the letter to the MDU to be sent as rafted or if you would like any amendments. Would you like me to include information that we ill not be proceeding regarding Service/Gregory or would you prefer for this to wait until ervice of the DNOH?

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vidence they may be asked questions by Dr Barton's representatives and by the Panel, any uestions would have to be relevant to the subject matter of the hearing which will be whether)r Barton is guilty of serious professional misconduct."

'lease could you check for me if any of them have any FTP issues also?

look forward to hearing from you.

:egards

'amsin

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

lobile Code A

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/eb www.ffw.com **CDE**823

'rom: Code A
ent: 05 Feb 2008 15:08
'o: The Empanelment Team
ubject: RE: Barton
ill,

don't recall that time has been set aside for non sitting days but I can raise it at the Adjudication telecon n 4 March 2008.

lease let me know before then whether more than 2 non sitting days are required.

Code A

---

rom: Gillian Graves Code A) **On Behalf Of** The Empanelment Team
ent: 05 Feb 2008 15:02
o: Code A
c: The Empanelment Team
ubject: Barton

li Code A

an you let me know if there has been any time put aside for non sitting days, I have had one request for October, but I think someone else is going to request 1 or 2..

lany thanks

ill

illian Graves
mpanelment Team
Code A

rom: Code A
ent: 06 Feb 2008 16:59
o: 'Hall, Tamsin'
c: Ellson, Sarah
ubject: RE: Dr Barton
amsin,

hanks for the info.

he draft letter is fine but as per our per my prior email the defence cannot be informed that we are not roceeding with the allegations concerning Mrs Gregory and Mrs Service until the relatives have been formed.

Code A

---

ro Hall, Tamsin Code A
ent: 06 Feb 2008 16:23
o: Code A
c: Ellson, Sarah
ubject: RE: Dr Barton

li Juliet

he details of the report that we have are:

'ro sor Richard Henry Baker
don't have the exact date of the report but think it was around September 2004
is a Statistical Report on Mortality Rates

hope that this information helps.

lave you had a chance to look over my draft letter to the defence yet as I would like to get this ent out asap?

hanks

amsin

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP

Code A

lobile Code A

:onsider the environment, think before you print!

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el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
/eb www.ffw.com **CDE**823

rom: Code A
ent: Wednesday, February 06, 2008 1:33 PM
o: Hall, Tamsin; Ellson, Sarah
ubject: Dr Barton
mportance: High

lello,

ve taken over the task of liaising with the DOH to obtain a copy of Dr Barker's report, do you have is full name and the date of the report?

Code A

t James Building, 79 Oxford Street Manchester. M1 6FQ

egents Place, 350 Euston Road, London. NW1 3JN

he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

el: 0845 357 8001
ax: 0845 357 9001

'rom: Ellson, Sarah Code A
ent: 08 Feb 2008 15:15
'o: Peter Swain Code A ; Hall, Tamsin; Code A
ubject: RE: Barton - counsel
'hanks Peter

Ve will reconfirm with Tom that he understands and is happy. We do feel we need a sufficiently junio unior to do the leg work on this. We have not gone for a QC but I think we agreed Tom was the right senior" for this case. Do call me if you want to discuss.

arah Ellson | Partner
or Field Fisher Waterhouse LLP
Code A

---

rom: GMC - Peter Swain Code A
ent: Friday, February 08, 2008 3:12 PM
o: Hall, Tamsin; Code A
c: Ellson, Sarah
ubject: RE: Barton - counsel

amsin

am happy with this provided Tom Kark is – and I presume he will say that he is! But if he is in any doubt s to the level of support he will require then we may need to consider offering him someone more senior. part the issue here is one of perception – we are already going with Tom (due to his strong experience nd high quality of GMC work) when the profile of the case might have taken us towards silk. So I'm more an usually conscious that we could also be potentially under-pitching in terms of the junior. As you know e complainant group are already quite vocal and will become more so the closer we get to the hearing. Ve can't afford for it to be suggested that we deliberately instructed a legal team that was not sufficiently xperienced to take on a case of this size and stature.

s I say, I'm happy if Tom is, but he needs to understand the risks - both practical and in terms of erception - to which we might be exposing ourselves and to confirm that he is happy to accept those risk ith this choice of junior.

eter

---

rom: Hall, Tamsin Code A
ent: 08 February 2008 14:55
o: Code A ; Peter Swain Code A
c: Ellson, Sarah
ubject: Barton - counsel

ear Code A and Peter,

arah has asked me to email you about junior counsel in this case. As you will recall we greed last year to have a junior and then settled upon Rebecca Harris who is at QEB but was n maternity leave.

nfortunately, we have now been advised by QEB Hollis Whiteman that Rebecca Harris is no nger able to act as the junior, due to her family commitments, and she has returned the brief. /e are very disappointed with chambers and Matthew has raised our concerns with their ractice manager. We have been working hard this week to ensure that a suitable replacement instructed as a matter of urgency.

learly, the priority is for us to move forward and ensure that no delay is incurred as a result of iis. om has been very busy throughout January working on this case and he has prepared ie advice and has made a first draft of the DNOH, which I am working on with him. He is about start work on the expert reports and advising on supplementary questions to Professor Black nd also witness evidence in general (this was the task we had understood Rebecca would be oing).

EB Hollis Whiteman have offered us Ben Fitzgerald instead. His CV can be found at http:// Code A He is 2000 call and is rated very ighly with regard to his criminal practice. Tom regards him highly and thinks he will be xcellent. He does not have any GMC experience however this is not necessarily a barrier as e will be led by Tom and really we need someone who has excellent experience with dealing ith large and complex cases.

he other junior members of chambers at QEB Hollis Whiteman who do have GMC experience Code A are not available.

en is available to start work immediately and for the next month or so, which is when we need omeone to do the bulk of the work. He is obviously also available for the hearing. The clerk at EB Hollis Whiteman (Code A) has said that he may be able to reduce the rates for Ben take account of the fact that he is not experienced in GMC work which is something Sarah nd I will negotiate if you are happy to go with Ben.

/e have also found two other possibilities, however we don't think that they are as suitable. Code A has had a cancellation and is free immediately (and for the hearing) but e would be a very senior junior and would therefore be a bit more expensive. Also Code A ates at 23 Essex Street is available. She is an ex-nurse and keen to do GMC work. We think iat she is an interesting option for future cases but perhaps her lack of GMC experience would ot be ideal for a high profile case such as this. Also, the practicalities of having barristers from ifferent chambers working together could make things potentially more difficult.

would be grateful if you would confirm that you are happy that we transfer the papers to Ben

itzgerald. As ever, please do give either Sarah or I a call if you wish to discuss matters further.

:egards

'amsin

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

lobile Code A

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

lobile Code A

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ax: 0845 357 9001

00103387

Department of Health

Wellington House
133-155 Waterloo Road
LONDON
SE1 8UG

Tel: 020 7972 2000
Direct Line: Code A

Michael Cotton
Policy and Planning Manager – Fitness to Practice
GMC
Regent's Place
350 Euston Road
London
NW1 3JN.

11 February 2008

Dear Mr Cotton

Thank you for your recent email to David O'Carroll here at the Department of Health, requesting a release of a copy of Professor Richard Baker review of patient deaths at Gosport War Memorial Hospital.

I am advised that the Department can comply with the GMC's request for a copy of this review, provided a formal request is made under section 35A of the Medical Act for a specific purpose.

Any further requests for information will need to be considered in the light of the particular request being made.

Yours sincerely

Code A

Colin Phillips
Head of Investigation and Inquiries Unit
Department of Health

rom: Code A
ent: 12 Feb 2008 10:24
o: Code A
c: Tamsin Hall ffw (formerly Tomlinson) Code A
ubject: Gosport War Memorial Case

nportance: High
ear Ms Ferrao,

y colleague Mr Michael Cotton had previously been liaising with Alexandra Mortimer concerning this ase.

lexandra has asked us to contact you direct as we are seeking **urgent** disclosure of Professor Richard enry Baker's report which is dated about September 2004 and it is a Statistical Report on Mortality Rates

s I am on leave from 13-22 February 2008, I would be grateful if you would copy your reply to our olic rs who are in the Ccbox.

/ith kind regards
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Vith kind regards
Code A

From: Code A
Sent: 12 Feb 2008 15:09
To: Sarah.Ellson@ffw.com; Tamsin Hall ffw (formerly Tomlinson)
Code A
Cc: Code A
Subject: Professor Barker's report

Attachments: Scan001.PDF

Dear All,

I attach a letter from the DOH, you will see that they request that we make a formal request under section 35 A in order to obtain Professor Barker's report.

In light of this I would be grateful if you would provide reasons why you consider that such a request is warranted, particularly in light of the public interest and provide a draft order as appropriate.

As I will now be on leave until 22 February 2008, I would be grateful if you would send your reply to Code A

Code A

-----Original Message-----
From: Patricia Collins Code A
Sent: 12 Feb 2008 15:02
To: Code A
Subject: FW: Scan from a Xerox WorkCentre Pro

-----Original Message-----
From: scannerlondon@gmc-uk.org [mailto:scannerlondon@gmc-uk.org]
Sent: 12 Feb 2008 15:18
To: Patricia Collins (020 7189 5145)
Subject: Scan from a Xerox WorkCentre Pro

Please open the attached document. It was scanned and sent to you using a Xerox WorkCentre Pro.

Sent by: Guest [scannerlondon@gmc-uk.org]
Number of Images: 1
Attachment File Type: PDF

WorkCentre Pro Location: 2nd Floor - OPCE
Device Name: S2-2E-CPY3

For more information on Xerox products and solutions, please visit
http://www.xerox.com

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Department of Health

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SE1 8UG

Tel: 020 7972 2000
Direct Line: Code A

Michael Cotton
Policy and Planning Manager – Fitness to Practice
GMC
Regent's Place
350 Euston Road
London
NW1 3JN.

11 February 2008

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I am advised that the Department can comply with the GMC's request for a copy of this review, provided a formal request is made under section 35A of the Medical Act for a specific purpose.

Any further requests for information will need to be considered in the light of the particular request being made.

Yours sincerely

Code A

Colin Phillips
Head of Investigation and Inquiries Unit
Department of Health

'rom: Code A
ent: 14 Mar 2008 15:21
'o: 'Hall, Tamsin'
:c: Ellson, Sarah
ubject: RE: Professor Baker's report
amsin,

hank you for Professor Baker's report and your helpful summary, in due course please let me know
:ounsel's views.

Code A

---

rom: Hall, Tamsin Code A
ent: 14 Mar 2008 14:35
o: Code A
:c: Ellson, Sarah; Tom Kark; Ben FitzGerald; Watson, Adele
ubject: Professor Baker's report

li Code A

lease find attached Professor Baker's report which I finally received yesterday. I have read it
nd it is a lot more critical of Dr Barton's actions than I thought it would be. We had thought it
as primarily a statistical analysis, however the report's conclusions mirror our charges and
ıdeed go somewhat further.

ı summary, Professor Baker's main conclusions are that: the starting doses of diamorphine
ere higher than expected; the analgesic ladder was not followed; opiates were commonly
rescribed on admission although not administered until some days or even weeks later;
ecords failed to show careful assessment to determine causes of deterioration; opiates may
ave been administered prematurely; records commonly did not report detailed assessments of
ıe cause of patient's pain; the pattern of early use of opiate medication was evident from 1988;
ır Barton had a higher than usual incidence of describing patient's as dying of
roncopneumonia on death certificates and did not report fractures; the records do not contain
ıll details of care.

le refers to an 'almost routine use of opiates before death.... irrespective of the principal clinical
ondition' and a 'prevailing attitude or culture of limited hope and expectations towards the
otential recovery of patients'. He then concludes that 'some patients who were given opiates
hould have received other treatment' and that he expects that, with further investigation 'the
arly resort to opiates will befound to have shortened lives' and 'some patients would have had
good chance of surviving to be discharged from hospital'.

rofessor Baker is careful not to be too critical of Dr Barton as that was outside his original mit, but the report is potentially useful to us.

will discuss with counsel how best to proceed with this information. I have disclosed the report the defence.

egards

amsin

amsin Hall | Solicitor
r Field Fisher Waterhouse LLP
Code A

lobile Code A

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el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
/eb www.ffw.com **CDE**823

From: Hall, Tamsin [Code A]
Sent: 21 Feb 2008 15:56
To: [Code A]
Cc: Ellson, Sarah
Subject: RE: Professor Barker's report

Attachments: DOCS_6840104_1.DOC

Hi [Code A]

Please find attached a draft s35 Order as requested.

We know relatively little about Professor Baker's report and had understood that the GMC were making some inquiries as to how it might be relevant. It is clear that it informed previous investigations including the police work and as such would seem to be an important background document. We understand it was commissioned by the DOH to analyse the deaths at GWMH statistically. We have not had sight of the document and do not know what conclusions are reached. Whilst we would not intend to bring a case against Dr Barton based on statistics the report's conclusions could potentially impact upon our investigation and might place parameters around what Dr Barton can say in mitigation if she seeks to say the cases we are bringing are isolated examples. In our view our obligations as prosecutors mean that we ought to pursue obtaining this document and that it should be disclosed to the defence as we anticipate it may be relevant to the background and context of our allegations.

Thanks

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
dd [Code A]

Mobile [Code A]

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Tel+44 (0)161 238 4900 Fax+44 (0)161 237 5357 E-mail info@ffw.com
Web www.ffw.com CDE823

responsibility to ensure that viruses do not adversely affect your system and that your messages to us meet your own security requirements. We reserve the right to read any e-mail or attachment entering or leaving our systems without notice.

From: Code A
Sent: Tuesday, February 12, 2008 3:09 PM
To: Ellson, Sarah; Hall, Tamsin
Cc: GMC - Code A
Subject: Professor Barker's report

Dear All,

I attach a letter from the DOH, you will see that they request that we make a formal request under section 35 A in order to obtain Professor Barker's report.

In light of this I would be grateful if you would provide reasons why you consider that such a request is warranted, particularly in light of the public interest and provide a draft order as appropriate.

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WorkCentre Pro Location: 2nd Floor - OPCE Device Name: S2-2E-CPY3

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Regus House, Falcon Drive, Cardiff Bay. CF10 4RU

20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001

IN THE MATTER OF THE GENERAL MEDICAL COUNCIL AND DR JANE BARTON

REQUEST FOR DOCUMENTATION PURSUANT TO SECTION 35A(1) OF THE MEDICAL ACT 1983 (AS AMENDED)

To: Department of Health, Wellington House, 133 – 155 Waterloo Road, London, SE1 8UG (FAO: Colin Phillips, Head of Investigation and Inquiries Unit)

I, PETER SWAIN, Head of Case Presentation, General Medical Council ('GMC'), 350, Euston Road, London, NW1 5JE say that:

1. I am an authorised person for the purposes of Section 35A(1) of the Medical Act 1983 (as amended by the Medical Act Amendment Order 2000).

2. I request that you make available to the GMC's solicitors, Field Fisher Waterhouse, the following information:

    (a) 'Review of patient deaths at Gosport War Memorial Hospital' by Professor Richard Baker

3. This information is relevant to the discharge by the GMC of its functions in relation to professional conduct and disclosure of this information is required accordingly.

4. I confirm that Field Fisher Waterhouse will reimburse your reasonable costs incurred in providing the information requested.

We ask that the information requested be provided to Field Fisher Waterhouse within 14 days.

DATED:

.....

SIGNED:

.....

Paul Philip
Director of Fitness to Practise

rom: Hall, Tamsin Code A
ent: 25 Feb 2008 15:32
o: Code A ; Peter Swain Code A
ubject: Barton - timetable

ttachments: DOCS_6840516_1.DOC; DOCS_6807243_1.DOC; DOCS_6807173_1.DOC

ear Code A and Peter

nope that you had a pleasant break Code A and that you received the draft s.35 notice.

lease find attached a letter to the defence regarding Professor Black's availability to omplete the work we have instructed him on.

nfortunately we were unable to get the formal instructions to him until last week (although e had forwarded him the papers and he had commenced work and indeed provided a first raft of his report on Eva Page).

/e have asked him to do a substantial amount of additional work, based upon the advice eceived from counsel. I attach counsel's advice to this e-mail for your information also.

rofessor Black is preparing new reports on Eva Page, Alice Wilkie and also preliminary eports on Edna Purnell and Jean Stevens (who do not currently form part of the proposed harges). We have also instructed him to draft a general report covering topics in common etween the patients. There will then be work for him to carry out on drafting supplementary eports on the patients whom he has previously reported on. This is to make the onclusions clearer and to ensure that he adequately addresses points covered by the other xperts instructed by the Police.

his is a significant amount of work and is very time consuming on top of Professor Black's th professional commitments. We were not able to send the instructions to him earlier for number of reasons. We did not receive formal approval from you to instruct him until late 1 December. In early January we then immediately commenced sending out copies of all /itness statements to him. It then came to light on 17 January that he had recorded the earing dates wrongly. This led to a week of trying to make suitable arrangements for the earing and then gaining your approval for him to attend the hearing from 22 September.

:ounsel, who as you know have suffered setbacks in the preparation regarding Rebecca larris who was preparing a list of the supplementary issues for Black to address, provided s with their advice on 18 February 2008.

/e have then immediately incoporated this into the instructions and sent them out.

/e are exceedingly conscious that to maintain the hearing date is a priority. We therefore ropose an amended timetable as follows:

)NOH - we have received a preliminary draft of this from counsel - we are currently making ome amendments and propose to send you this for your comment by 29 Feb 2008.

:xpert reports
:va Page and Alice Wilkie - by 29 Feb 2008
:dna Purnell and Jean Stevens - by end of April 2008
;eneral report - by 9 May 2008
;upplementary reports - to be prepared between 9 May and beginning July.

Vitness statements

Ve have been to Hampshire last week and inspected the medical records (some of these ad been missed in previous copying), we also met with some of the witnesses and are oing again next week to meet with the remainder. We had hoped to go down in early anuary but the PCT took a lot longer than anticipated to contact the witnesses.

Ve received advice on Drs Lord, Tandy and Reid on 18 January and forwarded this to you. Ve have made contact with them and are about to interview them. (Dr Lord is in New :ealand but has now responded to our contacts)

Ve hope to have finalised all statements by the end of March but will disclose them to the efence on a rolling basis.

Ve remain of the opinion that the defence have sufficient time to prepare - however we nticipate that they may not share this view. Our arguments are set out in our letter to them /hich we would invite you to approve.

would be helpful to have your reply so that I can send the letter as soon as possible.

'hanks

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

Mobile Code A

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP
Code A

Mobile Code A

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21 February 2008

Dear Sirs

General Medical Council - Dr J Barton

We write to update you on the current position regarding our investigation.

As you know we intend to rely upon Professor Black's expert evidence in this case. We are writing to update you with our current time estimates as to when he will be able to complete the outstanding work.

We are keen to be open with you with regard to our progress to enable you to structure your hearing preparation accordingly.

Professor Black is in the process of preparing reports for Eva Page and Alice Wilkie. We will disclose these to you as soon as we receive them; we are hoping that this will be by 29 February 2008.

This delay has been caused, in part, by the fact that it came to light that the medical records for Alice Wilkie were incomplete. Tamsin Hall inspected the original medical records on 12 February 2008 and we have now received the missing pages. This means that Professor Black can complete his work.

Please find enclosed with this letter, by way of disclosure, a copy of Alice Wilkie's medical record between 4 August 1998 and 21 August 2008.

Professor Black will also prepare reports for Jean Stevens and Edna Purnell. We are hoping to receive these by the end of April 2008 and will then disclose them to you forthwith.

We have also instructed Professor Black to prepare a general report covering topics such as: pain relief - the methods of administering opioid medication, dosages, drug combinations; the significance of old age in relation to pain medication; medical assessments and principles for seeking advice from colleagues and/or specialists; medical records; drugs charts; standards and guidelines (BNF, Wessex Protocols, Good Medical Practice) and the role of the Clinical Assistant. Professor Black is aiming to have this completed by 9 May 2008. This will not necessarily be new evidence but is intended to be a core document which will be relevant and easy to refer to at the hearing.

We have further instructed Professor Black to provide supplementary reports in relation to those patients on whom he previously prepared reports for the Police. He has indicated that he will commence these upon completion of the general report. He anticipates that the reports will each take a week of work and we will disclose them to you on a rolling basis as and when they are ready. This process may take up to the end of June/beginning of July 2008. Much of the work here will be to make his reports more user-friendly for the hearing. We do not anticipate that they will contain new evidence to the extent that the charge would need revision and we still intend to disclose the draft charge to you very shortly.

We would like to stress that we remain of the opinion that you will have sufficient time to prepare for the hearing. The new reports (on Eva Page, Alice Wilkie, Jean Stevens and Edna Purnell and the general report) will be provided to you over 3 months in advance of the proposed hearing date. We do not anticipate that the other reports will contain any additional information, in the main they will contain stylistic changes and will clarify existing information.

We previously agreed to serve the Draft Notice of Hearing by 3 March 2008. We are still aiming to send be able to comply with this.

Tamsin visited Hampshire last week and met with many of the witnesses and will be visiting again next week. We are in the process of drafting production statements or supplementary statements for those witnesses whom we will intend to call at the hearing and propose to serve these upon you as and when these are completed. We will start sending these to you shortly.

Yours faithfully

Field Fisher Waterhouse LLP

GENERAL MEDICAL COUNCIL

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DR JANE BARTON

APPENDIX: GUIDANCE TO PROFESSOR DAVID BLACK IN PREPARING FURTHER REPORTS ON TREATMENT AT GOSPORT WAR MEMORIAL HOSPITAL

In preparing further reports in relation to the medical treatment of (A) Leslie Pittock, (B) Elsie Lavender, (C) Eva Page, (D) Alice Wilkie, (E) Gladys Richards, (F) Ruby Lake, (G) Arthur Cunningham, (H) Robert Wilson, (I) Enid Spurgin, (J) Geoffrey Packman and (K) Elsie Devine, Professor Black is kindly asked to address the matters set out below. Professor Black should provide a single generic report covering paragraphs one to sixteen below and then a separate short addendum statement for each patient.

PRINCIPLES OF MEDICAL CARE

Pain Relief

1. Explain the principles of prescribing and administering medication for pain relief, if appropriate by reference to the British National Formulary. Explain the nature and purpose of opioid analgesics, and how they fit within the range of analgesic medication available. Explain the Analgesic Ladder and the 'step-by-step' principle of prescribing analgesia. Explain the principles governing assessment and review of a patient's condition and the appropriate administration of pain relief. Assess the dangers of failing to follow the correct approach.

2. Explain the different methods by which opioid medication may be administered (ie orally, parenterally) and when each is appropriate. When is it appropriate to use a syringe driver? Are there any inherent dangers of using syringe drivers? Assess the dangers of failing to follow the correct approach.

3. Explain the process of obtaining the equivalent doses of orally-administered Morphine and parenterally-administered Diamorphine, if appropriate by reference to the British National Formulary.

4. Explain whether, and if so when, it may be appropriate to administer opioid analgesia parenterally in combination with sedative drugs. What level of monitoring is required in such cases. Explain the nature and purpose of

Midazolam, when and how it may be administered. Assess the dangers of failing to follow the correct approach.

Elderly Patients

5. Explain the significance of old age in relation to prescribing and administering medication for pain relief, if appropriate by reference to the British National Formulary. Assess the dangers of failing to follow the correct approach.

Medical Assessments

6. Explain the principles governing the requirement to make adequate medical assessment of a patient, by reference to any appropriate standards including GMC Guidelines. Assess the dangers of failing to follow the correct approach.

7. Explain the principles governing when and how it is appropriate to seek advice in this respect from colleagues, specialists or other sources of information.

Medical Records

8. Explain the principles governing the requirement of keeping adequate medical records in relation to the assessment and treatment of a patient, by reference to any appropriate standards including GMC Guidelines. Assess the dangers of failing to follow the correct approach.

9. Explain the use of drug charts (for example in Gosport War Memorial Hospital) and the principles governing how they should be used. Assess the dangers of failing to follow the correct approach.

Standards and Guidelines

10. Produce in evidence any relevant sections of the British National Formulary, for example the sections dealing with (a) Pain Relief, (b) Prescribing for the Elderly and (c) Syringe Drivers.

11. Produce in evidence any relevant sections of the Palliative Care Handbook Guidelines on Clinical Management, 3rd Edition (1995) - the "Wessex Protocols."

12. Produce in evidence any relevant GMC Guidelines.

13. Produce in evidence any other written materials which are of particular significance to appropriate medical practice in relation to the matters set out above.

MATTERS SPECIFIC TO GOSPORT WAR MEMORIAL HOSPITAL

14. If possible explain the nature of the position of 'Clinical Assistant' - the position of Dr Jane Barton at Gosport War Memorial Hospital in the period in question. Comment generally on the responsibilities she had. (If you consider this to be more properly dealt with by Trust Management please so indicate).

15. Explain how the drug chart in a hospital such as Gosport War Memorial Hospital should work. What do the terms 'written up,' 'prescribed' and 'administered' mean in this regard? Whose responsibility is it to ensure the drug chart is properly kept?

16. If a drug was written up PRN, for how long would this arrangement go on? When would or should the position be reassessed?

COMMON POINTS TO BE ADDRESSED IN RELATION TO EACH PATIENT

17. In a 'Summary of Conclusions' section for each patient, any failing identified should be particularised. For example, if there has been a failure to maintain adequate medical records, the matters that should have been recorded should be particularised.

18. In a "Summary of Conclusions' section for each patient, the significance of any failing identified should be set out. For example, if an excessive amount of opioid analgesia has been prescribed, the dangers of such a course of action should be made clear.

19. For each patient, set out in bullet-point format in chronological order the drugs prescribed, written up and administered and by whom it was done in each case.

20. Wherever a medical note of significance can be attributed to a particular doctor, it should be.

21. Set out the nature of Dr Barton's responsibility for each patient.

22. Failings attributable to Dr Barton must be clearly identified. Where failings are attributable to persons other than Dr Barton, this must be clearly identified. It must be clear where Dr Barton personally was at fault and where she was not.

23. Comment on the adequacy of the drug chart in each case. Was the drug chart used appropriately? Were any drugs 'written up' but not used? Were any drugs 'written up' but actually prescribed later? Was sufficient guidance given in each case by Dr Barton as to the administration of drugs? Was sufficient guidance given in each case by Dr Barton as to when it would be appropriate to commence a syringe driver?

24. Comment on the appropriateness of prescribing a range in dose of drugs such as Diamorphine and Midazolam by syringe driver in each case that this practice appears - for example the prescription of Diamorphine 20-200mg/24hr PRN. Is this good practice? Are there any inherent dangers? Does it provide adequate guidance in terms of the dose of the drug actually to be administered? Who decides in such a case what the dose actually to be administered is? In each case, was there any justification for the top range of the dose prescribed, taking into account the age and personal circumstances of the patient in question?

MATTERS SPECIFIC TO EACH PATIENT

Leslie Pittock

25. **Age.** Mr Pittock's age at the time of his death should be checked.

26. **Page numbers.** References to the page numbers in the medical/nursing records should be added, as with the other reports.

27. **Pain assessment.** Do the medical notes reveal whether any assessment of pain was undertaken? If pain was assessed, were any efforts made to deal with the underlying causes? Set out in detail what the medical and nursing notes disclose in relation to the nature and degree of pain experienced by Mr Pittock. Do these matters have any significance for determining the purpose for which opiates were prescribed in this case?

28. **Agitation and opiate medication.** Was any assessment undertaken to determine the possible causes of Mr Pittock's agitation? Should such an assessment have been undertaken? Should it have included any consideration of whether drugs such as Diamorphine were a contributing factor? Should any review have been undertaken of the dose of opiate medication prescribed in this context? Was any consideration given to lowering the dose of Diamorphine?

29. **Use of syringe driver.** Was the use of a syringe driver appropriate in Mr Pittock's case? Was he able to take medication orally? Clarify from the medical and/or nursing notes who was responsible for commencing the syringe driver on 15/1/96.

30. **Sertraline and Lithium Carbonate.** Comment on the discontinuance of Sertraline and Lithium Carbonate on 12/1/96, particularly in terms of any effects on Mr Pittock's condition.

31. **Nozinan**. Comment on the appropriateness of the prescription of Nozinan on 18/1/96 and 20/1/96.

32. **Seeking advice.** Would it have been appropriate in this case for Dr Barton to have sought advice from any other source on the appropriate treatment for Mr Pittock? Do the records disclose any attempt to do so? Comment on the significance of any failing in this regard.

Elsie Lavender

33. **Age.** Mrs Lavender's age at the time of her death should be checked.

34. **Dr Lord/Dr Tandy.** Clarify which doctor examined Mrs Lavender on 16/2/96 (after referral on 13/2/96).

35. **Date of transfer.** Clarify the date of transfer to Daedalus Ward.

36. **Purpose of transfer to Daedalus Ward.** Clarify the purpose of Mrs Lavender's transfer to Daedalus Ward. Was this purpose appropriately taken into account upon Mrs Lavender's transfer? Comment on the significance of the purpose of transfer in assessing the appropriate treatment in Mrs Lavender's case.

37. **Pain assessment.** Expand upon the efforts apparent from the records to perform an appropriate pain assessment in Mrs Lavender's case. What efforts were made to identify, assess and address the causes of pain? What is required by the Wessex Guidelines in this respect? What course of action was appropriate? Comment upon Dr Barton's actions in this regard.

38. **Deterioration and opioid medication.** Should any consideration have been given to whether the use of opioid analgesia was contributing to Mrs Lavender's deteriorating condition on Daedalus Ward? What steps were appropriate in this regard? Should any review of the prescription or dose of opioid medication have been undertaken?

39. **Treatment of underlying medical conditions.** What efforts were there to treat Mrs Lavender's underlying medical conditions? What assessment took place of Mrs Lavender's urinary retention and the success of treatment for a urinary tract infection? What assessment and treatment took place in relation to her low platelet count, deteriorating kidney function, high blood sugars and leakage of faecal fluid? What advice or assessment was sought from colleagues or specialists in this regard? Comment on the significance of the approach adopted.

40. **Assessment of 24/2/96.** Clarify what basis Dr Barton had on 24/2/96 to provide a prognosis to Mrs Lavender's son on that day. What diagnoses had been made? Comment on the significance of the outcome of the meeting between Dr Barton and Mrs Lavender's son that day.

41. **Midazolam.** Clarify the conclusion (at current paragraph 6.18) that the dose of Midazolam was too high. Is this correct? If so, an explanation as to why the dose was too high should be reflected in the report. Comment also upon the range of Midazolam prescribed in this case, particularly in respect of a patient who has not previously received opiates.

Eva Page

42. **Drug chart.** Clarify the correctness of the entry at current paragraph 5.11 of report - currently refers to a single dose of Oramorphine 5mg on 28/3/98 - should it refer to Diamorphine on 2/3/98? Clarify also whether it is possible to identify the date upon which the prescriptions for Diamorphine and Midazolam by syringe driver were written. Also, clarify in relation to paragraph 5.11 whether the Fentanyl was administered by patch or otherwise.

43. **Pain assessment.** Clarify whether there is any indication of the symptoms of lung cancer and/or pain experienced in Mrs Page's case. What pain assessment was carried out? What was the purpose of prescribing opiate analgesia in this case?

44. **Seeking advice.** Clarify whether expert psychogeriatric advice was sought and/or obtained in relation to the control of anxiety and stress in Mrs Page's case. Comment on the appropriateness of this course of action.

45. **Medical Records.** Do the medical records adequately set out the reason for the prescription of opiate medication on Mrs Page's admission to Dryad Ward?

46. **Drug combination.** Clarify whether it was appropriate in Mrs Page's case to commence Diamorphine and Midazolam in combination. Whether there was any justification for it and the potential harmful effects. What significance has the previous prescription of Fentanyl in this regard? What were the likely effects of this medication? Were the reasons for the administration of these drugs adequately recorded?

Alice Wilkie

47. No report has yet been produced by Professor Black in relation to Alice Wilkie. The following matters should be addressed in the forthcoming report, in addition to the general issues to be considered in respect of each patient set out above.

48. **Medical/pain assessment.** What evidence is there of pain on behalf of Mrs Wilkie? Was appropriate pain assessment carried out? Were appropriate efforts made to address the underlying causes of pain? What medical assessment was carried out between 10/8/98 and 21/8/98?

49. **Prescription of opioid analgesia.** What was the basis of the decision to prescribe opioid analgesia? Were less powerful analgesics used first? Was the prescription of opioid analgesia appropriate? Comment on the dose prescribed and administered. Comment on the method of administration of the drugs in question. Was Mrs Wilkie able to take medication orally? Did adequate review of the dose of Diamorphine take place?

50. **Drug combination.** Was the prescription of Diamorphine and Midazolam in combination appropriate in Mrs Wilkie's case? What were the likely effects of the drugs administered on Mrs Wilkie?

51. **Medical records.** Were the medical records in Mrs Wilkie's case adequate? Were the reasons for the prescription and dose of opioid analgesia appropriately recorded?

Gladys Richards

52. **Date of transfer.** Clarify the date of Mrs Richards' transfer to Gosport War Memorial Hospital. Paragraph 5.6 may require correction.

53. **Drug chart.** Clarify the date of the prescription of Diamorphine 20-200mg - paragraph 5.9 currently suggests it was on 4/8/98 and should refer to 14/8/98. Also, paragraph 7.2 refers to a prescription on 17/8/98 - should this be 18/8/98?

54. **Purpose of transfer.** Clarify the purpose of Mrs Richards' transfer to Gosport War Memorial Hospital. Was this purpose appropriately taken into account upon Mrs Richards' transfer? Comment on the significance of the purpose of transfer in assessing the appropriate treatment in her case.

55. **State of health at date of transfer.** Clarify Mrs Richards' state of health at the time of her transfer to Gosport War Memorial Hospital. Comment in this regard on the significance of the fact that she was deemed well enough to undergo two operations on her right hip. Was Mrs Richards suffering from any life-threatening disease at the time of her transfer? Were these matters appropriately taken into account at the time of her receipt at Gosport War Memorial Hospital?

56. **Pain assessment - first transfer.** Was an adequate pain assessment carried out in Mrs Richards' case in relation to her first transfer to Gosport War Memorial Hospital? What do the medical and nursing records show in relation to whether she was in pain? What conclusions were reached by those treating Mrs Richards in this regard? Were these conclusions appropriate? Were appropriate steps taken to identify and address any underlying causes of pain? What is the significance of behavioural disturbance in this regard?

57. **Pain assessment - second transfer.** Was an adequate pain assessment carried out upon Mrs Richards' return to Gosport War Memorial Hospital on 17/8/98? Were appropriate steps taken to identify and address any underlying causes of pain?

58. **Opiate medication - first transfer.** Was it appropriate to prescribe oral opiates and subcutaneous Morphine on Mrs Richards' initial admission to Gosport War Memorial Hospital? Could Mrs Richards take medication orally at that time?

59. **Drug sensitivity**. Comment upon any particular sensitivity that Mrs Richards had to Oramorphine and Midazolam. If such sensitivity did exist, did and should this have had any effect on the prescribing of opiate medication and benzodiazepines?

Ruby Lake

60. **Transfer to Gosport War Memorial Hospital.** Comment upon Mrs Lake's progress or deterioration prior to her transfer to Gosport War Memorial Hospital on 18/8/98. Comment in this regard on the significance of her cardiac enzyme measurements on 10/8/98 and 12/8/98. What was her condition on the day of transfer? Was her condition at the time adequately taken into account upon her receipt at Gosport War Memorial Hospital?

61. **Medical assessment.** What medical/pain assessment was appropriate on 19/8/98? Was an appropriate assessment conducted? Were adequate steps taken to identify and address any underlying medical condition and/or the causes of pain?

62. **Prescription of Oramorphine.** Clarify whether adequate justification is recorded for the prescription of Oramorphine on 19/8/98. Was such prescription appropriate?

63. **Prescription of Diamorphine and Midazolam.** Clarify whether adequate justification is recorded for the prescription of Diamorphine and Midazolam from 19/8/98. Was the prescription of these drugs appropriate, on the evidence available? Is it apparent whether the prescription was carried out before or after the chest pain of 19/8/98 was apparent?

64. **Syringe driver**. Clarify whether the medical records provide any justification for the use of the syringe driver in Mrs Lake's case? Were there any indications that Mrs Lake could not take medication orally? Is there any indication on the face of the records of a diagnosis of myocardial infarction and/or cardiogenic shock?

Arthur Cunningham

65. **Date.** Correct the date given at paragraph 6.27 of the present report - "by 29th he is clearly delirious."

66. **Conclusions.** The 'Summary of Conclusions' should clearly set out whether it is the dose of Diamorphine or the dose of Midazolam which is criticised, or both, as well as the dates upon which the dose was excessive.

67. **Medical notes.** Comment generally on the adequacy of the medical notes in relation to Mr Cunningham's time on Dryad Ward.

68. **Note by Dr Barton.** Comment upon the entry in the medical records by Dr Barton on 25/9/98 - see page 837 of 928.

69. **Pain assessment.** Was an adequate pain assessment carried out in Mr Cunningham's case? Were appropriate efforts made to assess and address the underlying causes of pain?

70. **Morphine prescription.** Comment on the administration of Morphine 10mg at 22.20 on 21/9/98. Was this appropriate? Do the medical records provide an adequate justification?

71. **Syringe driver.** Comment on whether it was appropriate to commence the syringe driver on 21/9/98. Was the decision justified? Was adequate justification for this decision set out in the medical notes? What indication do the notes contain as to whether Mr Cunningham was able to take medication orally?

72. **Medical re-assessment.** In the light of the difficulty in controlling Mr Cunningham's symptoms, should any re-assessment of possible contributing factors to his condition have taken place? Should further information or advice have been sought from colleagues or any other source? Was this done?

73. **Deterioration and medication**. Should Mr Cunningham's deterioration by 23/9/98 have prompted any review of the doses of Diamorphine and Midazolam? Did this take place?

74. **Shortening of life.** Clarify the degree to which Mr Cunningham's like may have been shortened by the drug regime.

Robert Wilson

75. **Failure to obtain senior medical opinion.** Professor Black's criticism of the failure to obtain senior medical opinion on 16/10/98 should feature in the 'Summary of Conclusions' section.

76. **Hepatic Encephalopathy.** Explain further the condition of hepatic encephalopathy, particularly in relation to the likely effects of the administration of Oramorphine.

77. **Oramorphine.** Clarify by reference to the medical/nursing notes (page 263) the start date for Oramorphine – was it 14/10/98 rather than 15/10/98?

78. **Oral medication.** Clarify how it is known that by 16/10/98 Mr Wilson was unable to take oral medication.

79. **Prescription of Diamorphine and Midazolam.** Comment on the appropriateness of the prescription of Diamorphine and Midazolam on the day of transfer to Dryad Ward. Were the reasons for such a prescription adequately recorded? Was the prescription appropriate considering Mr Wilson's response to Oramorphine?

80. **Medical notes.** Do the medical notes adequately record the reason for commencing the syringe driver and Diamorphine on 16/10/98?

81. **Increase in dose of Diamorphine.** Professor Black's criticism of the increase in dose of Diamorphine and the addition of Midazolam from 17/10/98 should feature in the 'Summary of Conclusions' section.

82. **Consciousness.** What do the medical and nursing notes suggest in relation to the levels of pain, distress or discomfort suffered by Mr Wilson from 16/10/98. Do they reveal anything in relation to Mr Wilson's consciousness or unconsciousness from 16/10/98? Comment on the significance of these matters upon the appropriateness of increasing the dose of Diamorphine and Midazolam in Mr Wilson's case.

83. **Dr Peters.** Comment upon the involvement of Dr Peters in the treatment of Mr Wilson.

Enid Spurgin

84. **Diamorphine dose.** The dose of Diamorphine prescribed on 12/4/99 should be clarified – current paragraphs 5.17 and 6.9 are inconsistent (6.9 appears to be correct). Clarify also whether the criticism of the dose expressed at paragraph 6.9 refers to the dose *prior to* the reduction from 80mg to 40mg by Dr Reid.

85. **Pain assessment.** In the context of the criticism of the failure properly to assess Mrs Spurgin, expand upon the detail of the nursing notes in relation to any description of pain in Gosport War Memorial Hospital up to 7/4/99. What response was appropriate?

86. **Medical treatment.** Comment upon the adequacy of medical treatment of Mrs Spurgin and what measures may have been appropriate to treat her underlying medical conditions. Were adequate steps taken in this regard?

87. **Seeking advice.** Was it appropriate in Mrs Spurgin's case to seek advice and/or expert opinion from colleagues or other sources in relation to further treatment? Were appropriate steps taken in this regard?

88. **Response to vomiting**. Comment upon the appropriateness of the medical response to Mrs Spurgin's vomiting after the initial administration of Oramorphine - ie the substitution of Codydramol. Does this sequence reveal anything in relation to the appropriateness of the initial prescription of Oramorphine?

89. **Further medical assessment.** Was any further medical assessment conducted after Mrs Spurgin's deterioration on 11/4/99? Comment on the appropriateness of this course of action.

90. **Dr Reid**. Comment on the involvement of Dr Reid in the treatment of Mrs Spurgin and the appropriateness of Dr Reid's conduct.

Geoffrey Packman

91. **Date of review by Dr Reid.** This date is given at paragraph 5.12 of the current report as 9/9/99 - should this be 1/9/99?

92. **Blood count results.** Clarify whether the failure to obtain and act upon the result of Mr Packman's blood count is attributable to Dr Barton. Do the nursing notes reveal anything in this regard?

93. **Medical notes**. Comment generally on the adequacy of the medical notes relating to Mr Packman's time on Dryad Ward. Comment in particular on the adequacy of medical notes in relation to the prescription of medication on 26/8/99.

94. **Drug chart.** Comment on the multiple prescriptions written on 26/8/99 in conjunction with one another. Is this appropriate practice?

95. **'Not for resuscitation.'** Comment on the significance of the words 'not for resuscitation' in Mr Packman's medical notes. Do they have any significance in relation to the provision of other medical treatment to the patient?

96. **Condition on 26/8/99.** Explain the conditions which may have accounted for Mr Packman's presentation on 26/8/99. What do the blood test and the drop in haemoglobin levels reveal in this regard? What were the possible appropriate responses at this time, other than a decision to treat the patient

symptomatically? Was successful treatment a possibility? Was Dr Barton's conclusion that Mr Packman was too unwell to be moved to an acute unit justified?

97. **Medical assessment.** Comment on the adequacy of medical assessment after 26/8/99.

98. **Verbal message to administer Diamorphine.** Comment on the appropriateness of the use of a verbal message to administer Diamorphine, as on 26/8/99.

Elsie Devine

99. **Fentanyl.** Expand upon the appropriateness of the prescription of a Fentanyl patch in Mrs Devine's case. What pain assessment had taken place? Had less powerful analgesia been considered or used? Was the dose appropriate?

100. **Initial medical assessment.** Comment on the adequacy of the initial medical assessment of Mrs Devine upon her transfer to Gosport War Memorial Hospital. Explain the significance for the treatment provided of the incorrect recording that Mrs Devine suffered from myeloma.

101. **Pain assessment.** Comment on the adequacy of any pain assessment conducted in relation to Mrs Devine. Were efforts made to identify and address any underlying causes?

102. **Later medical assessment.** In relation to the need to consider whether to treat Mrs Devine as terminally ill or referring her to the District General Hospital from 15/11/99 to 18/11/99, what do the medical records reveal in relation to such considerations and the reasoning for the approach adopted? Was the decision adequately considered and recorded?

103. **Fentanyl and deterioration.** Comment on the appropriateness of the response to Mrs Devine's deterioration on 19/11/99 following the administration of Fentanyl. Should consideration have been given to the possible contribution of Fentanyl to Mrs Devine's deterioration and to reducing the dose of opiate medication?

104. **Doses of Diamorphine and Midazolam.** Professor Black states that the doses were "higher than conventional guidance." Clarify whether they were excessive and what level of criticism should be attached.

105. **Chlorpromazine.** Comment on the appropriateness of the prescription of Chlorpromazine 50mg in Mrs Devine's case.

GENERAL MEDICAL COUNCIL

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DR JANE BARTON

ADVICE ON FURTHER REPORTS BY PROFESSOR BLACK AND OTHER AREAS OF OUTSTANDING EVIDENCE
18th February 2008

INTRODUCTION

1. This case concerns the treatment of a number of elderly patients who were admitted to the Gosport War Memorial Hospital and came under the direct medical care of Dr Jane Barton on Dryad and Daedalus Wards.

2. The primary purpose of this advice is to assist with the preparation by Professor David Black of final expert reports dealing with the medical care afforded to the eleven patients who are the subjects of the draft charges.

3. In addition, there are a number of further areas where work is outstanding. This advice is intended to identify the action required.

REPORTS OF PROFESSOR BLACK

4. Attached as an Appendix to this advice is a document setting out the matters that we would kindly ask Professor Black to address in preparing his further reports.

5. The Appendix has been compiled after detailed consideration of Professor Black's existing reports, and comparison with the other expert reports obtained as a result of the investigations into the standards of care on Dryad and Daedalus Wards. These other reports have assisted in identifying the general points that must be covered, the materials that establish the standards applicable, and numerous specific points of significance that do not appear to have been considered by Professor Black.

6. The document aims to set out the matters that need to be addressed with sufficient clarity and precision to ensure that Professor Black tackles each point effectively. However, we have considered it important to avoid, insofar as it is possible, questions or requests that are leading and could damage the integrity of the reports. We expect that these requests will be incorporated in further

instructions to Professor Black from those instructing us. Such instructions are of course potentially disclosable.

7. Many of the points set out in the Appendix are self-explanatory. However, it may be of some assistance to set out the reasoning in a number of instances.

General Matters

8. The first section of the Appendix deals with the general principles of medical care that are of particular application in this case. It also invites Professor Black to set out and produce in evidence the relevant sections of such documents as the British National Formulary to demonstrate the applicable standards.

9. It is important that Professor Black deals with these general matters before considering the specific merits of the treatment provided in each case. In his individual reports, he does not provide this sort of analysis. By comparison, the reports of Dr Wilcock and Professor Ford benefit enormously from the presence of sections on these areas. They provide essential context for the subsequent evaluation of Dr Barton's conduct.

10. As the Appendix makes clear, the key areas to be covered are:

    - Pain relief.
    - Prescribing for the elderly.
    - Medical assessments.
    - Medical records.

11. Additionally, Professor Black should be in a position to assist with the following general points which are of particular importance in this case:

    - The workings of the drug chart.
    - The practice of writing up drugs to be taken 'PRN.'

12. To assist all parties in understanding Professor Black's conclusions and his reasoning, the Appendix asks that a 'Summary of Conclusions' in each case sets out with particularity each failing and the significance of each failing. At present, the interrelation between the body of each report and the conclusions can be difficult to determine. This proposal is intended to promote clarity in terms of the charges faced by Dr Barton.

13. It is also important for the reports to make clear which failings can be levelled at which individuals - most importantly in this case, Dr Barton. This reasoning lies behind, for example, the requests for all entries on the drug charts to be attributed where possible and for Dr Barton's responsibilities in respect of each patient to be set out - in particular whether or not she has an over-arching

responsibility so far as the care of the patients where their primary carers are the nurses.

14. As the prescription and administration of drugs in each of the various cases can be complicated, it would be helpful to all parties if these matters could be set out as clearly as possible by means of bullet-points in date order. We are not suggesting a wholesale re-write of the reports but an appendix to each where these matters can be made clearer than they are in the original reports.

15. An assessment of all of the expert reports reveals that two matters require particular further consideration by Professor Black in relation to all (or almost all) of the eleven patients. These are (a) the adequacy of the drug charts and (b) Dr Barton's practice of prescribing a large range in dose of drugs such as Diamorphine and Midazolam, to be administered as required. These matters receive a very great deal of attention in the reports other than those of Professor Black. The view of the likes of Dr Wilcock is that the ranges in dose prescribed in these cases cannot be justified - that the highest end of the dose would be wholly excessive and that the practice provides inadequate control of the administration of very strong medication. This lack of control is reflected in the often chaotic nature of the drug charts. In occasion, these issues receive attention from Professor Black (for example, he criticises the practices markedly in relation to Elsie Devine) but in general they have not adequately been considered.

Specific Requests

16. The Appendix to this document sets out, in relation to each patient, a number of matters specific to that patient requiring further consideration. Sometimes this simply relates to the correction of a page number or date. In general, though, the requests arise from specific criticisms appearing in the reports of other experts. For clarity, the following paragraphs set out the criticisms appearing in other reports which do not appear to receive consideration in the reports of Professor Black.

17. Leslie Pittock:

- Dr Wilcock states: "If pain was a problem, it was not recorded or assessed," although there are references to generalised pain in the nursing notes. He criticises the lack of pain assessment and any efforts to address the underlying causes. Professor Black does make clear in his report that opiates and sedatives were prescribed for restlessness and distress rather than pain relief, but he should address the apparent lack of proper pain assessment and how this reflects on the approach taken to the patient from the time of his admission to Gosport War Memorial Hospital.

- Dr Wilcock states that consideration should have been given to whether drugs such as Diamorphine were actually contributing to Mr Pittock's agitation.

- Dr Wilcock clarifies Dr Barton's responsibility for setting up the syringe driver and that its use does not appear to have been justified.

- Dr Wilcock states that Sertraline and Lithium Carbonate should not have been discontinued abruptly on 12/1/96, as this can cause anxiety, agitation and delirium.

- Dr Wilcock also criticises Dr Barton's failure to seek advice from colleagues in her treatment of Mr Pittock.

18. Elsie Lavender:

- Dr Wilcock criticises heavily the failure to conduct a proper pain assessment and the failure to address the underlying causes of pain. Professor Black needs to expand upon his comments made in this regard.

- Dr Wilcock states that consideration should have been given to whether the use of opioid analgesia was actually contributing to Mrs Lavender's deterioration.

- Dr Wilcock points to contrast between the purpose of Mrs Lavender's transfer - rehabilitation - and the approach taken to her by Dr Barton. He also criticises the failure to address Mrs Lavender's underlying medical conditions - for example the failure to consider her low platelet count and deteriorating kidney function. Professor Black needs to consider these matters, essentially for the purpose of determining whether this was another case of Dr Barton taking an unnecessarily bleak and terminal view of her patient's condition. This same point is at the heart of asking Professor Black to consider what basis Dr Barton had for discussing Mrs Lavender's prognosis with her son on 24/2/96.

19. Eva Page:

- Dr Mundy points to the absence of symptoms of lung cancer and any notes relating to pain. This may assist to clarify the purpose of the prescription of opiates.

- Dr Mundy criticises the failure to seek expert advice on the relief of anxiety and stress, and the decision simply to start on opiate medication.

- Professor Ford criticises the failure to record the reason for the prescription of opiate medication.

- Professor Ford criticises the prescription of the combination of Diamorphine, Midazolam and Fentanyl. This could have resulted in fatal respiratory depression. Professor Black has considered in general the appropriateness of the medication in Mrs Page's case, but should consider in more detail the effect of the combination of drugs prescribed; whether there was any justification for it and the potential harmful effects.

20. In relation to Alice Wilkie, Professor Black has not yet produced a report. The matters which he is asked to consider are simply those areas where criticism appears in the reports of Professor Ford and Dr Mundy.

21. Gladys Richards:

- Professor Ford points to the contrast between the rehabilitative purpose of Mrs Richards' transfer to Gosport War Memorial Hospital and the approach taken to her from the time of her admission. Again, this needs to be considered by Professor Black.

- Dr Livesley points out that Mrs Richards was thought well enough to go through two operations on her right hip within about two weeks and that this indicates a general decent state of health. He also points to the lack of any specific terminal illness from which she could not have been expected to recover. Professor Black needs to consider these matters in determining whether the approach taken to Mrs Richards by Dr Barton was appropriate.

- Professor Ford criticises the lack of consideration of reasons other than pain for Mrs Richards' distress, and the general inadequacy of pain assessment. He and Dr Livesley also criticise the failure of a proper pain assessment upon Mrs Richards' transfer back to Gosport War Memorial Hospital on 17/1/98, and the failure to seek to deal with the underlying causes.

- Professor Ford's view is that the prescription of oral and subcutaneous Morphine on Mrs Richards' initial assessment was inappropriate and placed her at significant risk.

- Dr Livesley points of that Dr Barton knew or should have known that Mrs Richards was very sensitive to Oramorphine and had had a prolonged sedative response to Midazolam, and that she failed to take adequate account of these matters in prescribing opiates and benzodiazepines.

22. Ruby Lake:

- Dr Wilcock criticises the use of the syringe driver on the basis that Mrs Lake had none of the conditions that would have justified it. Professor Black speculates upon possible justifications for it, but needs to clarify whether any justification is actually apparent on the face of the evidence and notes.

- Dr Wilcock points to Mrs Lake's improving condition before her transfer to Gosport War Memorial Hospital. Professor Black needs to consider this matter further.

- Dr Wilcock criticises the total lack of justification recorded for the prescription of Diamorphine and other drugs by syringe driver from 19/8/98.

- Dr Wilcock also criticises the lack of medical assessment of the patient which may have led to the identification and treatment of the factors contributing to Mrs Lake's condition.

- Dr Wilcock states that there is no medical record justifying the use of Oramorphine on 19/8/98.

23. Arthur Cunningham:

- Dr Wilcock states that alternative strategies for managing Mr Cunningham's pain should have been considered.

- Dr Wilcock cannot find any recorded justification for the dose of Morphine 10mg at 22.20 on 21/9/98 or for the switch to the syringe driver on that date.

- Dr Wilcock points to Mr Cunningham's ability to take Sinemet-110 orally and regularly on 22/9/98. This may be of significance to whether the use of the syringe driver was appropriate at this stage.

- Dr Wilcock criticises the failure to conduct a re-assessment of Mr Cunningham's condition in light of the difficulty in controlling his symptoms, as well as the failure to seek advice from others on this issue.

- Professor Ford's view is that the realisation that Mr Cunningham had become 'chesty' overnight on 23/9/98 should have led to a re-assessment of the symptoms and consideration of whether the doses of Diamorphine and Midazolam should have been reduced.

24. Robert Wilson:

- Dr Wilcock points to the contrast between the Mr Wilson's transfer for 'gentle mobilisation' and the prescription on the same day of broad ranges in dose of Diamorphine and Midazolam with no apparent justification.

- Dr Wilcock criticises that absence of any medical note relating to the commencement of the syringe driver and the use of Diamorphine on 16/10/98.

- Dr Wilcock points to the medical and nursing notes from 16/10/98, which show that Mr Wilson was not distressed by pharyngeal secretions and appeared comfortable. This suggests, in Dr Wilcock's view, that Mr Wilson may have been unconscious from that time. It also suggests that the subsequent increase in dose of Diamorphine and Midazolam was not justified.

25. Enid Spurgin:

- Dr Wilcock criticises the failure to consult colleagues for further advice and assessment, particularly in light of Mrs Spurgin's worsening pain. He highlights the possible treatments that could have reversed her condition, which were as a result not considered.

- Dr Wilcock deals with the nursing notes in detail to show that there should have been better medical assessment of the patient and her pain. It would be helpful for Professor Black to perform a similar exercise.

- Dr Wilcock's view is that Dr Barton's response to Mrs Spurgin's vomiting after the initial administration of Oramorphine was nonsensical. If her pain was thought severe enough to warrant the use of regular Morphine, the addition of an anti-emetic would be the appropriate response. Instead a weaker analgesic, Codydramol, was substituted. This suggests that the initial prescription was not justified.

- Dr Wilcock criticises the failure to conduct a proper medical assessment after Mrs Spurgin's deterioration on 11/4/99.

26. Geoffrey Packman:

- Dr Wilcock criticises the general inadequacy of the medical notes.

- Dr Wilcock helpfully clarifies that the entry 'not for resuscitation' in the medical notes does not act as a bar to the provision of other appropriate medical treatment.

- Dr Wilcock's view is that Mr Packman's presentation on 26/8/99 and the large drop in haemoglobin levels clearly indicated a serious gastrointestinal bleed - a serious and life-threatening emergency which required transfer without delay to the acute hospital. Dr Wilcock also states that he cannot understand Dr Barton's conclusion that Mr Packman was too unwell to be moved to an acute unit, pointing out that if he had been taken ill with this condition at home, he would surely have been taken to an acute hospital by ambulance. Professor Black's view is that, although advice should have been sought, it was reasonable simply to treat Mr Packman symptomatically. He should be asked to consider this issue further, by reference particularly to the range of options open to Dr Barton at that time.

- Dr Wilcock also flags up a nursing note from 26/8/99 which clarifies that Dr Barton had seen the patient and should have been aware of the haemoglobin test.

- Dr Wilcock criticises generally the lack of medical assessment after 26/8/99.

27. Elsie Devine:

- Dr Wilcock criticises the inadequate assessment of the patient's condition, particularly in relation to the cause of the acute confusion upon her admission to the Ward. This may have affected the way in which she was subsequently treated. Dr Wilcock also criticises Dr Barton's error in recording that Mrs Devine suffered from the serious condition of myeloma, and opines that this may have had a significant effect on the type of care that Dr Barton thought fit subsequently to provide.

- Dr Wilcock criticises generally the lack of pain assessment and any efforts to deal with the underlying causes.

- Dr Wilcock states that there should have been a re-assessment of Mrs Devine's medication after her deterioration on Fentanyl on 19/11/99.

- Dr Wilcock criticises the dose of Chlorpromazine (an anti-psychotic), as it was likely to have caused prolonged drowsiness.

Limitations of the Report

28. It should be recognised that there are a variety of instances where Professor Black is in clear disagreement with the other experts. For example:

- In relation to Leslie Pittock, Professor Black's view is that Diamorphine was prescribed to deal with Mr Pittock's restlessness and distress, and that this cannot be criticised. On the contrary, Dr Wilcock's approach is that this is not an appropriate use of opiate drugs.

- In relation to Elsie Lavender, Dr Wilcock's view is that the patient's condition was not necessarily terminal. Professor Black's view is the opposite, which affects his assessment of the correctness of administering Diamorphine and Midazolam.

- In relation to Gladys Richards, Professor Ford considers that the administration of Diamorphine and Midazolam by syringe driver at the time of Mrs Richards' second admission to Gosport War Memorial Hospital was completely inappropriate, due to the likely hazardous effects. Professor Black's view is that the prescription cannot be seen as unreasonable, in light of Mrs Richards' poor prognosis by the time of the prescription.

- In relation to Arthur Cunningham, Dr Wilcock and Professor Black disagree on the adequacy of Dr Barton's initial assessment.

- In relation to Geoffrey Packman, Dr Wilcock and Professor Black disagree on whether the doses of Oramorphine and Diamorphine administered were excessive.

29. Where the disagreement reveals issues which have not apparently been considered by Professor Black, the Appendix asks him to consider them. However, in general where there is simply disagreement between Professor Black and another expert on a point which Professor Black has properly considered, the Appendix does not ask him to reconsider his view. This is because (a) he has considered the issue fully already, making any change in view extremely unlikely and (b) the low evidential value of a changed opinion in such an area would render the exercise pointless.

OTHER EVIDENTIAL ISSUES

Dr Barton's Role at Gosport War Memorial Hospital

30. The nature of the role of 'Clinical Assistant' should be clarified in evidence. What are the responsibilities? What relationship would such a doctor have with other involved with treatment on the ward, such as consultants and nurses?

31. Evidence should be produced from the management of Gosport War Memorial Hospital (for example the Director of the Trust) to explain:

    - Dr Barton's role at the Hospital and her responsibilities.

- Dr Barton's working hours. Was she on call 24 hours during the week? What would 3½ sessions per week mean in terms of hours? Her contract should be produced in evidence.

- Whether or not the wards were understaffed in the period in question. If so, why the situation continued.

- What support there was for Dr Barton. When were there consultants available to her? When were there not?

- Why Dr Barton was allowed to work in 1998 without Consultant cover. How was this situation allowed to continue?

32. A copy of the rota produced by Dr Lord in her police interview of 27/9/00 should be produced.

33. Is there a statement from Barbara Robinson, the hospital manager at the time?

34. Evidence should be sought as to whose responsibility it was to ensure that the drug charts for each patient were properly kept. Professor Black has been asked his view on this point, but it may be something with which the hospital management can also assist.

Defence Points

35. It must be clarified whether the consultants featuring in the case accept that they regularly reviewed Dr Barton's prescriptions, as claimed in the MDU letter of 28/8/02 (Tab 4).

36. Are the figures given in the MDU letter of 28/8/02 agreed?

37. Is there a better copy of this MDU letter?

38. A copy of the PPC papers referred to in Dr Barton's statements should be provided.

39. In relation to Gladys Richards, it appears that there is no police report or interview in the files, but there is a police statement from Dr Barton. Are we missing some documentation and, if not, could we be told how this state of affairs came about?

Other Evidence

40. Could it be clarified what 'FCEs' are?

41. A report into Gladys Richards' death is recorded in Dr Lord's second police interview (at page 16). Do we have a copy of this?

42. The police reports refer to Clinical Team Members Assessments (eg police report page 6 on Geoffrey Packman). Do we have these?

43. Professor Black's report on Elsie Devine suggests obtaining a pharmacist's opinion on the way that the drugs were written up (see paragraph 6.18). A preliminary view should be sought from a pharmacist on this issue. It may well be that a generic statement as to what controlled drugs were being prescribed by Dr Barton on Dryad and Daedalus and how they should have been written up.

44. Copies of the following exhibits should be provided:

- CSY/HF/2.
- CSY/HF/3 - Palliative Care Handbook.
- CSY/HF/4 - Essential Info for Medical Staff.
- CSY/HF/7 and/or GJQ/HF/7 - Operation Policy Dryad Ward Continuing Care.
- CSY/HF/27 - Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion.
- GJQ/HF/39 - Protocol for Prescription.

Documents/Bundles

45. Better quality copies of the notes/drug chart at pages 222-226 of Eva Page's medical records must be obtained - parts are chopped off on the current copies.

46. Better quality copies of the drug chart at page 369 of Ruby Lake's medical records must be obtained.

47. Better quality copies of the notes at page 222 and 277 of Elsie Devine's medical records must be obtained.

48. Page 27 of the transcript of Dr Lord's second police interview in 2000 is missing.

49. Although the attached Appendix contains a fair amount of extra work for Professor Black, a preliminary view should be sought from him as to whether he feels the draft charges are appropriate or not in reflecting any criticism that

he has of Dr Barton's conduct. Provided he is in broad agreement with them, the additional information he is being asked for need not hold up the service of the draft charges.

50. It is important to bear in mind that because Professor Black is the central GMC witness in this case it is crucial that he has had an opportunity of considering, reflecting and reporting upon all of the various aspects of Dr Barton's care of these patients. Time spent by him now will undoubtedly benefit the presentation of the case in due course.

Tom Kark
Ben FitzGerald

QEB Hollis Whiteman
Temple
London EC4Y 9BS

18th February 2008

Field Fisher Waterhouse

Case Report
October 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Hall / Sarah Ellson
Date of Rule 8 letter:	Old rules
Date considered by Case Examiner:	14/02/02
Date FFW Instructed:	11 May 2007
Class of Case (1-5)	Class 5
Target date for completion of investigation:	
Interim Order Expires:	IOPs held 21 June 2001, 21 March 2002, 19 September 2002 – No orders made

Summary: Dr Barton is a GP. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis at the Gosport War Memorial Hospital. Dr Barton retired from this post in 2000. A number of complaints were made by relatives of elderly patients who had died at GWMH in 1998. The common complaint was that patients admitted to the GWMH for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. Hampshire Police carried out three extensive investigations between 1998 and 2006 and the deaths of 92 patients were examined. Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation. 10 cases were referred to the CPS. The Crown Prosecution Service reviewed the evidence and concluded that the prosecution test was not satisfied and there was insufficient evidence for criminal proceedings.

The 10 cases were ED, EL, SG, RW, ES, RL, LP, HS, GP and AC [RW and AC together with EP, AW and GR were included in the GMC rule 6 referral letter sent in 2002 after the first police referral]. There are 2 further cases where the patient's relatives have expressed an interest in the investigation.

Investigations: We have now completed our analysis of the witness statements and transcripts of interviews and the expert evidence. We have had a conference with counsel and Professor Black. We have provisionally spoken to Dr Ford about acting as an additional expert. Counsel will advise the GMC on which cases have merit to be taken forward. We are considering instructing a junior.

Recommendation: Conference with Counsel and advise GMC regarding merits of cases, confirm expert instructions, production statements from witnesses for their police statements and visits to witnesses as necessary, liaise with Coroner and police.

Listing time estimate: 8 weeks.

Counsel: Tom Kark & Junior

Listed: 8 September – 31 October 2008

Prospects of Success: Medium

From: Ellson, Sarah Code A
Sent: 27 Feb 2008 12:26
To: Code A
Cc: Hall, Tamsin
Subject: RE: Dr Barton

Attachments: DOCS_6858103_2.DOC

Dear Code A

I have just been working on these and they are attached. The situation is this - Counsel provided a first draft and this needed some amendment. Quite a lot was simply style so we have reformatted, renumbered, changed "failed" to "did not" etc. Where we have done this I have highlighted the changes to Counsel but in your copy (attached) I have just adopted the changes. (If the odd formatting/numbering point is outstanding rest assured we will sort this before we serve a copy).

The other amendments were a little more substantive and largely included me flagging up either narrative or subheads where we need to be clear what criticism is or can be made of Barton. I would encourage Counsel to raise "consequences" (eg excessive doses or death) in the opening and presentation of the case rather than in the charge. Clearly Counsel needs to be involved in this more substantive changes and we have sent him details of these (I have left these amendments in your draft too - together with my questions and footnotes).

Counsel is involved in a large fraud case and has said he cannot look at these until tomorrow but I am expecting him and Tamsin to discuss them then. It would be very helpful if you and Peter can also contribute to the debate so that we produce an agreed version for disclosure.

Of course we will have to serve this with adequate caveats given that we are awaiting further reports from Professor Black.

Sarah Ellson | Partner

for Field Fisher Waterhouse LLP
dd: Code A

Field Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
Tel+44 (0)161 238 4900 Fax+44 (0)161 237 5357 E-mail info@ffw.com
Web www.ffw.com CDE823

action in reliance upon it. You should ensure this e-mail and any attachments are virus free. E-mail is not a 100% virus-free or secure medium. It is your responsibility to ensure that viruses do not adversely affect your system and that your messages to us meet your own security requirements. We reserve the right to read any e-mail or attachment entering or leaving our systems without notice.

From: Code A
Sent: Wednesday, February 27, 2008 12:10 PM
To: Hall, Tamsin
Cc: Ellson, Sarah
Subject: Dr Barton

Tamsin,

I attach a copy of the signed section 35 A order and I will send you the original today.

DRAFT CHARGES

Is it possible to have the charges tomorrow as Peter and I have to approve the charges before disclosure on Monday and there is not much time left if we consider that any amendments are required and they then have to go back to Counsel for his view?

Code A

-----Original Message-----
From: scannerlondon@gmc-uk.org [mailto:scannerlondon@gmc-uk.org]
Sent: 27 Feb 2008 12:21
To: Code A
Subject: Scan from a Xerox WorkCentre Pro

Please open the attached document. It was scanned and sent to you using a Xerox WorkCentre Pro.

Sent by: Guest [scannerlondon@gmc-uk.org] Number of Images: 1 Attachment File Type: PDF

WorkCentre Pro Location: machine location not set Device Name: S2-2E-CPY2

General Medical Council

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

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The Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

Regus House, Falcon Drive, Cardiff Bay. CF10 4RU

20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001

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20 Adelaide Street, Belfast. BT2 8GD

Tel: 0845 357 8001
Fax: 0845 357 9001

From: Code A
Sent: 28 Feb 2008 14:24
To: 'Ellson, Sarah'
Cc: Tamsin Hall ffw (formerly Tomlinson) Code A
Subject: RE: Dr Barton

Importance: High

Attachments: Comments on draft charges.doc

Sarah,

Thank you for the draft charges which I discussed with Peter.

Our comments are attached.

Juliet

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Cc: Hall, Tamsin
Subject: RE: Dr Barton

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Dr Barton - Comments on draft charges

2b

The word paragraph should be in stated in full.

2c

Refers to diamorphine being administered on 17 January, is this correct as there is no prior direct reference to it?

2e

Please ensure that cross referencing is correct.

2g ii, 3 eii, 4 eii, 5e ii ,6f ii, 7 e ii, 8 eii, 9 gii, 10 g ii, 11 f 2 and 12 f ii

We don't allege unprofessional any more so please remove it from the above paragraphs.

3 a) iv)

Are we alleging that the prescribing of Ormaroph twice a day was inappropriate, if not this is just narrative and should be removed.

4 a) ii) and iii)

Are we alleging that the prescriptions of the drugs were inappropriate, if not this is just narrative and should be removed.

5b, 6b and 7b –first line

I think the word should be describe**d** rather than describe.

6 a) iv)

Appears to be just narrative.

6d)

Narrative as the paragraph which it is referenced to has been deleted.

7 a ii

Narrative as no allegation in respect of it.

9 a iv

Appears to be narrative as no allegations made in respect of it.

10 a ii

Narrative as no allegation in respect of it.

11 g 2

Allegation that Dr B did not ensure that drug chart was not properly kept.

If we are sure that it was Dr Barton's responsibility to ensure that the drug charts were properly kept we should allege it in respect of all patients as appropriate.

12 a iv and 12 vi

Narrative unless allegations made in respect of them.

'Dose range was too wide'

This has been alleged in many instances and Peter wants us to be sure that we have the evidence to support it eg. is this the term used by Professor Black.

Allegations concerning not keeping clear, accurate and contemporaneous notes

Peter has noted that exactly the same allegations have been made in respect of each patient and suggest that to in order to cut down on the length of the charges it may be preferable to have one head of charge in respect of all the patients eg. In relation to patients A to K you did not ...then state the allegations.

Patient Died ...

We are content for references to patients dying being removed from the charges, as long as expert evidence does not state that Dr Barton's actions caused or contributed to a patient's death.

IN THE MATTER OF THE MEDICAL ACT 1983

AND IN THE MATTER OF

THE GENERAL MEDICAL COUNCIL

AND

DR JANE BARTON

DRAFT CHARGES

---

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

Patient A (Leslie Pittock)

2. a) i) Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care,

ii) Between 5 and 10 January 1996 you prescribed Oramorphine as well as Diamorphine with a dose range of 40 – 80 mgs over a twenty-four hour period to be administered subcutaneously (SC) on a continuing daily basis,

iii) On 11 January you prescribed Diamorphine with a dose range of 80 – 120 mgs and Midazolam with a range of 40 – 80 mgs to be administered subcutaneously over a twenty-four hour period,

iv) On 15 January a syringe driver was commenced at your direction containing 80 mgs Diamorphine and 60 mgs Midazolam as well as Hyoscine Hydrobromide,

[1]

vii) On 18 January you prescribed 50 mgs Nozinan in addition to the drugs already prescribed,

viii) On 20 January you increased the prescription of Nozinan to 100 mgs,

ix) [2]

Deleted: v) [On 16 January Haloperidol was prescribed in addition to the other drugs,;]¶

Deleted: vi) [On 17 January the dose of Diamorphine was increased to 120 mgs and Midazolam to 80 mgs (SC),;]

Deleted: above

Deleted: ;

Deleted: [On 24 January 1996 patient A died.,]

b) In relation to your prescription described in para. 2a (ii) and/or 2a (iii):

i) the dose range was too wide,

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

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

d) Your prescriptions on 18 and 20 January of Nozinan in combination with the other drugs already prescribed were excessive to the patient's needs,

e) Your actions in prescribing the drugs set out at 2b(ii), 2b(iii), 2b(iv), 2b(v) and 2b(vi) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

[1] If not prescribed by BARTON then this is probably narrative

[2] Technically narrative but an important point for opening (same for all cases)

f) You did not keep clear, accurate and contemporaneous notes in relation to Patient A's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

g) Your actions and omissions in relation to keeping notes for patient A were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

Patient B (Elsie Lavender)

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

ii) On 24 February you prescribed the patient Morphine Slow Release Tablets (MST) 10 mgs twice a day,

iii) On 26 February you increased the prescription for MST and prescribed Diamorphine with a range of 80 mgs - 160 mgs and Midazolam with a range of 40 - 80 mgs to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

iv) On 4 March you prescribed Oramorph 30 mgs twice a day,

v) On 5 March you prescribed Diamorphine with a range of 100 - 200 mgs and Midazolam with a range of 40 mgs – 80 mgs over a twenty-four hour period to be administered subcutaneously (SC) and a syringe driver was commenced containing Diamorphine 100 mgs and Midazolam 40 mgs,

Deleted: vi) On 6 March patient B died.

b) In relation to your prescription for drugs on 26 February and 5 March:

i) the dose range for Diamorphine on 26 February and on 5 March for ?[3] was too wide,

ii) the lowest commencing dose on 5 March of 100 mgs Diamorphine was excessive to the patient's needs,

iii) the prescriptions created a situation whereby drugs[4] could be administered to the patient which were excessive to the patient's needs,

c) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

d) In relation to your management of patient B you:

i) did not perform an appropriate examination and assessment of the patient on admission,

[3] ?? Midazolam – do we criticise this? Is this a missing word?
[4] Drugs – plural – see footnote 3

ii) did not conduct an adequate assessment as the patient's condition deteriorated,

iii) did not provide a plan of treatment,

iv) did not obtain the advice of a specialist when her condition deteriorated,

e) And you actions and omissions in relation to your management of patient B were:

i) inadequate,

ii) unprofessional,

iii) not in the patient's best interests,

f) You did not keep clear, accurate and contemporaneous notes in relation to the Patient B's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

g) Your actions and omissions in relation to keeping notes for patient B were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

Patient C (Eva Page)

4 a) i) On 27 February 1998 this patient was transferred to Dryad Ward at GWMH for palliative care;

ii) On 27 February 1998 you prescribed Oramorphine and Thioridazine 25mg (SC),

iii) On 2 March you prescribed Phentanyl 25mgs by patch,

iv) On 3 March 1998 you prescribed Diamorphine at a dose range of 20mg - 200mg and Midazolam at dose of 20-80mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

b) In relation to your prescription for drugs on 3 March:

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

d) You did not keep clear, accurate and contemporaneous notes in relation to Patient C's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

e) Your actions and omissions in relation to keeping notes for patient C were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

Patient D (Alice Wilkie)

NO REPORT FROM BLACK

5. a) i) On 6 August 1998 patient D was transferred to Daedalus Ward at GWMH for observation prior to a decision being made about placement,

ii) On or before 20 August you prescribed Diamorphine with a range of 20mg - 200mg and Midazolam with a range of 20mg - 80mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis.[5]

b) In relation to your prescription for drugs as describe in para 5a (ii) above:

[5] Do we need these left in to go with 5d or are they narrative if not Dr Barton?

Deleted: ;¶
iii) On 20 August a dose of 30 mgs Diamorphine was administered to the patient with 20 mg Midazolam;¶
iv) On 21 August a further dose of 30 mg Diamorphine was administered to the patient;

Deleted: ¶
v) On 21 August the patient died.

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

d)[6] You did not keep clear, accurate and contemporaneous notes in relation to the patient's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

e) Your actions and omissions in relation to keeping notes for patient D were:

i) inappropriate,

ii) unprofessional,

Deleted: ;

Formatted: Indent: Left: 36 pt

Deleted: 29. The doses of Diamorphine combined Midazolam administered on 20 and 21 August were excessive to the patient's needs.

[6] Is this a criticism we can level at Barton or is it just a consequence of 5b(ii)?

iii) not in the best interests of your patient,

Patient E Gladys Richards

6 a) i) Patient E was admitted to Daedalus Ward at GWMH on 11 August 1998 having received treatment at the Haslar Hospital for a fractured neck of femur,

ii) On 11 August you prescribed 10 mgs Oramorphine 'prn' (as required),

iii) On 11 August you also prescribed Diamorphine with a range of 20 mg - 200 mg and Midazolam with a range of 20 mg - 80 mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

iv) On 14 August the patient was readmitted to Haslar Hospital and then returned to GWMH on 17 August,

b) In relation to your prescription for drugs as describe in para (iii) above:

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

Deleted: v) On 18 August in addition to Oramorph the patient was commenced on 40 mg Diamorphine and 20 mg Midazolam by syringe driver over a twenty-four hour period. ¶
vi) This drug plan was continued on 19, 20 and 21 August;¶
vii) patient E died on 21 August 1998.¶

d) The doses of Diamorphine combined with Midazolam and Oramorth administered on 18, 19, 20 and 21 August were excessive to the patient's needs[7],

e) You did not keep clear, accurate and contemporaneous notes in relation to the patient's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

f) Your actions and omissions in relation to keeping notes for patient E were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

Patient F (Ruby Lake)

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

[7] See earlier footnotes – is this Barton's fault or a consequence we might use as narrative?

ii) On 18 August you prescribed Oramorphine 10 mgs in 5 ml 'prn' (as required),

iii) On 19 August you prescribed Diamorphine with a range of 20 - 200 mgs and Midazolam (check date) with a range of 20 - 80 mgs to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

b) In relation to your prescription for drugs as describe in para (iii) above:

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

d) You did not keep clear, accurate and contemporaneous notes in relation to Patient F's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

Deleted: iv) On 19 and 20 August the patient received Diamorphine at 20 mgs via syringe driver and on 20 August Midazolam at 20 mgs and then 40 mgs;¶
v) On 21 August the patient received Diamorphine at 40 mgs and Midazolam at 60 mgs via a syringe driver¶
vi) patient F died on 21 August 1998. ¶

Deleted: 41. The doses of Diamorphine combined with Midazolam administered on 21 August were excessive to the patient's needs.

Deleted: ¶

[8] As before

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

e) Your actions and omissions in relation to keeping notes for patient F were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

Patient G (Arthur Cunningham)

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

ii) On 21 September 1998 you prescribed Diamorphine with a range of 20 - 200 mgs and Midazolam with a range of 20 - 80 mgs to be administered subcutaneously over a twenty-four hour period on a continuing daily basis;

jii) On 25 September you wrote a further prescription for Diamorphine with a range of 40-200mg and Midazolam with a range of 20 – 200mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis;

b) In relation to your prescription for drugs as describe in para (ii) and (vii) above:

i) the dose range was too wide,

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

Deleted: iii) On 21, 22, and 23 September 20 mgs Diamorphine and 20 mgs of Midazolam was administered to the patient;¶
iv) On 23 September the dose of Midazolam was increased to 40 mgs;¶
v) On 24 September 40 mgs Diamorphine and 80 mgs Midazolam was administered to the patient;¶
vi) On 25 September 60 Diamorphine and 80 mgs Midazolam was administered to the patient;¶
v

Deleted: viii) On 26 September 80 mgs Diamorphine and 100 mgs Midazolam was administered to the patient; ¶
ix) patient G died on 26 September 1998.¶

c) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

d) You did not keep clear, accurate and contemporaneous notes in relation to the patient's care and in particular you did not sufficiently record:

Deleted: 47. The doses of Diamorphine combined with Midazolam administered on 25 and 26 September were excessive to the patient's needs. ¶

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

e) Your actions and omissions in relation to keeping notes for patient G were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

Patient H (Robert Wilson)

9. a) i) Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation

suffering from a fracture of the left upper humerus, liver disease Code A and other medical conditions,

ii) on 14 October you prescribed Oramorphine 10 mgs in 5 mls At a dose of 2.5mls to be given every four hours thereafter as needed, following which regular doses of Oramorphine were administered to the patient,

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

iv) on or before 17 October you prescribed Midazolam with a range of 20 mgs - 80 mgs to be given subcutaneously via syringe driver over a twenty-four hour period on a continuing daily basis,

b) You did not properly assess this patient upon admission,

c) In light of the patient's Code A liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9a (ii) above was:

i) inappropriate;

ii) potentially hazardous;

iii) not in the best interests of your patient;

iv) likely to lead to serious and harmful consequences for your patient,

d) In relation to your prescription written on or before 16 October for Diamorphine to be given subcutaneously:

i) the dose range was too wide,

Deleted: v) on 16 October and 17 October 20 mgs Diamorphine was administered to the patient via syringe driver;¶
vi) on 17 October a new syringe driver containing 40 mgs Diamoprhine together with 20 mgs Midazolam was commenced;¶
vii) on 18 October a new syringe driver containing 60 mgs Diamorphine and 40 mgs Midazolam was commenced.¶
viii) patient H died on 18 October 1998.¶
51.

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

e) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

f) You did not keep clear, accurate and contemporaneous notes in relation to Patient H's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

g) Your actions and omissions in relation to keeping notes for patient H were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

Patient I (Enid Spurgin)

10 a) i) Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital,

ii) On 26 March you prescribed Oramorph 10 mgs in 5 mls 'as required' which was administered until 28 March,[9]

iii) On 12 April you prescribed Diamorphine with a range of 20 - 200 mgs and Midazolam with a range of 20 - 80 mgs to be administered subcutaneously over a twenty-four hour period on a continuing daily basis,

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

b) You failed properly to assess this patient upon admission,

c) In relation to your prescription described in paragraph 10a(iii) above of Diamorphine and Midazolam to be given subcutaneously:

i) the dose range was too wide,

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

d) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

Deleted: Thereafter Morphine Slow Release Tablets were prescribed and administered

Deleted: ;

Deleted: v) patient I died on 13 April 1999.¶ 58.

[9] Do we know by whom? If not Barton then as before?

e) The dosage you authorised/advised on 12 April of 80 mgs Diamorphine via syringe driver was excessive to the patient's needs,

f) You did not keep clear, accurate and contemporaneous notes in relation to Patient I's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

g) Your actions and omissions in relation to keeping notes for patient I were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

Patient J (Geoffrey Packman)

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

ii) On 26 August the patient the patient was feeling less well and blood was taken for testing[10];

iii) On 26 August 1999 you gave a verbal permission for Diamorphine 10 mg to be administered to the patient;

iv) You saw the patient that day and noted as follows: 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death';

v) You did not consult with anyone senior to you about the future management of this patient nor did you undertake any further investigations in relation to his condition;

vi) On 26 August you prescribed Diamorphine with a range of 40 - 200 mg and Midazolam with a range of 20 - 80 mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis;

vii) On 26 August you also prescribed Oramorphine 20 mg at night;

b) In relation to your prescription written 26 August for Diamorphine and Midazolam to be given subcutaneously:

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

Deleted: viii) Between 26 August and 3 September the patient was administered increasing doses of Diamorphine and Midazolam;¶
ix) patient J died on 3 September 1999.¶
65

[10] Can we confirm how Dr Barton was involved in this rather than using the passive?

d) Your failure to obtain senior medical advice on 26 August when taking a serious decision in relation to the future management of this patient was:

i) inappropriate,

ii) not in the patient's best interests;

e) You did not keep clear, accurate and contemporaneous notes in relation to Patient J's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

f) Your actions and omissions in relation to keeping notes for patient J were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient,

g) You did not ensure that the drug chart in relation to this patient was properly kept,[11]

[11] Is this a unique allegation for this particular case? Can we be sure this was Barton's responsibility? Should we charge it in relation to other patients?

Patient K - Elsie Devine

12. a) i) Patient K was admitted to Dryad Ward at GWMH on 21 October 1999 following a period of care at Queen Alexandra Hospital since 9 October. She had been reported to be confused, aggressive and wandering,

ii) On admission on 21 October to GWMH she was reported to be suffering from chronic renal failure and multi infarct dementia and was transferred for the purpose of continuing care,

iii) On admission you prescribed Morphine solution 10mg in 5 ml as required,

iv) On 18 and 19 November there was a deterioration in the patient's condition and on 18 November you prescribed Fentanyl 25 µg by patch,

v) On 19 November you prescribed Diamorphine with a range of 40 - 80 mg Midazolam with a range of 20 to 80 mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis

vi) On 19 November Diamorphine and Midazolam were administered before the effect of the Fentanyl patch wore off.

b) The prescription on admission on 21 October of Morphine solution was not justified by the patient's presenting symptoms;

c) In relation to your prescription written 19 November for Diamorphine and Midazolam to be given subcutaneously:

i) the dose range was too wide,

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

Deleted: v) On 19 November the Fentanyl patch was removed at approximately 12:30;¶

Deleted: vii) On 19, 20 and 21 November 40mg Diamorphine and 40 mgs Midazolam were administered via the syringe driver on a daily basis;¶

Deleted: ii

Deleted: ix) patient K died on 21 November 1999.¶
72.

d) Your actions in prescribing the drugs on admission and on 19 November were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

e) You failed to keep clear, accurate and contemporaneous notes in relation to Patient K's care and in particular you did not sufficiently record:

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed/directed by you,

f) Your actions and omissions in relation to keeping notes for patient K were:

i) inappropriate,

ii) unprofessional,

iii) not in the best interests of your patient;

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

Field Fisher Waterhouse

Case Report
December 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Hall / Sarah Ellson
Date of Rule 8 letter:	Old rules
Date considered by Case Examiner:	14/02/02
Date FFW Instructed:	11 May 2007
Class of Case (1-5)	Class 5
Target date for completion of investigation:	End of January 2008
Interim Order Expires:	IOPs held 21 June 2001, 21 March 2002, 19 September 2002 – No orders made

Summary: Dr Barton is a GP. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis at the Gosport War Memorial Hospital. Dr Barton retired from this post in 2000. A number of complaints were made by relatives of elderly patients who had died at GWMH in 1998. The common complaint was that patients admitted to the GWMH for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. Hampshire Police carried out three extensive investigations between 1998 and 2006 and the deaths of 92 patients were examined. Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation. 10 cases were referred to the CPS. The Crown Prosecution Service reviewed the evidence and concluded that the prosecution test was not satisfied and there was insufficient evidence for criminal proceedings.

The 10 cases were ED, EL, SG, RW, ES, RL, LP, HS, GP and AC [RW and AC together with EP, AW and GR were included in the GMC rule 6 referral letter sent in 2002 after the first police referral]. There are 2 further cases where the patient's relatives have expressed an interest in the investigation.

Investigations: Counsel is in the process of preparing further questions for Professor Black in order that he may prepare supplementary reports. We are in the process of finalising production statements and are liaising with the PCT to contact the healthcare professionals whom we have identified will need to act as witnesses. Counsel will advise the GMC on which cases have the merits to be taken forward and also regarding potential action against the consultants in charge of Dr Barton.

Recommendation: Confirm expert instructions, production statements from witnesses for their police statements and visits to witnesses as necessary, liaise with Coroner, police and PCT. Obtain Counsel's advice on cases and other doctors.

Listing time estimate: 8 weeks.

Counsel: Tom Kark & Rebecca Harris

Listed: 8 September – 31 October 2008

Prospects of Success: Medium

Field Fisher Waterhouse

Case Report
September 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Hall / Sarah Ellson
Date of Rule 8 letter:	Old rules
Date considered by Case Examiner:	14/02/02
Date IIS issued/FFW Instructed:	
Class of Case (1-5)	Class 5
Target date for completion of investigation:	
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Summary: Dr Barton is a GP. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis at the Gosport War Memorial Hospital. Dr Barton retired from this post in 2000. A number of complaints were made by relatives of elderly patients who had died at GWMH in 1998. The common complaint was that patients admitted to the GWMH for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. Hampshire Police carried out three extensive investigations between 1998 and 2006 and the deaths of 92 patients were examined. Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation. 10 cases were referred to the CPS. The Crown Prosecution Service reviewed the evidence and concluded that the prosecution test was not satisfied and there was insufficient evidence for criminal proceedings.

The 10 cases were ED, EL, SG, RW, ES, RL, LP, HS, GP and AC [RW and AC together with EP, AW and GR were included in the GMC rule 6 referral letter sent in 2002 after the first police referral]. There are 2 further cases where the patient's relatives have expressed an interest in the investigation.

Investigations: We have now completed our analysis of the witness statements and transcripts of interviews and the expert evidence. We have provisionally spoken to Professor Black who has indicated that he would be interested in acting as an expert. We have arranged a conference with Counsel, Tom Kark, for 19 October 2007. After the conference we hope to be in a position to advise the GMC on which cases have merit to be taken forward.

Recommendation: Conference with Counsel and advise GMC regarding merits of cases, confirm expert instructions, production statements from witnesses for their police statements and visits to witnesses as necessary, liaise with Coroner and police.

Listing time estimate: 8 weeks.

Counsel: Tom Kark

Listed: 8 September – 31 October 2008

Prospects of Success: Medium

'rom: Code A
ent: 03 Mar 2008 17:39
'o: 'Hall, Tamsin'
:c: 'Ellson, Sarah'
ubject: RE: Barton DNOH
amsin,

,s discussed, I discussed the charges with Peter.

)ate of Death

'eter has responded by separate email.

e

think the reference should be to 2 a rather than 2b.

iv, v, vi

Ve confirm that unless we are making allegations in relation to these paragraphs they should be removed s narrative.

c

,s discussed in due course you will look into whether we have sufficient evidence to support charge 7 a ii as it has not been stated why the prescribing was inappropriate.

e

,s discussed in due course you will look into whether we have sufficient evidence to support charge 9 iv as it has not been stated why the prescribing was inappropriate.

1 iv

he word of has been omitted ie... about the future management **of** ....

1c

think the reference should be to paragraph) ii and **v** rather vi.

1d

think the reference should be to paragraph **iv,** rather than v.

2ai

he word she should not have a capital letter.

2 v and vi

/e note Counsel's comments but unless we are making allegations in relation to these paragraphs they ıould be removed as narrative.

Code A

---

ro Hall, Tamsin Code A
ent: 03 Mar 2008 15:37
o: Code A
c: Peter Swain Code A ; Ellson, Sarah; Tom Kark; Ben FitzGerald
ubject: Barton DNOH

i Code A

s promised, please find the 'amended - amended' DNOH.

ha also attached:

1. Counsel's advice re the amendments
2. Professor Black's report on Alice Wilkie
3. Professor Black's report on Eva Page

fter discussion with Counsel (and his detailed advice) I have re-instated the paragraphs egarding the patient's death. I agree with Tom that to exclude mention of death denegates the eriousness of the charges. From my meetings with some of the relatives over the past couple f weeks I am reminded even more strongly of the sensitivity that they have to this matter and, s Tom states, whilst this is not a key consideration in drafting charges, I think that we need to ontinue to be respectful to their concerns and feelings. Also, it does leave it open to the efence to argue against the admissibility of evidence regarding the patient's deaths. Although, s Tom again states, this is unlikely to be successful I am mindful that we would wish to avoid pending considerable time and incurring delay at the hearing on legal argument if we can at all void it.

have, however, kept most of the narrative description about the drugs administered out of the

)NOH. I think that this can be brought out in evidence. I think that the charges make sense as rafted.

have made all of the other changes suggested by you and by Counsel. I have also spent ome considerable time ensuring that the phraseology is consistent and ensuring the formatting ; right.

would like to get this over to the defence this afternoon if at all possible (we have a telecon cheduled for tomorrow and I don't want them to be able to argue that they have not received ıis).

'hanks for your help.

'amsin

'amsin Hall | Solicitor
)r Field Fisher Waterhouse LLP

Code A

:onsider the environment, think before you print!

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
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/eb www.ffw.com **CDE**823

'rom: Peter Swain Code A
ent: 03 Mar 2008 17:25
'o: 'Hall, Tamsin'; Code A
:c: Ellson, Sarah; Tom Kark; Ben FitzGerald
ubject: RE: Barton DNOH
)ear all,

thought I might just put down briefly in writing by email why I am concerned about the issue of including ıe fact of the death of the patients in the Notice of hearing.

think Tom very helpfully puts his finger on the issue when he refers in his advice to painting a true picture f the GMC's case. This immediately begs the question of what we mean by 'case'. If we mean the contex f the events in question then I can see the argument for including reference to the deaths. The fact of the eaths also of course raises the public interest issue which very firmly forms part of our core jurisdiction. lowever, if by 'case' we mean the case the GMC brings ***against this practitioner***, then to include eference to the deaths we must be confident that the case we are bringing against this doctor includes ıat she bears a degree of responsibility for the deaths of the patients. My understanding is that this not ıe case we are able to bring. I am of the view that the charge should only contain that which is alleged gainst the practitioner. This is why I arrive at the conclusion that the deaths should not be referred to in ıe charge.

recognise the point about keeping these issues in the mind of the Panel; but I also think the alternative an be argued – the Panel may well bend over backwards not to be seen to give any weight to the deaths hen judging the conduct of the doctor if they do not see the evidence to support the inference in the harge that the doctor was somehow responsible. We will of course be bringing out in full the context of ıe events, including the deaths of the patients, in how we present the evidence.

lope this helps.

eter

---

rom: Hall, Tamsin Code A
ent: 03 March 2008 15:37
o: Code A
c: Peter Swain Code A ; Ellson, Sarah; Tom Kark; Ben FitzGerald
ubject: Barton DNOH

Code A

s promised, please find the 'amended - amended' DNOH.

ıave also attached:

1. Counsel's advice re the amendments
2. Professor Black's report on Alice Wilkie
3. Professor Black's report on Eva Page

fter discussion with Counsel (and his detailed advice) I have re-instated the paragraphs ıgarding the patient's death. I agree with Tom that to exclude mention of death denegates the ıriousness of the charges. From my meetings with some of the relatives over the past couple f weeks I am reminded even more strongly of the sensitivity that they have to this matter and, s Tom states, whilst this is not a key consideration in drafting charges, I think that we need to ɔntinue to be respectful to their concerns and feelings. Also, it does leave it open to the ɛfence to argue against the admissibility of evidence regarding the patient's deaths. Although, s Tom again states, this is unlikely to be successful I am mindful that we would wish to avoid ɔending considerable time and incurring delay at the hearing on legal argument if we can at all void it.

have, however, kept most of the narrative description about the drugs administered out of the NOH. I think that this can be brought out in evidence. I think that the charges make sense as rafted.

have made all of the other changes suggested by you and by Counsel. I have also spent ɔme considerable time ensuring that the phraseology is consistent and ensuring the formatting right.

would like to get this over to the defence this afternoon if at all possible (we have a telecon cheduled for tomorrow and I don't want them to be able to argue that they have not received ıis).

hanks for your help.

amsin

amsin Hall | Solicitor
ɔr Field Fisher Waterhouse LLP

Code A

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

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/e use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with quivalent standing and qualifications.

rom: Code A
ent: 03 Mar 2008 17:42
o: 'Hall, Tamsin'
ubject: RE: Barton DNOH
hanks, I omitted to mention that you confirmed that the allegations about the drug charges have been moved from the charges as we could not prove this was Dr Barton's responsibility.

---

rom: Hall, Tamsin Code A
ent: 03 Mar 2008 17:39
o: Code A
c: Ellson, Sarah
ubject: RE: Barton DNOH

hanks for your confirmation in writing, I have made the amendments as you have suggested and sent iem over to the defence.

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP

Code A

---

rom: Code A
ent: Monday, March 03, 2008 5:39 PM
o: all, Tamsin
c: Ellson, Sarah
ubject: RE: Barton DNOH

amsin,

s discussed, I discussed the charges with Peter.

ate of Death

eter has responded by separate email.

e

think the reference should be to 2 a rather than 2b.

iv, v, vi

Ve confirm that unless we are making allegations in relation to these paragraphs they should be removed s narrative.

c

s discussed in due course you will look into whether we have sufficient evidence to support charge 7 a ii as it has not been stated why the prescribing was inappropriate.

e

s discussed in due course you will look into whether we have sufficient evidence to support charge 9 iv as it has not been stated why the prescribing was inappropriate.

1 iv

he word of has been omitted ie... about the future management **of** ....

1c

think the reference should be to paragraph) ii and **v** rather vi.

1d

think the reference should be to paragraph **iv,** rather than v.

2ai

he word she should not have a capital letter.

2 v and vi

Ve note Counsel's comments but unless we are making allegations in relation to these paragraphs they hould be removed as narrative.

uliet

---

rom: Hall, Tamsin Code A
ent: 03 Mar 2008 15:37

o: Code A

c: Peter Swain Code A Ellson, Sarah; Tom Kark; Ben FitzGerald

ubject: Barton DNOH

i Code A

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egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

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ax: 0845 357 9001

'rom: Hall, Tamsin Code A
ent: 03 Mar 2008 15:37
'o: Code A
:c: Peter Swain Code A ; Ellson, Sarah; Tom Kark; Ben FitzGerald
ubject: Barton DNOH

ıttachments: DOCS_6858103_3.DOC; DOCS_6887273_1.DOC; DOCS_6888669_1.DOC;)OCS_6850725_1.DOC

li Code A

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'amsin

amsin Hall | Solicitor
›r Field Fisher Waterhouse LLP
d Code A

lobile Code A

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'eb www.ffw.com **CDE**823

IN THE MATTER OF THE MEDICAL ACT 1983

AND IN THE MATTER OF

THE GENERAL MEDICAL COUNCIL

AND

DR JANE BARTON

DRAFT NOTICE OF HEARING

---

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

Patient A (Leslie Pittock)

2. a) i) Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care,

ii) Between 5 and 10 January 1996 you prescribed Oramorphine as well as Diamorphine with a dose range of 40 – 80 mg over a twenty-four hour period to be administered subcutaneously ("SC") on a continuing daily basis,

iii) On 11 January you prescribed Diamorphine with a dose range of 80 – 120 mg and Midazolam with a range of 40 – 80 mg to be administered SC over a twenty-four hour period,

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

v) On 17 January the dose of Diamorphine was increased to 120 mg and Midazolam to 80 mg,

vi) On 18 January you prescribed 50 mg Nozinan in addition to the drugs already prescribed,

vii) On 20 January you increased the prescription of Nozinan to 100 mg,

viii) On 24 January 1996 Patient A died.

b) In relation to your prescriptions described in paragraphs 2a (ii) and 2a (iii):

i) the dose range was too wide,

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

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

d) Your prescriptions described at paragraphs 2a) vi) and/or vii) in combination with the other drugs already prescribed were excessive to the patient's needs.

e) Your actions in prescribing the drugs as described in paragraphs 2b ii), iii), iv), v), vi) and/or vii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient A.

Patient B (Elsie Lavender)

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

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

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

iv) On 5 March you prescribed Diamorphine with a dose range of 100 - 200 mg and Midazolam with a dose range of 40 mg – 80 mg over a twenty-four hour period to be administered SC and a syringe driver was commenced containing Diamorphine 100 mg and Midazolam 40 mg,

v) On 6 March Patient B died.

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

i) the dose range for Diamorphine on 26 February and on 5 March for Diamorphine and Midazolam was too wide,

ii) the lowest commencing dose on 5 March of 100 mgs Diamorphine was excessive to Patient B's needs,

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

c) Your actions in prescribing the drugs described in paragraphs 3a) ii), iii) and/or iv) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient B.

d) In relation to your management of Patient B you:

i) did not perform an appropriate examination and assessment of Patient B on admission,

ii) did not conduct an adequate assessment as Patient B's condition deteriorated,

iii) did not provide a plan of treatment,

iv) did not obtain the advice of a specialist when Patient B's condition deteriorated.

e) Your actions and omissions in relation to your management of patient B were:

i) inadequate,

ii) not in the best interests of Patient B.

Patient C (Eva Page)

4. a) i) On 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care,

ii) On 3 March 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20-80mg to be administered SC over a twenty-four hour period on a continuing daily basis,

iii) On 3 March 1998 Patient C died.

b) In relation to your prescription for drugs described in paragraph 4a) ii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraph 4a) ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

Patient D (Alice Wilkie)

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

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

iii) On 21 August Patient D died.

b) In relation to your prescription for drugs as described in paragraph 5a (ii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs as described in paragraph 5a (ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient D.

Patient E (Gladys Richards)

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

ii) On 11 August you prescribed 10 mg Oramorphine 'prn' (as required),

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

iv) On 14 August Patient E was readmitted to the Royal Haslar Hospital and then returned to GWMH on 17 August,

v) On 18 August, in addition to the Oramorphine, Patient E was commenced on 40 mg Diamorphine and 20 mg Midazolam by syringe driver over a twenty-four hour period. This drug plan was continued on 19, 20 and 21 August 1998.

vi) Patient E died on 21 August 1998.

b) In relation to your prescription for drugs described in paragraph 6a) (iii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraph 6a) ii) and/or (iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient F.

Patient F (Ruby Lake)

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

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

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

iv) Patient F died on 21 August 1998.

b) In relation to your prescription for drugs described in paragraph 7b) (iii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraphs 7a) ii) and/or iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient F.

Patient G (Arthur Cunningham)

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

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

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

iv) Patient G died on 26 September 1998.

b) In relation to your prescriptions for drugs described in paragraphs 8a) (ii) and/or (iii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraphs 8a) (ii) and/or (iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient G.

Patient H (Robert Wilson)

9. a) i) Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease Code A and other medical conditions,

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

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

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

v) Patient H died on 18 October 1998.

b) You did not properly assess Patient H upon admission. This was:

i) inadequate,

ii) not in the best interests of Patient H.

c) In light of the Patient H's Code A liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9a (ii) was:

i) inappropriate,

ii) potentially hazardous,

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

iv) not in the best interests of Patient H.

d) In relation to your prescription described in paragraph 9a) iii):

i) the dose range was too wide,

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

e) Your actions in prescribing the drugs described in paragraphs 9 ii), iii) and/or iv) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient H.

Patient I (Enid Spurgin)

10 a) i) Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital,

ii) On 12 April you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

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

iv) Patient I died on 13 April 1999.

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

i) inadequate,

ii) not in the best interests of Patient I.

c) In relation to your prescription for drugs described in paragraph 10a) ii):

i) the dose range was too wide,

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

d) Your actions in prescribing the drugs described in paragraph 10a) ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient I.

e) The dosage you authorised/directed described in paragraph 10a) iii) was excessive to Patient I's needs. This was:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient I.

Patient J (Geoffrey Packman)

11. a) i) Patient J was admitted to Dryad Ward at GWMH on 23 August 1999 following his treatment at the Queen Alexandra

Hospital where the patient had been admitted as an emergency following a fall at home,

ii) On 26 August 1999 you gave verbal permission for 10 mg of Diamorphine to be administered to Patient J,

iii) You saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death',

iv) You did not consult with anyone senior to you about the future management Patient J nor did you undertake any further investigations in relation to Patient J's condition,

v) On 26 August you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

vi) On 26 August you also prescribed Oramorphine 20 mg at night.

b) In relation to your prescription for drugs described in paragraph 11a) v):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraphs 11a) ii) and/or vi) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient J.

d) Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11a) v) was:

i) inappropriate,

ii) not in the best interests of Patient J.

Patient K (Elsie Devine)

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

ii) On admission you prescribed Morphine solution 10mg in 5 ml as required,

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

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

v) On 19 November the Fentanyl patch was removed at approximately 12:3, subsequently Diamorphine and Midazolam were administered before the effect of the Fentanyl patch wore off,

vi) Patient K died on 21 November 1999.

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

c) In relation to your prescription for drugs described in paragraph 12a) iv):

i) the dose range was too wide,

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

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

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient K.

Records

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

i) the findings upon each examination,

ii) an assessment of the patient's condition,

iii) the decisions made as a result of examination,

iv) the drug regime,

v) the reason for the drug regime prescribed by you,

vi) the reason for the changes in the drug regime prescribed and/or directed by you,

b) Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J and/or K were:

i) inappropriate,

ii) not in the best interests of your patients;

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

Dr Barton

Advice following consideration of the charges as amended

1 In relation to the amendment of the draft charges which I received last week may I comment as follows:

2 I am quite happy with the reformatting, paragraph re-numbering etc.

3 I have no difficulty with the amendment from "failed to" to "did not".

4 I do however have concerns about some of the deletions of the factual background which had been included.

5 I appreciate the GMC's resolve to reduce the narrative as far as possible but, this must not be done at the expense of making sense of the charges.

6 This is a case, in essence, where the allegations revolve around excessive prescribing of Morphine to elderly patients as a result of which the patients received excessive amounts of Morphine and some died earlier than they otherwise might have done.

7 Where medication was issued in accordance with the prescriptions written by Dr Barton that is relevant to the facts. Although the drugs may not have been issued

by Dr Barton herself, they were issued under her authority and her prescription. It is for that reason that I included those events in the factual matrix.

8 The arguments for including the dates of death are as follows:

i) Although this is not a 'Shipman' case of deliberate killing, the death of these patients is certainly not irrelevant to the factual matrix. This is not simply a case of over-prescribing which was negligent but which had no effect because the patient did not receive excessive medication. In the majority of the cases charged the patient did receive excessive medication and, in some cases, their lives may have been shortened albeit by a small margin.

ii) The Panel on first reading the charges have to understand what the factual background to the case is. Furthermore when they come to formulate their determination (should they find the facts proved) in my experience they almost invariably base their determination upon the charges as set out. It would be very surprising if the Panel, in delivering their determination, made no reference to the death of these patients or to the fact that they had indeed, on some occasions, received excessive medication.

iii) Members of the public, most particularly in this case relatives of the deceased, are entitled to know what has happened in a case and the charges are in the public forum. Any of the relatives of these deceased would in my view be most perturbed to see the charges making no reference whatever to the loss of their loved ones. Although I appreciate this is by no means a deciding factor it does reflect the fact that the charges as presently drafted do not paint a true picture of the GMC's case.

iv) Had these patients been discharged from the hospital and from Dr Barton's care instead of dying it would obviously have been appropriate to have included the date of discharge in the heads of charge. The same applies where the patient has not been discharged but has, instead, died.

v) The defence could conceivably mount an argument that what is not reflected in the charges does not need to be proved. Although we might resist such an argument the defence could submit that the deaths of the patients, not being reflected anywhere in the charges, is quite irrelevant and so could object to the admission of that evidence. Although such an argument is unlikely to succeed, it is worth considering what would be the effect upon this case. In reality the whole trial would, in my view, be neutered of its effect. One only has to consider this scenario to appreciate the importance of properly reflecting the facts, including the deaths of the patients, in the heads of charge as part of the factual matrix.

9 Specifically (using my old paragraph numbers where relevant): –

10 2 (vi) has been removed but the criticism of that dose increase has been left in at para.1 (c) (new charges).

11 The paragraph presently numbered 1 (b)(i) has a typo.

12 The paragraph numbering in the new 1 (e) has to be sorted out so that it is in accordance with the allegations.

13 The present 4 (c) has removed the date of the 3rd March which was put into Head 21 deliberately. As it now stands there is criticism of the prescriptions on 27th February and on 2nd March which I am not sure is the intended consequence.

14 In relation to Patient D we must ensure that the words "NO REPORT FROM BLACK" are excised before the draft is served.

15 Charges 26 (iii) to (iv) have been excised so that the dates of the administration of the doses have been deleted. Although I would have preferred to include those in the allegations I accept that they are not essential to an understanding of the case.

16 Charges 32 (v) to (vii) have been removed and it is difficult to follow from the charges what happened unless it is understood that the regime of Diamorphine etc. continued once the patient had returned from the Haslar Hospital.

17 In the new draft 7 (a) (iii) the words "check date" should be removed from the draft.

18 Charges 34 (iv) and (v) have been removed, the effect of which is that the drugs which were administered on the basis of Dr Barton's prescription do not appear in the factual matrix. However, since the drugs themselves are not said to be excessive I am relatively content for that to remain as it is although I would have preferred those charges to remain in.

19 In relation to the removal from the charges in relation to Arthur Cunningham setting out the administration of the drugs, for the same reason I am relatively content for the charges to remain as now amended.

20 In relation to Patient H (Robert Wilson) the same applies. However, having now amended paragraph 51 so that it now reads "You did not properly assess the patient upon admission" there is no attached criticism of that omission. Accordingly, I would suggest that a new paragraph be inserted immediately following that allegation to the effect that by not properly assessing the patient Dr Barton was not acting in the best interests of her patient.

21 In relation to the new charge 10 (b) (re: Enid Spurgeon) the word "failed" has not been amended to "did not" which is inconsistent with the view taken previously. If failed is to be amended to "did not" then an additional charge should be inserted immediately following that allegation to the effect that, by not properly assessing the patient, Dr Barton was not acting in the best interests of her patient.

22 In relation to Geoffrey Packman the new charge 11 (a) (v) alleges that Dr Barton did not undertake further investigations however there is no correlating criticism of that failure. 11 (d) should be amended to incorporate such criticism by amending 11 (d) to include the words "and not undertaking any further investigation" before the word "was".

23 In relation to Elsie Devine, charge 71 (v) has been removed so that nowhere in the charges is it now clear when the Fentanyl patch was removed. This is directly relevant to the allegation which as been retained in the new 12 (a) (vi) that the Diamorphine and Midazolam were administered before the effect of the Fentanyl patch wore off. I find it difficult to see how this charge can make sense without it being stated that the Fentanyl patch had been removed and when that happened

Summary

24 I would strongly urge those instructing me to reinsert the paragraphs alleging the dates of death for each patient.

25 I would strongly urge the reinsertion of such paragraphs where drugs have been administered which were in fact excessive or where it is directly relevant to the charges remaining as set out in this advice.

26 Whilst I would have preferred to include the dates of the administration of the drugs generally I concede that it is not essential to do so.

27 Where the word "failed" has been amended to "did not " care must be taken to ensure that there is a corresponding criticism.

Tom Kark

QEB Hollis Whiteman Chambers

Queen Elizabeth Building

Temple, London EC4Y 9BS

2nd March 2008

Alice WILKIE
DOB: Code A
Died: 21/08/1998

SUMMARY OF CONCLUSIONS

Alice Wilkie, a 92 year old lady with severe end-stage Alzheimer's disease who was certainly entering the terminal phase of her disease at the time of her admission with pyrexial illness, possibly a UTI, on 31 July 1998.

Her investigations and management in the Queen Alexandra Hospital were generally acceptable. It was appropriate to transfer her to the Gosport War Memorial Hospital.

The documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence except for two unnumbered pages which are referred to as UN).

3.1. Alice Wilkie was a 92 year old lady at the time of her death in the Gosport War Memorial Hospital on 21st August 1998.

3.2. Alice Wilkie's main problem was progressive dementia presumably of the Alzheimer's type. In 1992 her dementia was already known (243) and she was having problems with wandering (164). She started to

have respite care for her dementing illness in 1994 (189). Depixol was already started in 1995 (186). By 1996 she was having problems with aggressive behaviour (201) and was subsequently started on Carbamezepine as well as her major tranquilisers to help try and manage her behavioural problems (207). Eventually she ended up in a specialist psychiatric residential home by the summer of 1997. As she continued to have regular Depixol injections through 1998 although on 21st July the dose was reduced because of reported sleepiness (221). This appeared to be her last dose of Depixol, which was subsequently withdrawn by the psycho-geriatric team on 6th August (222). This was as a result of a visit by the community psychiatric nurse, part of the psycho-geriatric team, who saw the patient on Daedalus Ward. The psycho-geriatric team also either saw the patient or contacted the ward on 12th August (222).

3.3. From a medical as opposed to psychiatric perspective there had been a number of problems including rectal bleeding in 1993 and 1994 and known diabetes, controlled by diet since at least 1995 (381). She had a previous pneumonectomy many years before for possible tuberculosis. In 1995 she had problems with an oesophageal stricture (201) and was put on long term Omeperazole.

3.4. On 31st July 1998 she was admitted as an emergency to the Queen Alexander Hospital. The letter from the admitting GP (69) states that she had had a urinary tract infection and had fallen the night before and was now refusing fluids. Medical clerking (85-86) notes that Mrs Wilkie was pyrexial but there were no other specific abnormalities apart from conjunctivitis noted on examination. The diagnosis was of a urinary tract infection which had not responded to oral antibiotics.

3.5. Various investigations are undertaken but her blood tests are normal (87) and a sample of urine from her catheter grows nothing (101). Her blood glucose is appropriately requested, she is thought to be diabetic but was never measured or reported (91). She is known to have a long term catheter (24, 86). There is no biochemical evidence of dehydration with a normal sodium urea and creatinine (91).

3.6. The nursing notes also document her admission pyrexia and undertake a nutritional assessment which show that she is at high risk (33, 34). She is also noted to be almost completely dependent with a Barthel score of 1 on 31st July and a 2 on 5th August (22). The temperature chart shows that she becomes apyrexial by 1st August (39).

3.7. On the 3rd August she is apyrexial and is on subcutaneous fluids but had 500 mls of oral intake the previous day. The plan was to stop the subcutaneous fluids (88).

3.8. The nursing notes demonstrate that she has settled by 1st August (24) and also comments that she is sleeping well on 3rd August (23).

3.9. The next medical notes are on the unnumbered sheets where Alice Wilkie is seen by a consultant, Dr Lord on 4th August. However, this history sheet is marked GWM. It is difficult to be certain but I assume this was added when the patient was transferred to the Gosport War Memorial Hospital on 6th August because Mrs Wilkie must have been seen on 4th August in the Queen Alexander Hospital.

3.10. Dr Lord refers as diagnosis – see problem sheet, I believe this is the sheet (83) which summarises the problems as dementia, urinary tract infection, dehydration and catheterised. Dr Lord's notes summarise the very severe dementia and dependency and the current functional status. The plan is then made to continue the oral antibiotic, to continue the subcutaneous fluids (although it had already been decided the day before to stop these) (88) and states the overall prognosis as poor and that Mrs Wilkie is now too dependent to return to her residential home. She is therefore to be transferred to Deadalus Ward for continuing care, observation and possible placement, although she does ask that her bed is kept at the residential home for a further period. Dr Lord confirms the do not resuscitate status of Mrs Wilkie (UN) previously made by the medical team in the Queen Alexander Hospital (88).

3.11. Mrs Wilkie is transferred on 6th August. There is a very brief note in the medical notes that she is to continue the Augmentin. There is no evidence that she is on subcutaneous fluids at that time or that any subcutaneous fluids are given at the Gosport War Memorial Hospital.

3.12. On 10th August, the consultant, Dr Lord reviews Mrs Wilkie and notes that she has improved a little and that she is now eating and drinking better but remains very confused and highly dependent. The request is that the residential place is given up, and a plan is made to review in a month's time the possibility of a long term nursing home placement.

3.13. The next medical note is on 21st August in Dr Barton's handwriting which states marked deterioration over the last few days. Subcutaneous analgesia commenced yesterday, family aware and happy. Someone has written in a different handwriting "syringe driver" on the photocopied page.

3.14. The final note is on 21st August at 1830 where charge nurse confirms death. The family were present.

3.15. Nursing notes at the Gosport War Memorial state that on admission that she is for assessment and observation (115) and document that she has a Waterlow score of 15 on admission which is high risk (123) and "does have pain at times" (117). Although the signature is unreadable in the medical notes, the nursing contact record (125) confirms that it was a Dr Peter who admitted Mrs Wilkie into the Gosport War Memorial Hospital on 6th August. The contact record also states that on 17th August that her condition has generally deteriorated over the weekend, the daughter seen and aware that mum's condition is worsening, agrees active treatment not appropriate and to use syringe driver. Mrs Wilkie is in pain. The notes also comment that there is some food and fluid intake up until 18th August (129).

3.16. There is a single drug chart (57-64) that goes from her admission on 31st July to 21st August.

3.17. The PRN side, a Promazine syrup 25mgs orally is prescribed as is magnesium hydroxide neither of which are given. Haloperidol 2.5 – 10 mgs subcutaneously is also prescribed and single dose of 2.5 mgs is given at 2045 on 1st August in the Queen Alexander Hospital.

3.18. Regular prescriptions of Prozac, Co-danthramer, Zopiclone, Lactulose and Augmentin are written up. Zopiclone and Co-danthramer certainly continue until 15th August and the Augmentin until 9th August.

3.19. Diamorphine 20 – 200 mgs subcut in 24 hours is written up on the daily review prescriptions part of the drug chart together with Hyoscine 20 – 80 micrograms subcut in 24 hours and Midazolam 20 – 80 mgs subcut in 24 hours although there is nothing to say which days the prescriptions was written up. However, Diamorphine 30 mgs and Midazolam 20 mgs appear to have both been started at 1350 in a syringe driver on 20th August and the same does re-prescribed on 21st August.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Diamorphine 20 – 200 mgs	No date	Daily review prescriptions	BARTON	30 mgs 20/08 30 mgs 21/08
Midazolam 20 – 80 mg	No date	Daily review prescriptions	BARTON	20 mgs 20/08 20 mgs 21/08

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Alice Wilkie, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Wilkie was a very elderly lady with severe end-stage Alzheimer's disease. This disease is documented in the notes for at least 6 years with increasing behavioural problems requiring both pharmacological intervention and specialist residential care.

4.3. She also had a number of medical problems in particular her oesophageal stricture and diabetes although this diagnosis was completely ignored in her final admission. Although her admission to Queen Alexander is presented as an acute UTI there had probably been a longer period of deterioration. The GP's letter documents weight loss and her dose of Depixol had been reduced 10 days earlier because of sleepiness. However, there is no doubt she was pyrexial on admission and her condition had significantly deteriorated to the point where she could not be managed in the residential home.

4.4. She was appropriately investigated and treated with antibiotics and subcutaneous fluids in the Queen Alexander Hospital and becomes apyrexial. She is seen by a consultant Geriatrician who makes an adequate assessment and arranges for Mrs Wilkie to be transferred to the Gosport War Memorial Hospital for a period of observation to determine a final outcome.

4.5. The consultant states the prognosis is poor, this usually means that the expected outcome is the patient is not going to leave

hospital and really is in the terminal phase of their illness. Although it is quite appropriate to have a plan that should that not be the case a long term nursing placement might be needed as she was not far too dependent to return to her residential home. I believe this was all appropriate management.

4.6. The patient is transferred to Gosport War Memorial on 6th August and the admission clerking is unacceptably brief. Indeed it is not clear the admitting doctor, a Dr Peter saw the patient although the nursing cardex does refer to "clerked in". It is impossible from the notes to make a judgement of the clinical status of Mrs Wilkie on arrival.

4.7. However, she is reviewed by Dr Lord on 10th August who does an assessment and this would suggest that she is now clinically stable as Dr Lord remarks "eating and drinking better". The plan is to review progress in a month's time.

4.8. There is nothing further in the medical notes until the day of her death, the 21st August which states a marked deterioration over the last few days. Her syringe driver had been started the day before.

4.9. There are clues in the nursing records that deterioration must have started several days before, for example in the contact record on 17th August (125) states her condition has generally deteriorated over the weekend, however, there is no evidence at all that this lady was seen by the medical staff, or if they did, no record has been written in the notes. However, it is also impossible to tell from the notes whether the nursing staff informed the medical staff that there had been any change in condition.

4.10. A syringe driver is started on 20th August. There is absolutely no documentation as to the clinical reason to do this. There is one comment in the nursing notes about pain at times (117) but no evidence from the drug chart of any other analgesia apart from the syringe driver is needed or used. In my view the failure to document any medical reasons for her deterioration or why she was started on a syringe driver is unacceptable medical practice. I cannot exclude the possibility that she needed symptom palliation during her last few days but there is no evidence that I can find in the medical or nursing notes to justify use of the syringe driver.

4.11. Diamorphine 30 mgs in 24 hours and Midazolam 20 mgs in 24 hours were started on 20th August. The prescriptions are not dated so it is impossible to tell when they were originally written, it is also impossible to tell who made the final decision to start the Diamorphine on 20th August or indeed who chose the starting dose of 30 mgs when 20 mgs was the lowest dosed prescribed.

4.12. 30 mgs of Diamorphine by subcutaneous infusion is equivalent to oral morphine at 15 mgs every 24 hours. In my view this is an unnecessarily high dose for someone who has received no previous opiate analgesia or indeed any other analgesia. Midazolam is a sedative which can be suitable for a very restless patient and is usually initially given in a dose of 20 mgs in 24 hours although some believe the dose should be much lower (5-20 mgs in older people, in particularly the most frail). There is nothing in the notes to explain why it was thought that both Midazolam and a high dose of Diamorphine were required in this patient. In my view the doses of Diamorphine and Midazolam were unacceptably high as a starting dose from the evidence available in the notes. There would have been a very significant risk of over sedation, for example causing respiratory depression, impaired conciousness and a possibility of shortening her life by some hours or days.

5. OPINION

5.1. Alice Wilkie, a 92 year old lady with severe end-stage Alzheimer's disease who was certainly entering the terminal phase of her disease at the time of her admission with pyrexial illness, possibly a UTI, on 31 July 1998.

5.2. Her investigations and management in the Queen Alexandra Hospital were generally acceptable. It was appropriate to transfer her to the Gosport War Memorial Hospital.

5.3. The documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical assessment on admission.
- The lack of any medical records after 10th August until the day of her death.
- The lack of any description of why she was deteriorating sometime after 10th August.
- The failure to explain why a syringe driver was required for symptom control.

- The lack of any written justification of the doses of Diamorphine and Midazolam actually used in the syringe driver.
- Any observations to look for possible side effects of the high doses of Diamorphine and Midazolam used.
- Inability to tell from the notes who made the final decision to start the syringe driver and the dose to be used.

5.4. The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient. In particular:

- The prescription of a large range of a controlled drug (in particular, Diamorphine) in the "daily review prescriptions" side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.
- The failure to date the prescriptions of Diamorphine, Hyoscine and Midazolam.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature:_____ Date:_____

Eva PAGE
DOB: Code A
Died: 03/03/1998

SUMMARY OF CONCLUSIONS

Mrs Eva Page, an elderly lady who was admitted to Queen Alexander Hospital in February 1998. She was subsequently transferred to the Gosport War Memorial Hospital with a terminal illness almost certainly a carcinoma of the lung on a background of other chronic diseases including stroke and cardiac disease.

Her investigations and management were appropriate to her condition while in the Queen Alexandra Hospital.

The use of the drug chart in the Gosport War Memorial Hospital was seriously deficient.

There is inadequate documentation of clinical review of the patient in particular on 3rd March and inadequate documentation regarding decision making to start the syringe driver. This represents poor medical practice.

1. INSTRUCTIONS

To examine the medical records and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence).

3.1. Eva Page was an 88 year old lady at the time of her final admission to hospital on 6th February 1988.

3.2. She lived in a residential home for a number of years and was reported as being independent in 1995 (32). During 1995 she had been admitted to hospital with chest pain (28) left ventricular failure in atrial fibrillation (22) and Digixon toxicity (14). At the time of her

admission with Digixon toxicity she had also been noted to have a transient impairment of renal function (14).

3.3. Eva Page was admitted to hospital on the 30th March 1997 (10) with confusion, right sided weakness and a probable dysphasia caused by a probable stroke (90) (112), however she improved rapidly and her comprehension was good and she was much less confused by the time of her discharge back to her residential home on 6th May 1997 (116).

3.4. The next documented hospital admission was 6th February 1998 when she was admitted to Victory Ward from home (157) (medical notes 246). The notes document that she had several days of rapid deterioration but she had been depressed for the last few weeks, increasingly withdrawn and had been started on Sertraline, an anti-depressant (246). Investigations showed a modestly raised urea of 8.4 (247), a low albumin of 30 (247) and a white cell count of 13.

3.5. Further investigations showed an abnormal chest x-ray that was thought to be a very suspicion of a carcinoma of bronchus (248) confirmed by an x-ray report (240). A decision is made not to bronchoscope her (249) and on 15th February there is a discussion with the son about the diagnosis (249). She has a documented fall on the ward (250) and the medical notes confirm her continued confusion. There is a good summary in the notes on 19th February (252) confirming that she is sleepy but responsive, incontinent of urine and faeces and has a low MTS (252-3).

3.6. On 25th February she is confused with some agitation (254) and the medical notes document that she has started on Thioridazine because of her anxiety and distress.

3.7. The nursing notes confirm her rapid physical decline during her time after admission. Her Barthel falls from 13 on admission to only 4 on 23rd February (162). Her Waterlow score also rises from 11 to 20 on 21st February (164). She has very little food intake during her admission (204-217). There is continual evidence from the nursing notes of anxiety, fear and variable confusion (180, 183, 184). She is catheterised, leaking faeces, frightened and agitated on 23rd February (189).

3.8. On 27th February she is transferred to Dryad Ward (254). The notes document her diagnosis of Ca Bronchus made on a chest x-ray on admission; she is generally unwell and off legs; and needs help with eating and drinking, and has a Barthel of 0. The notes also state that the family have been seen and are aware of prognosis and that Dr

Barton is happy for the nursing staff to confirm death (255). Needs hoisting and opiates commenced.

3.9. On 28th February (255), Mrs Page is confused, agitated particularly at night but not in pain. Medical notes say for regular Thioridazine (412). The next medical notes are 2nd March: there has been "no improvement on the major tranquilisers. I suggest adequate opiates to control fear and pain". A further note on 2nd March by a different doctor says "spitting out Thioridazine, quieter – now on sub-cut Oramorphine". "Fentanyl patch started today. Agitated and calling out even when staff present". "Diagnosed carcinoma bronchus ?Cerebral metastases". Continue Fentanyl patches. The son is seen. The next note in the medical section is on 3rd March and states the patient continues to deteriorate and died peacefully at 2130 hours. Death verified and signed by the staff nurse.

3.10. Drug Cardex. The drug chart before transfer to the Gosport War Memorial Hospital (234) shows that Thioridazine 10mgs was given 3 times a day on 25th and 26th February.

3.11. The drug chart at Dryad (222-224) demonstrates that on the once only prescription side that Diamorphine 5mgs was given at 0800 and 1500 mgs – date not visible on photocopies. On the PRN part of the drug chart Thioridazine 25mgs sub-cut is written up on 27th February and prescribed on 28th February at 1300. Oramorphine 10 mgs of 10ml is written up on 27th February and a single dose of 5mgs given on 28th February. Fentanyl patch 25 mgs is written up on 2nd March and prescribed once on 2nd March at 0800. There is no documentation if this ever removed.

3.12. On the regular side of the drug chart, Digoxin, Frusemide, Ramipril, Sotalol and Sertraline are written up and then crossed off and never given. Thioridazine is written up on 28th February and prescribed twice a day on 1st and 2nd March. Heminevrin is written up on 28th February and given once in the evening on 28 February and once on 1st March. Diamorphine 20-200 mgs sub-cut in 24 hours is prescribed on the regular prescription part of the drug chart which has been crossed out and PRN written. Hyoscine 200-800 mcgs in 24 hours and Midazolam 20-80 mgs sub-cut in 24 hours are also written up in the same way. I could not identify which day these prescriptions were written but 20 mgs of Diamorphine with 20mgs of Midazolam were both started in a syringe driver at 1050 am on 3rd March.

3.13. All the prescribing of opiates on Dryad Ward appear to be in Dr Barton's handwriting.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Diamorphine 5mg	? Date	Once only	BARTON	0800 am ? date 1520 am ? date
Thioridazine 25mg	27th February	PRN	BARTON	1300 am 28th Feb
Oramorphine 10 mgs in 10 mls	27th February	PRN	BARTON	5mg 28th Feb
Fentanyl 25mgs x 5 days	2nd March	PRN	BARTON	0800 am 2nd March
Diamorphine 20 – 200 mg S/C in 24 hours	? Date	"PRN" Regular prescription crossed out	BARTON	20 mg 1050 am 3rd March
Midazolam 20 – 80 mg S/C in 24 hours	? Date	"PRN" Regular prescription crossed out	BARTON	20 mg 1050 am 3rd March

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Eva Page, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Page was an elderly frail lady with multiple pathology having documented evidence of cardiac and cerebro vascular disease with intermittent confusion diagnosed previously.

4.3. The final admission seems to have been preceded by fairly rapid physical decline. The diagnosis of probable carcinoma of the lung was made on radiological grounds on her admission to the Victory Ward. This was an appropriate diagnosis and would explain her rapid physical decline. A decision was made not to bronchoscope which would have been extremely difficult and an unlikely to have changed management in any way. This was also appropriate.

4.4. The nursing cardex and medical notes confirm her rapid physical and mental deterioration after admission. The objective evidence from both her decreasing Barthel, increasing Waterlow dependency and her rapidly falling albumin are all signs of a rapidly deteriorating condition, and compatible with a diagnosis of carcinoma of lung.

4.5. Although it is not specifically mentioned in the medical notes it is clearly documented in the nurses' notes that before transfer the she is for palliative care (at 157).

4.6. It was decided to transfer to the Gosport War Memorial Hospital to be nearer her son. There is a good summary of her problems written in the notes shortly prior to transfer (252).

4.7. On admission to Dryad Ward there is a very basic summary of the condition and dependency of Mrs Page but in view of the clear understanding that she was for palliative care and the good summary in the notes just prior to transfer I do not think that this was an unreasonable summary.

4.8. During her stay in the Queen Alexander Hospital and the Gosport War Memorial Hospital she continues to be frightened, agitated and confused. She is started on a major tranquiliser (Thioridazine) before transfer and this continued after transfer. The continued notes on 2nd March suggests that this drug management regime which then included Heminevrin was not being successful. All these symptoms are compatible with someone rapidly deteriating with carcinoma of lung, and probably also indicate mild delirium. A psycogeriatric opinion would not be needed in these circumstances.

4.9. The medical notes on the 27th February (254) state that opiates have been commenced but it is not clear though from the drug chart what this is referring to unless she received two doses of Diamorphine on the 27th, however, the photocopy is inadequate (222) to determine if this was the case. She receives a single dose of 5mg Oramorphine on 28th February and the next opiate

documented in the drug chart is the Fentanyl patch on 2nd March (222).

4.10. There is no doubt in my mind that this lady was rapidly deteriorating and dying and that in view of her failure to get adequate palliation from a regular major tranquiliser for her continued distress and agitation that it was appropriate to start a regular opiate by a syringe driver. It was also evident that she was not able to take her tablets orally (255).

4.11. Clinically it is slightly surprising that she was started with Fentanyl as this is likely to take 24 hours to have a maximal affect and that it might have been more clinically appropriate to start a syringe driver on 2nd March.

4.12. Diamorphine 20mgs in 24 hours and Midazolam 20mg in 24 hours was then started on 3rd March. It is not clear if the patient was seen by a doctor on 3rd March. It is not clear when the prescription was written up and if the decision to start Diamorphine and Midazolam on 3rd March was a medical or nursing decision. It is also not clear from the notes whether the Fentanyl patch was removed. 20mgs of Diamorphine by subcutaneous infusion is equivalent to oral morphine at 10mgs every 4 hours. In my opinion this would be high but not an unreasonable dose in somebody where there was a good reason to start an opiate and there had been an inadequate response to the Fentanyl in the previous 24 hours. Midazolam is a sedative which can be suitable for a very restless patient and is usually initially given in a dose of 20 – 80 mgs in 24 hours although some believe the dose should be much lower (5 – 20 mgs) in older people but particularly the most frail.

4.13. In my view a dose of Diamorphine and Midazolam was on the high side but within written clinical guidelines such as the British National Formulary. However, if the Fentanyl patch was continued there would have been a risk of over sedation for example causing unnecessary respiratory depression. The medical notes are inadequate to make an assessment as to whether the doses that were given were appropriate to her condition or excessive.

5. OPINION

5.1. Mrs Eva Page, an an 88 year old lady was admitted to Queen Alexander Hospital in February 1998 subsequently transferred to the Gosport War Memorial Hospital with a terminal illness almost

certainly a carcinoma of the lung on a background of other chronic diseases including stroke and cardiac disease.

5.2. Her investigations and management were appropriate to her condition while in the Queen Alexandra Hospital.

5.3. The use of drug charts in The Gosport War Memorial Hospital is seriously deficient. In particular:

- The use of the regular side of the drug chart for a PRN prescription.
- The prescription of a large range of controlled drugs (in particular diamorphine) on a PRN basis.
- The failure to write dosages in words and figures as well as total dosages to be given.

5.4. There is inadequate documentation of medical review of the patient. In particular:

- The failure to record who made the final decision to start the syringe driver on the 3rd of March.
- The failure to record the clinical condition of the patient that led to that decision.
- The failure to document how the final starting dose of the drugs in the syringe driver was made, in particular why the dose used was chosen.
- The failure to record in the medical or nursing notes if the Fentanyl patch was removed or the reason for not removing it.
- The failure to document relevant medical or nursing assessments to check on possible side effects (for example oversedation) with the high starting dose of both Diamorphine and Midazolam used.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature: _____ Date: _____

'rom: Hall, Tamsin Code A
ent: 03 Mar 2008 16:50
'o: Code A
ubject: Barton - Letter to DOH 03.03.08.DOC

ıttachments: DOCS_6891050_1.DOC

'YI - letter to DOH regarding Professor Baker's report sent today. I will forward you a copy f the report when I have received it.

'amsin

'amsin Hall | Solicitor
ɔr Field Fisher Waterhouse LLP
d Code A

Iobile Code A

:onsider the environment, think before you print!

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
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/eb www.ffw.com **CDE**823

Investigation and Inquiries Unit
Department of Health
Wellington House
133 - 155 Waterloo Road
London
SE1 8UG

Our ref: TET/00492-15579/6891050 v1
Your ref: colin philips

3 March 2008

Dear Sirs

General Medical Council – Dr J Barton

We write further to your letter dated 11 February 2008 to the General Medical Council regarding the disclosure of Professor Richard Baker's review of patient deaths at Gosport War Memorial Hospital.

As you are aware, in relation to the disclosure of these documents to the GMC, the GMC has a statutory power to require persons to produce information relevant to its fitness to practise functions under its governing legislation, the Medical Act 1983. Section 35A of the Act provides as follows:

35A(1) "For the purpose of assisting the General Council or any of their committees in carrying out functions in respect of a practitioner's fitness to practise, a person authorised by the Council may require

(a) a practitioner (except the practitioner in respect of whom the information or document is sought); or

(b) any other person,

who in his opinion is able to supply information or produce any document which appears relevant to the discharge of any such function, to supply such information or produce such a document."

Please find enclosed with this letter a formal notice, issues under Section 35A(1) of the Medical Act 1983 (as amended by the Medical Act Amendment Order 2000) requesting that you make available Professor Richard Baker's report.

We look forward to receiving a copy of Professor Baker's at your earliest convenience. Please contact Tamsin Hall on Code A if you have any queries in relation to this matter.

Yours faithfully

Field Fisher Waterhouse LLP

rom: Code A
ent: 04 Mar 2008 11:02
o: 'Hall, Tamsin'; Ellson, Sarah
ubject: RE: Barton
amsin,

hank you for the letter.

ou have evidence more on the case than I do, so I am content with your statement that you have sclosed all used material.

rom our point of view we wish to retain the existing hearing date and it is course open to the defence to equest a further telecon to review their position.

on sitting day

lea note that a Panellist has requested a non sitting day on 8 October 2008.

Code A

---

rom: Hall, Tamsin Code A
ent: 04 Mar 2008 10:50
o: Code A ; Ellson, Sarah
ubject: Barton

i Code A

lease find attached, in advance of the telecon, letter received from the defence. I thought you ould like to see it so that we can anticipate what they are likely to say in the course of the elecon.

nless you do not agree, we are of the opinion that they have all of our used material, the NOH and all of the expert evidence for the charges as drafted and therefore we should still all e aiming for the September date.

Ve are in the process of copying the very voluminous unused material and will respond to their etter confirming which witnesses we have interviewed and which are simply production tatements and start sending these over to them later in the week.

hanks, speak shortly.

amsin

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/eb www.ffw.com **CDE**823

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/e use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with quivalent standing and qualifications.

rom: Hall, Tamsin [Code A]
ent: 04 Mar 2008 10:50
o: [Code A]; Ellson, Sarah
ubject: Barton

ttachments: 20080304104450695.pdf

i Juliet

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/eb www.ffw.com **CDE**823

Please quote our reference when communicating with us about this matter

Our ref: 1SPB/jh/9900079/Legal
Your ref: TET/00492-15579/6636488 v1
04 March 2008

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

The MDU
DX149141
Legal
Blackfriars 5

Legal Department of The MDU

Telephone: 020 7202 1500
Fax: 020 7202 1663

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

For the attention of: Tamsin Hall
Messrs Field Fisher Waterhouse LLP
Solicitors
Portland Tower
Portland Street
Manchester M1 3LF

BY FAX TO NUMBER: Code A
ALSO BY EMAIL

Dear Sirs

General Medical Council - Dr Jane Barton

Thank you for your recent correspondence, including letters yesterday enclosing the draft Notice of Hearing.

Can I say at the outset I do not share your confidence in relation to the preparation for this hearing. It is unfortunate that you should have suggested in your letter of 25 February that you "would like to stress that [you] remain of the opinion [we] will have sufficient time to prepare for the hearing". In circumstances in which the draft Notice of Hearing has arrived almost 2 months late, in which I have received no witness statements from any interviews conducted by your goodselves, and in which it is proposed that expert evidence should not be concluded in terms of service by you until the end of June at the earliest, when all of this should have been achieved by the middle of January, that confidence is misplaced.

As you are aware, I have been at pains to stress that I do not suggest the delays which have taken place in this case result from your tardiness or inefficiency. It is no doubt due to the weight of documentation. Although I do not have that clearly from your letter, for example, dated 8 February, I think that is the essence of your position. That being the case, how do you suggest we will fair better? You will appreciate that although you have given me documentation – specified in your letter of 8 February, I still do not have the vast quantity of unused material which I have requested for some very long time now. It will clearly be necessary for that unused material to be reviewed in detail. All of this material should have been produced by the middle of January.

In your letter of 25 February, you indicate that Professor Black is preparing reports in relation to Jean Stevens and Edna Purnell. You will of course appreciate that these patients are not the subject of the draft Notice of Hearing. This appears to give rise to the possibility that you will amend the draft Notice of Hearing, and that yet two further patients might be added as late as April. As I say, this is all against the backdrop of an original agreement that your case would be completed by January, in order then to allow the defence sufficient time for preparation.

Our ref: ISPB/jh/9900079/Legal
Your ref: TET/00492-15579/6636488 v1
04 March 2008

You have previously supplied me with a list of witnesses, some 33 in number. Whilst police statements exist for a number of these individuals (note not all appear to have been disclosed to me thus far), my expectation is that you will have sought to interview these individuals specifically for the purposes of the GMC hearing.

Can you please advise me of the identity of those witnesses you have interviewed, when such interviews took place, when you anticipate any witness statements will be available for service upon me, and why they have not been concluded already?

Again, this is all against the backdrop that your case was to have been concluded by 18 January.

In your letter of 8 February you indicated that you had had to identify witnesses out of the large number interviewed by the Police, and getting in contact with them had taken some considerable amount of time. I am not entirely clear why that should have been so. Nevertheless, it remains the case that any statements you intend to serve are now almost two months late, eating in to the time available for defence preparation.

Accordingly, it will be my position at the telephone conference later that I simply will not be in a position to confirm the defence will have concluded its preparations by the time this hearing is due to start. We will obviously use our best endeavours, but cannot share what I fear may be a misplaced confidence on your part.

Finally, in your letter of 8 February you set out a list of the provisional panel members, stating that I "should not contact any of the panellists". Can you please explain why you felt it necessary to state that?

Code A

Dr J Barton

rom: Rebecca Faulkner Code A
ent: 04 Mar 2008 11:49
o: 'Hall, Tamsin'; Code A Ellson, Sarah
c: Code A
ubject: RE: Dr J Barton

ttachments: Barton GMC Case Protocol stage 5 form.doc
hank you Tamsin - my apologies for the error. Amended minutes attached!
ebecca

---

rom: Hall, Tamsin Code A
ent: 04 March 2008 11:46
o: ebecca Faulkner Code A Ellson, Sarah
c: Code A
ubject: RE: Dr J Barton

hanks Rebecca

here is a small error in the first section it should read:

Draft notice was disclosed on 3 March. All USED material and expert reports in the ossession of the GMC HAVE also been disclosed."

hanks

amsin

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP
Code A

lobile Code A

onsider the environment, think before you print!

Dr J Barton

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/eb www.ffw.com **CDE**823

rom: Rebecca Faulkner Code A
ent: Tuesday, March 04, 2008 11:44 AM
o: Code A Ellson, Sarah; Hall, Tamsin
c: Code A
ubject: Dr J Barton

lello,

lease find attached the minutes of today's conference.

<Barton GMC Case Protocol stage 5 form.doc>>

s noted, we will speak again on 22 April 2008 at 10am. For your ease of reference, I attach the ial up details and a blank stage 5 proforma.

<Annex F - BT Meet Me Guide.doc>> <<GMC Case Protocol stage 5 form.doc>>

est wishes,

ebecca

ebecca Faulkner
djudication Co-ordinator
eneral Medical Council
lanchester DDI : Code A

Dr J Barton

eneral Medical Council

: James Building, 79 Oxford Street Manchester. M1 6FQ

egents Place, 350 Euston Road, London. NW1 3JN

he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

egus House, Falcon Drive, Cardiff Bay. CF10 4RU

) A laide Street, Belfast. BT2 8GD

el: 0845 357 8001
ax: 0845 357 9001

GMC Case Protocol - Stage 5 Telephone Conference

Attendees:
Sarah Ellson & Tamsin Hall, Field Fisher Waterhouse
Ian Barker, Medical Defence Union
Code A GMC Investigation Officer
Rebecca Faulkner, GMC Adjudication Team

Case: Dr Barton

Conference date:4 March 2008 @ 10:00am

Areas to be covered

	Action	Outcome
1.	Stage 3 actions complete? If no, please record below actions and timescale for completion Draft notice was disclosed on 3 March. All used material and expert reports in the possession of the GMC has also been disclosed. However a significant amount of documentation is still awaited by Defence (including boxes- possibly 25- of unused material, also production, police & witness statements, and further expert reports). Defence state,without prejudice, due to the slippage in timescales, their preparation time is reduced and whilst they will endeavour to meet the current hearing schedule, it may not prove possible. Parties are in agreement to maintain the set hearing date, but to keep matters under close review. A further telecon has been arranged for **10:00am on 22 April** for parties to check progress. It is hoped that by this stage GMC will be able to confirm whether the additional cases will be included. Parties agreed to discuss a date for the disclosure of unused material (including a substantive reply by GMC) outside of the conference.	No
2.	Any outstanding procedural or legal issues? If so, please record below As above	As above
3.	Are you aware of any health issues regarding the doctor, which may affect the planned hearing date for this case	TBC
4.	Confirm hearing date	8 Sep- 31 Oct 08
5.	Confirm time estimate Non sit day on 8 October (at panellist request) Agreed by parties.	39 days

6.	Confirm location of hearing	London
7.	Check whether there will witnesses giving evidence via video link up. If so check where they will be giving evidence from i.e Country or location in UK	TBC
8.	Check whether facilities are required i.e: Video player / tape player etc	TBC

'rom: Hall, Tamsin Code A
ent: 14 Mar 2008 14:35
'o: Code A
:c: Ellson, Sarah; Tom Kark; Ben FitzGerald; Watson, Adele
ubject: Professor Baker's report

ıttachments: Review of deaths at GWMH.pdf

Ii Code A

'lease find attached Professor Baker's report which I finally received yesterday. I have read and it is a lot more critical of Dr Barton's actions than I thought it would be. We had ıought it was primarily a statistical analysis, however the report's conclusions mirror our harges and indeed go somewhat further.

ı summary, Professor Baker's main conclusions are that: the starting doses of diamorphine /ere higher than expected; the analgesic ladder was not followed; opiates were commonly rescribed on admission although not administered until some days or even weeks later; ecords failed to show careful assessment to determine causes of deterioration; opiates may ave been administered prematurely; records commonly did not report detailed assessments f the cause of patient's pain; the pattern of early use of opiate medication was evident from 988; Dr Barton had a higher than usual incidence of describing patient's as dying of roncopneumonia on death certificates and did not report fractures; the records do not ontain full details of care.

le refers to an 'almost routine use of opiates before death.... irrespective of the principal linical condition' and a 'prevailing attitude or culture of limited hope and expectations ɔwards the potential recovery of patients'. He then concludes that 'some patients who were iven opiates should have received other treatment' and that he expects that, with further ıvestigation 'the early resort to opiates will befound to have shortened lives' and 'some atients would have had a good chance of surviving to be discharged from hospital'.

'rofessor Baker is careful not to be too critical of Dr Barton as that was outside his original ɜmit, but the report is potentially useful to us.

will discuss with counsel how best to proceed with this information. I have disclosed the ɜport to the defence.

:egards

'amsin

'amsin Hall | Solicitor
ɔr Field Fisher Waterhouse LLP
d Code A

obile Code A

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eb www.ffw.com **CDE**823

A Review of Deaths of Patients

at

Gosport War Memorial Hospital

Final version: October 2003

Contents

Acknowledgements

The staff of the records department of Gosport War Memorial Hospital have provided considerable assistance in identifying and obtaining documents for the review, and I am grateful to them for their assistance. I also thank Peter Goldblatt of National Statistics and Stephen Price of Hospital Episode Statistics, and Professor David Jones of the Department of Epidemiology and Public Health, University of Leicester, for advice and for undertaking the analysis of the relationship between numbers of deaths and periods of leave. I also acknowledge the assistance of Paul Sinfield, research associate, in management of the databases required for the review, and Ms Vicki Cluley for assistance in preparation of the manuscript.

Richard Baker

Clinical Governance Research and Development Unit

Department of Health Sciences

University of Leicester

Summary

This report presents the findings of an audit of care at Gosport War Memorial Hospital that was commissioned by the Chief Medical Officer. Concerns about the care of patients in Gosport hospital were first raised in 1998, and a police investigation is continuing.

The audit has drawn on documentary evidence that has included:

1. A random sample of 81 clinical records of patients who died in Gosport hospital between 1988 and 2000
2. The counterfoils of medical certificates of the cause of death (MCCDs) retained at Gosport hospital relating to deaths in the hospital 1987-2001
3. The admissions books of Dryad ward at Gosport, 1993-2001
4. Surviving controlled drugs registers at Gosport hospital
5. MCCDs completed by a sample of general practitioners in Gosport.

On the basis of these sources of evidence, I have concluded that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that a small number of these would otherwise have been eventually discharged from hospital alive.

The practice was disclosed in several key findings.

- Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver.
- Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia, and strokes.
- Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later.
- In many records, evidence of a careful assessment before use of opiates was absent, and the stepped approach to management of pain in palliative care had not been followed.

In addition to these findings, two other matters also gave rise to concern. The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths, most commonly fractured hips, had not been reported on MCCDs.

Most patients admitted to Gosport under the care of the Department of Medicine for Elderly People had severe clinical problems, and many had been transferred from acute hospitals after prolonged in-patient stays. Some had been admitted for rehabilitation, but many were believed to be unlikely to improve sufficiently for discharge to a nursing home. Consequently, a relatively high number of deaths among those admitted would have been expected. The types of patients (case mix) admitted to Gosport varied during the period of interest (1988-2000), and it was not possible to identify an adequate source of data about numbers of deaths in similar hospitals that admitted similar types of patients in the same time periods to enable a reliable estimate of excess deaths to be calculated. Nevertheless, the findings tend

to indicate that the finding of a statistical excess of deaths among patients admitted to Gosport would be unlikely.

In undertaking the audit, I have drawn on documentary evidence only. There has been no opportunity for relatives or staff involved in the care of patients in Gosport to give information or comment on the findings. Dr Barton in particular has not been invited to give a first hand account of care at Gosport or comment on the findings of the review. It is possible, therefore, that my conclusions would be altered in the light of information from Dr Barton or other individuals. However, such information would be more appropriately considered in a different type of inquiry, for example that being undertaken by the police, rather than in the context of an audit.

Recommendations

In view of the findings of the audit, I submit the following recommendations:

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.
4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to

suspect that some patients at the end of life do not receive adequate analgesia.

5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

Chapter One: Introduction

This report describes a review of the deaths of older patients at Gosport War Memorial Hospital. The review was commissioned by the Chief Medical Officer because concerns had been raised about the care of some elderly patients who had died in the hospital, and is particularly concerned with the deaths of elderly patients under the care of the Department of Medicine for Elderly People.

Gosport War Memorial Hospital is a 113-bed local hospital situated on the Gosport peninsula. It was part of Portsmouth Health Care NHS Trust from April 1994 until April 2002, when the services at the hospital were transferred to the local primary care trusts (Fareham and Gosport PCT, and East Hampshire PCT). Gosport itself is a relatively isolated community at the end of a peninsula with some areas of high deprivation. It is reported to be under-provided with nursing homes

Concerns about deaths at the hospital were raised in September 1998, when police commenced investigations into an allegation that a patient had been unlawfully killed on Daedalus ward. In March 1999, the Crown Prosecution Service (CPS) decided that there was insufficient evidence to prosecute. In 2001, a further police investigation took place, and again the CPS decided that there was insufficient evidence to proceed. In January 2000 an NHS Independent Review Panel found that whilst drug doses were high, they were appropriate in the circumstances.

A complaint was made to the Health Service Commissioner against Portsmouth Healthcare NHS Trust about the death of a patient who had undergone an operation on a broken hip at another hospital and had been transferred in October 1998 to Gosport War Memorial Hospital 1998. The patient had died of bronchopneumonia in

December 1998, and the complaint was that the patient had received excessive doses of morphine, had not received reasonable medical and nursing care, and had been allowed to become dehydrated. The Commissioner undertook an investigation, at the conclusion of which he accepted professional advice that medical management had been appropriate and that the patient's nursing needs had been systematically assessed and met. The pain relief was judged to have been appropriate and necessary for the patient's comfort and the commissioner did not uphold the complaint.

In March 2001, 11 families raised further concerns with the police about the care and deaths of relatives in 1998, and four of these deaths were referred for an expert opinion. In August 2001, the police shared their concerns with the Commission for Health Improvement (CHI), and CHI then began an investigation.

The CHI Review (2001-2002)

The terms of reference of the review are shown in Box 1.1., and indicate that the aim of the review was to investigate care since 1998 rather than to undertake an investigation into care at the hospital leading up to the complaint first raised in 1998. During the review, CHI studied documents held by the trust, received views from samples of patients, relatives and friends, conducted a five-day site visit during which 59 staff from all groups involved in the care of elderly patients were interviewed, undertook an independent review of the notes of a sample of patients who had died on three wards (Daedalus, Dryad and Sultan) between August 2001 and January 2002, and interviewed relevant agencies, including those representing patients and relatives. On concluding its review, CHI did commend some features of services at Gosport, including leadership in Portsmouth Healthcare NHS Trust, the

standard of nursing care on Daedalus, Dryad and Sultan wards, and the trust's clinical governance framework. However, CHI also reported several concerns (Box 1.2.).

Box 1.1. Terms of reference of the CHI review (CHI, 2002).

The investigation will look at whether, since 1998, there has been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i) staffing and accountability arrangements, including out of hours

ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management

iii) arrangements for the prescription, administration, review and recording of drugs

iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations

v) arrangements to support patients and their relatives and carers towards the end of the patient's life

vi) supervision and training arrangements in place to enable staff to provide effective care.

In addition, CHI will examine how lessons to improve patient care have been learnt across the trust from patient complaints.

The investigation will also look at the adequacy of the trust's clinical governance arrangements to support inpatient continuing and rehabilitation care for older people.

Box 1.2. CHI's key concerns

- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.
- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the 'Wessex guidelines', this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.
- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non-physical symptoms of pain, the trust's policies do not include methods of non-verbal pain assessment and rely on the patient articulating when they are in pain.
- Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- The police investigation, the review of the Health Care Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

CHI did undertake an independent review of anonymised medical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. It should be noted that this was a period in which the clinical assistant no longer worked at the hospital, and in particular excludes deaths during the period 1998-1999, when concerns first arose. The case note review confirmed that the admission criteria for Dryad and Daedalus wards were being adhered to. CHI also investigated the amount of diamorphine, haloperidol and midazolam used on Daedalus and Dryad wards between 1997/1998 and 2000/01. These data indicated a decline in use of diamorphine and haloperidol on both wards after 1998/1999, with a relatively less marked decline in the use of midazolam in the later years.

Staff concerns about the use of diamorphine, 1991-2

Staffs concern about the use of diamorphine was brought to the attention of the branch convenor of the Royal College of Nursing (RCN) in April 1991, the convenor being told that the problem had been present for the past two years. At a specially convened meeting in July 1991, nursing staff of Redclyffe Annexe raised their concerns about the use of diamorphine with the patient care manager of Gosport Hospital. Among the points made at that meeting were that not all patients who had been given diamorphine had pain, no other forms of analgesia had been considered, the drug regime was not always tailored to each patient's individual needs, and that deaths were sometimes hastened unnecessarily. Discussions took place between nursing and medical staff, the patient care manager and the RCN convenor over the ensuring months, with the result that a plan for the use of diamorphine appears to have been agreed.

The role of the clinical assistant, Dr Barton

The concerns, police investigations and GMC referral have focussed on the role of the clinical assistant involved, Dr Jane Barton. Dr Barton is a general practitioner based in a practice in Gosport. She was employed for five sessions a week as a clinical assistant in the Department of Medicine for Elderly People from 1st May 1988 until her resignation on 5th July 2000. In this post, Dr Barton was accountable to the consultant physician in geriatric medicine, and responsible for arranging cover for annual leave and sickness absence with her practice partners. The post was subject to the terms and conditions of hospital, medical and dental staff.

When Dr Barton began work at the hospital, she had responsibility for patients in Redclyffe Annexe. This unit is isolated from the main parts of the hospital, and had

approximately 20 beds classified as continuing care. Until 1993/4, there were also two wards (referred to as the male and female wards) at the main hospital site, having a total of approximately 37 beds (Box 1.3.). Nineteen of these were designated for use by patients under the care of their GP, and seven designated as GP day surgery beds. Dr Barton was responsible for the care of patients in the remaining 11 beds. (The precise number of beds on the female ward is uncertain since the information is based on the memories of staff. It is believed to have been 20 or 21.) The total number of beds under the supervision of Dr Barton was therefore 31 until 1993/4.

From 1993/4, Dr Barton appears to have ceased responsibility for Redclyffe Annexe, and taken on responsibility for Dryad and Daedalus wards in the new hospital building, the male and female wards being closed. This gives a total of 44 beds under Dr Barton's care, with a mix of continuing care and rehabilitation. CHI was critical of arrangements for supervising the practice of the clinical assistant, and found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Some of the staff interviewed had indicated that the clinical assistant worked in excess of the five contracted sessions. The CHI review notes that in 1998, there was a fortnightly consultant ward round on Daedalus ward. Ward rounds were also scheduled fortnightly on Dryad ward, although they occurred less frequently.

Box 1.3 Reported bed use at the hospital

1980-1993:

Northcott house, 11-12 continuing care beds

Redclyffe Annexe 20 continuing care beds

Male ward - 17 beds (9 continuing care, 8 GP beds)

Female ward – 20 beds (2 continuing care, 7 GP day surgery, 11 GP beds)

Total beds 1980-1993=69

From 1994:

Redclyffe Annexe was still used;

Sultan ward – 24 GP beds

Dryad ward – 20 continuing care beds

Daedalus – 24 beds in total (8 slow stream stroke from April 1994. 16 continuing care [24 prior to April 1994]); from 2000, the Daedalus beds were used for intermediate care, comprising 8 fast stream stroke, 8 slow stream stroke, 8 general rehabilitation.

Other investigations

Several other investigations have been, or are being, undertaken into the events at Gosport War Memorial Hospital. Hampshire Constabulary are continuing an intensive investigation, and I am grateful to them for their agreement that the review requested by the Chief Medical Officer should be completed. A referral to the General Medical Council (GMC) has also been made. However, the review described in this report is an independent clinical review or audit. I have sought to come to an

independent view based on an analysis of clinical information from surviving documentary evidence (for example, clinical records, drug registers, medical certificates of the cause of death, and ward registers). The review does not consider statements from witnesses, and does not involve a detailed forensic inquiry into particular deaths, since these aspects are the proper responsibility of the police and other agencies.

Aims of the review

The aims of the review were:

1) To identify any excess mortality or clusters of deaths among patients who were on Daedalus and Dryad wards 1988-2000 and to identify initial evidence to explain any excess or clusters.

2) To determine whether the numbers of deaths among Dr Barton's general practice patients was higher than would have been expected.

Palliative and terminal care

Some understanding of current practice and policies on the care of dying patients is required in order to enable judgements to be made about the appropriateness of care given to patients who died in Gosport War Memorial Hospital. This section outlines relevant features of this aspect of care.

The World Health Organisation (WHO) defines palliative care as 'the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families' (O'Neill and Fallon, 1997). Palliative care for people with advanced cancer is now widely available. However, people with other chronic progressive

conditions may also need palliative care when other treatment ceases to be of benefit. Such conditions include advanced respiratory, cardiac or neurological disease (O'Brien et al, 1998). Some of the patients who died on Daedalus and Dryad wards had dementia, and in recent years, it has been increasingly recognised that palliative care also has a role to play in advanced (or 'end stage') dementia. Since a basic awareness of the care of the people with advanced dementia is required in order to interpret the findings of this review, an outline of selected key issues follow.

In advanced dementia, death occurs as a consequence of the many secondary impairments that arise, including progressive immobility, reduced ability for self-care, poor nutrition and reduced intake of fluids, infections related to immobility, skin breakdown, and general debilitation (Shuster, 2000). Although patients dying from dementia have symptoms and health care needs comparable with cancer (McCarthy et al, 1997), patients on long-stay wards who are dying at the end stage of dementia do not always received appropriate palliative care.

In a study undertaken in a long-stay psychogeriatric unit in England, patients with end stage dementia were found to have many symptoms, including pain, dyspnoea and pyrexia for which no palliative treatment was given. Instead, there was widespread use of parenteral antibiotics and infrequent use of analgesia in the last few days of life (Lloyd-Williams 1996). In a follow-up to this study, guidelines on palliative care in end stage dementia were developed, and an increase in the use of analgesics including opiates occurred (Lloyd-Williams and Payne, 2002). The data collected after the implementation of the guidelines related to the deaths of 27 patients, of whom 13 (48%) were prescribed 4-hourly morphine for the palliation of pain or shortness of breath (caused by pneumonia). Two patients who were unable

to take oral medication were commenced on diamorphine administered by syringe drivers. It should be noted that pneumonia can cause significant symptoms in people with dementia, including shortness of breath and discomfort (Steen et al, 2002). Deficiencies in palliative care of elderly patients with or without dementia are also found in other countries (Fox et al, 1999; Evers et al, 2002; Morrison and Siu, 2000).

Information about a palliative care service for elderly people in the same district as Gosport is pertinent to the review. In 1989, a 12-bedded palliative care ward was opened within the Geriatric Department at Queen Alexandra Hospital, Portsmouth (Severs and Wilkins, 1991). The aim was to improve the care of elderly people at the end of life. In the first year, 128 patients were admitted to the ward, of whom 101 (78.9%) had cancer, 17 had strokes and two had dementia. The service was therefore primarily caring for elderly people with terminal cancer.

Guidelines

Communication between professionals (nurses and doctors), and between professionals and relatives or dying elderly patients is sometimes poor (Costello, 2001), and decisions on whether resuscitation would be appropriate ('do not resuscitate' or DNR orders) may not be fully discussed (Costello, 2002). Wider use of clinical guidelines might assist health professionals overcome these problems and provide palliative care to more of those patients who need it. A growing number of publications offer guidance about palliative care for patients with cancer, but the two clinical guidelines discussed here illustrate current professional opinion about the care of people in the terminal phase of dementia. The first guideline was developed in a long-stay hospital in England (Lloyd-Williams and Payne, 2002), and was

concerned with the palliative care of patients with end stage dementia. It is summarised in Box 1.4.

Box 1.4. Guidelines for the management of patients with end stage dementia (from: Lloyd-Williams and Payne, 2002)

Consider treatable causes of pain (e.g. pressure sores, full bladder); use oral medication when possible, and administer on a regular basis; use co-proxamol initially; if still in pain, consider a non-steroidal anti-inflammatory drug.

When opiates are used, start with a low dose and increase as needed to control pain; always prescribe diamorphine 2.5-10mg for injection on an as required basis so that analgesia can still be given if the oral route is not available.

When converting from oral subcutaneous opiates, remember to divide the total oral dose by three e.g. 60mg oral morphine in 24 hours = 20mg diamorphine in syringe driver.

In the event of agitation, think of full bladder; midazolam 2.5mg-10mg subcutaneously or oral haloperidol or thioridazine may be used.

The most common cause of dyspnoea is bronchopneumonia. There is no evidence that using antibiotics in end stage dementia is helpful or improves patients' comfort or prolongs the quality of life. Oral morphine 5mg 4-hourly can reduce the sensation of breathlessness and improve patient's comfort.

The second guideline mentioned here was developed to help physicians decide whether to forgo curative treatment of pneumonia in patients with dementia resident

in nursing homes, and has been developed by a research group in the Netherlands (Steen et al, 2000). The guidelines were based on a literature review, discussion papers prepared by Dutch medical associations, and consensus procedures with experienced nursing-home physicians and international experts in the fields of nursing-home medicine, ethics and law. The guidelines were subsequently authorized by the Dutch professional organisation of nursing home physicians. The guidelines were presented in the form of a checklist for use by physicians in nursing homes (see Box 1.5.).

Box 1.5. Checklist on decision for starting or not starting a curative treatment of pneumonia in a patient with dementia (Steen et al, 2000).

The key factors to consider are:

1. the expected effect of a curative treatment from the medical perspective
2. the patient's wish: a living will, or the reconstruction of the wish
3. the patient's best interest when the wish of the patient is not clear, or remains unknown.

The checklist considerations:

1. Is an intentionally curative treatment indicated for this patient?
2. How physically and/or psychiatrically burdensome would the total curative treatment – antibiotics and (re)hydration – be for the patient?
3. Is the patient sufficiently mentally competent to indicate their wish, and if so, what treatment does the patient want?
4. What is the purport of the written will?
5. What is the purport of the reconstruction of the patient's will according to the representative(s)?
6. What is the purport of the reconstructed patient's wishes according to the other involved professional carers?
7. Which treatment seems to be in the patient's best interests (not certain, intentionally curative treatment, or palliative treatment)?

An important step in palliative care is the point at which terminal care begins. The factors that lead to the decision to begin terminal care will depend on the stage of the patient's disease. An example of criteria that may be used for initiating terminal care is shown in Box 1.6 (Edmonds and Rogers, 2003).

Box 1.6. Criteria for starting an integrated care pathway for patients dying in hospital (from Edmonds and Rogers, 2003)

Patients who have a known diagnosis and have deteriorated despite appropriate medical intervention. The multiprofessional team have agreed the patient is dying and at least two of the following apply:

The patient:

1. is bedbound
2. is only able to take sips of fluids
3. has impaired concentration
4. is semi-comatose
5. is no longer able to take tablets

General Medical Council Guidance

In 2002, the general Medical Council (GMC) (GMC, 2002) issued guidance on withholding life-prolonging treatment. Much of this guidance is not directly relevant to an assessment of the care of patients at Gosport, but the guidance does state guiding principles dealing with respect for human life and patients' best interests. These make clear what is expected of doctors in the UK, and are relevant to judgements that may be made about the care of people under the care of the Department of Medicine for Elderly People at Gosport Hospital. The relevant section of the guidance is quoted in full in Box 1.7.

Box 1.7 Respect for Human Life and Best Interests (GMC, 2002)

Doctors have an ethical obligation to show respect for human life; protect the health of their patients; and to make their patients' best interests their first concern. This means offering those treatments where the possible benefits outweigh any burdens or risks associated with the treatment, and avoiding those treatments where there is no benefit to the patient.

Benefits and burdens for the patient are not always limited to purely medical consideration, and doctors should be careful, particularly when dealing with patients who cannot make decisions for themselves, to take account of all the other factors relevant to the circumstances of the particular patient. It may be very difficult to arrive at a view about the preferences of patients, who cannot decide for themselves, and doctors must not simply substitute their own values or those of the people consulted.

Prolonging life will usually be in the best interests of a patient, provided that the treatment is not considered to be excessively burdensome or disproportionate in relation to the expected benefits. Not continuing or not starting a potentially life-prolonging treatment is in the best interests of a patient when it would provide no net benefit to the patient. In cases of acute critical illness where the outcome of treatment is unclear, as for some patients who require intensive care, survival from the acute crisis would be regarded as being in the patient's best interests.

End of natural life

Life has a natural end, and doctors and others caring for a patient need to recognise that the point may come in the progression of a patient's condition where death is drawing near. In these circumstances doctors should not strive to prolong the dying

process with no regard to the patient's wishes, where known, or an up to date assessment of the benefits and burdens of treatment or non-treatment.

Notes on selected drugs

1. *Morphine and diamorphine*

Important sections of the review are concerned with the use of selected drugs towards the end of life. Brief notes about relevant drugs are included here for those who may not be familiar with them. The transition from the weaker to the stronger analgesics is usually described in terms of a three step ladder (Twycross et al, 1998), beginning with non-opioid analgesics such as paracetamol (step one), followed by the addition of a weak opioid such as codeine or dextromoramide (step two), the final step being the addition of a strong opioid.

Morphine and diamorphine are both strong opiate analgesics. Although there is a risk of dependence if the drugs are administered repeatedly, the British National Formulary (2001) makes clear that this should not be taken as a reason for not using regular opiates in terminal care. Morphine is the treatment of choice for oral treatment of severe pain in palliative care, and a dose of 5-10mg given every 4 hours is enough to replace a non-opioid analgesic such as paracetamol or a non-opioid and weak opioid used in combination (for example, paracetamol with dihydrocodeine). However, the dose should be increased stepwise according to response. Oramorph is a pharmaceutical company's name for a particular preparation of oral morphine. Modified release preparations suitable for twice daily administration are available as tablets (for example MST Continus), capsules or in suspension.

If the patient becomes unable to swallow, intramuscular morphine may be given, the equivalent dose being half the dose of the oral solution. However, diamorphine is preferred for injection because it is more soluable and can therefore be given in smaller volumes. The equivalent intramuscular or subcutaneous dose of diamorphine is one third the oral dose of morphine (Twycross et al, 1998). Thus, if a patient has been receiving 10mg of morphine oral solution every 4 hours (a total of 50 mg in each 24 hours), the equivalent dose of diamorphine administered subcutaneously by syringe driver would be approximately 17 mg in 24 hours.

Agitation, confusion and myoclonic jerks occur as a consequence of opiate toxicity. These features may be interpreted as un-controlled pain, leading to the administration of more opiate medication. The consequences are increased sedation, dehydration and further toxicity (O'Neill and Fallon, 1997).

2. *Fentanyl*

Fentanyl (Durogesic) is a strong opioid analgesic that can be absorbed through the skin, and is therefore administered by self-adhesive patches applied to the skin. The patch releases a defined dose per hour over a perlod of 72 hours, after which the patch should be replaced.

3. *Haloperidol*

Haloperidol is given in syringe drivers to control nausea and vomiting, in doses of 2.5 to 10mg in 24 hours. It is an antipsychotic, but has little sedative effect.

4. *Hyoscine hydrobromide*

Hyoscine hydrobromide is used to control respiratory secretions and is given by syringe driver in doses of 0.6 to 2.4 mg per 24 hours. Drowsiness is a side-effect

5. *Midazolam*

Midazolam (Hypnovel) is a benzodiazepine sedative and is suitable for the very restless patient, in doses of 20 to 100 mg in 24 hours. Drowsiness is a side-effect, and haloperidol is an alternative if symptoms are not controlled by doses of 30mg or less per 24 hours (Twycross et al, 1998)

The Wessex Guidelines

Local guidelines on palliative care were available to health professionals in Gosport. They were published by the Wessex Specialist Palliative Care Unit, and were referred to as the "Wessex Guidelines". The edition of the guidelines current in 1998 recommended assessment of pain, including the site, severity, duration, timing, and aggravating and relieving factors. The use of a body diagram and the patient's own words were recommended as part of the assessment. Depending on the findings of the assessment, analgesics if appropriate were advised, in accordance with the three steps in the WHO analgesic ladder (step one non-opioids, step 2 weak opioids, step 3 strong opioids). The guidelines included advice about the choice of opiate analgesics, and selection of dose, the recommendations being in accordance with the notes and drugs discussed above. The guidelines noted that the use of nebulised opioids was not supports by scientific evidence and might induce bronchospasm. The guidelines address all aspects of clinical management in palliative care, in addition to use of medication.

An Overview of The Report

The review is presented in the following six Chapters. Chapter Two reports an investigation of a random sample of clinical records of patients who died between 1988 and 2000. The review of records was undertaken following review of five records of patients whose deaths were being investigated by the police, and sought to describe clinical practice in the Department of Medicine for Elderly People at Gosport hospital.

In Chapter Three, an analysis of the numbers of deaths in Gosport hospital 1988-2000 is presented, the data being based on counterfoils of medical certificates of the cause of death completed by doctors at the hospital. The data are used to describe the certified causes of death, to identify clusters of deaths, and the features of patients whose deaths had been certified by Dr Barton. The Chapter also outlines the difficulties encountered in use of Hospital Episode Statistics to explore patterns of deaths in Gosport hospital.

Chapter Four presents the findings of a review of information obtained from admissions books from Dryad ward. The admissions books contain information about the duration of admission, whether patients had died or were discharged from the ward, the place patients were admitted from, and some indication of the reason for admission.

An investigation of information contained in retained controlled drugs registers is reported in Chapter Five. Data in the registers indicate which patients received opiate medication, how much medication they received, and the wards on which patients were staying. The information was related to information from the

counterfoils of medical certificates of the cause of death to investigate the proportions of people who died who had received an opiate.

Chapter Six presents information obtained from medical certificates of the cause of death completed by Dr Barton and a comparison sample of general practitioners. This analysis was undertaken to determine whether the numbers of deaths among patients in general practice was as expected. Finally, Chapter Seven presents the conclusions and a small number of recommendations.

Ethics approval

Approval for access to data from Hospital Episodes Statistics and National Statistics was obtained from the ethics committees of these organisations. The methods of the audit were discussed with the Chair of the Isle of Wight, Portsmouth and SE Hants Local Research Ethics Committee, and it was confirmed that it was not a research study that required approval. The audit has been undertaken in accordance with the guidance of the GMC on confidentiality. In the Chapters that follow, care has been taken to exclude any material that might lead to the identification of individual patients.

Much of this review is focused on the work of Dr Barton. This should not be taken as meaning that Dr Barton was the origin of approach followed at Gosport hospital, or that her clinical practice was the key problem that has given rise to the concerns expressed by relatives. Since Dr Barton issued most of the medical certificates of cause of death for patients of the Department of Medicine for Elderly People, made most of the entries in the clinical records, and was responsible for most of the prescribing, she has served as a means of identifying patients and care that should be included in the review. However, it should be recalled that she was a member of a

clinical team, and the review has not investigated the process of decision making in the clinical team. The audit relied on documentary evidence about care of patients at Gosport, and did not involve consideration of statements from individuals. Therefore, conclusions about the actions of individuals should not be reached since they have not had the opportunity of presenting their own side of the story.

References

British National Formulary (2001). Edition 41. London: British Medical Association, Royal Pharmaceutical Society of Great Britain.

CHI (2002). Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. Commission for Health Improvement. The Stationery Office

Costello J (2001). Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards. J Advanced Nursing 35:59-68.

Costello J (2002). Do not resuscitate orders and older patients: findings from an ethnographic study of hospital wards for older people. J Advanced Nursing 39:491-9.

Edmonds P, Rogers A (2003). 'If only someone had told me ....' A review of the care of patients dying in hospital. Clinical Medicine 3:149-52.

Evers MM, Purohit D, Perl D, Khan K, Marin DB (2002). Palliative and aggressive end-of-life care for patients with dementia. Psychiatric Services 53:609-13.

Fox PL, Raina P, Jadad AR (1999). Prevalence and treatment of pain in older adults in nursing homes and other long-term care institutions: a systematic review. Canadian Med Ass J 160:329-33.

GMC (2002). Withholding and Withdrawing Life-Prolonging Treatment: Good Practice in Decision-Making. London: General Medical Council.

Lloyd-Williams M (1996). An audit of palliative care in dementia. Eur J Cancer Care 5:53-5

Lloyd-Willliams M, Payne S (2002). Can multidisciplinary guidelines improve palliation of symptoms in the terminal phase of dementia? Int J Palliative Nursing 8:370-5.

McCarthy M, Addington-Hall J, Altmann D (1997). The experience of dying with dementia: a retrospective study. Int J Geriatr Psychiatr 12:404-9.

Morrison RS, Siu AL (2000). Survival in end-stage dementia following acute illness. JAMA 284:47-52.

O'Brien T, Welsh J, Dunn FG (1998). Non-malignant conditions. ABC of palliative care. BMJ 316:286-9.

O'Neill B, Fallon M (1997). Principles of palliative care and pain control. ABC of palliative care. BMJ 315:801-4.

Severs MP, Wilkins PSW (1991). A hospital palliative care ward for elderly people. Age and Ageing 20:361-4.

Shuster JL (2000). Palliative care for advanced dementia. Clinics in Geriatric Medicine 16:373-86.

Steen JT van der, Graas T de, Ooms ME, (2000). When should physicians forgo curative treatment of pneumonia in patients with dementia? West J Med 173:274-7.

Steen T van der, Ooms ME, Wal G van der, Ribbe MW (2002). Pneumonia: the demented patient's best friend? Discomfort after starting of withholding antibiotic treatment. J Am Geriatr Soc 50:1681-8.

Twycross R, Wilcock A, Thorp S (1998). Palliative Care Formulary. Abingdon: Radcliffe Medical Press.

Chapter Two. Review of records

A review of records of cases reported to Hampshire Constabulary

In 1998, the initial police investigation into care of patients at Gosport War Memorial Hospital was prompted by the death of one patient that was reported to the police by the family of the deceased as a potential case of unlawful killing. In the months that followed, other families who had become aware of concerns about care at the hospital also contacted the police. From the cases notified to them, the police had, by December 2002, identified five cases that shared certain features that indicated the need for detailed investigation. The police permitted me to review the clinical records of these cases.

The aim of the review of these records was to identify those features recorded in the records that might give rise to concern about the care patients had received and the cause of death. The police had invited a small number of clinical experts to review the records, but I did not consult the reports of these experts in order to ensure that an independent opinion was reached. The records available included all those made by medical and nursing staff at Gosport War Memorial Hospital, drug charts, X rays and investigation reports, records made by staff in acute hospitals in the case of those patients who had been transferred to Gosport from another hospital, and correspondence from patients' general practitioners. The features identified from the five sets of records were:

1. *All were frail, with major clinical problems.* All five had been admitted to Gosport War Memorial Hospital from other services, for example from acute hospital following surgery for a fractured hip, or from a day hospital. All were

dependent on nursing care and had more than one health condition, including for example Alzheimer's disease, Parkinson's disease, or cancer. Their continuing problems included pressure sores, mobility, confusion and incontinence.

2. *In some cases, active treatment had been planned.* Some, although not all of the five patients had been admitted to Gosport to enable active treatment to be arranged, for example rehabilitation after a fractured hip, or aggressive treatment to heal a sacral ulcer. It should be noted, however, that in one case admission was for palliative care, and in another the prognosis had been noted as poor prior to transfer from an acute hospital.
3. *Oramorph was written on the drug chart on admission.* In four of the five cases, Oramorph was prescribed although not necessarily administered on the day of admission.
4. *Diamorphine was administered by syringe driver in all cases.* Diamorphine was commenced when a patient had pain not otherwise controlled, was noted to be agitated, or had deteriorated in some way. Diamorphine was usually administered with hyoscine and midazolam.
5. *Doses of opiates were unexceptional.* Patients were not given extremely high doses of diamorphine or Oramorph, although it should be noted that they were all frail and elderly, and diamorphine was administered along with midazolam.
6. *The records did not contain full explanations for the treatment decisions.* The medical records were generally rather brief, although the amount of detail varied between doctors. Consultants tended to make more detailed notes. The reason for selecting morphine rather than a non-opiate analgesic was not recorded, even though in some cases other analgesics had not been used. Likewise, the decision to initiate subcutaneous diamorphine by syringe

driver or the reasons for not investigating the potential causes of new symptoms such as pain or agitation were often not fully described.

7. *Remarks in the records suggested a conservative rather than active attitude towards clinical management.* Two of the five records included the instruction by a doctor to nursing staff: 'Please make comfortable'; three records included: 'I am happy for nursing staff to confirm death', written by Dr Barton in all cases on the day of admission.

Review of a random sample of records

Having identified features of cases that the police had been investigating, a review of a random sample of records of patients who had died in Gosport War Memorial Hospital was undertaken. The aims of the review were to (a) determine whether other cases shared these features, and (b) describe the pattern of care of patients who died in the hospital. The review concentrated on patients who had been under the care of Dr Barton, since the medical certificates of cause of death (MCCD) of most patients who had died on Daedalus and Dryad wards had been issued by Dr Barton. Most MCCDs issued by Dr Barton would have been for patients who have been under the care of the Department of Medicine for Elderly People.

Method

Patients whose deaths had been certified by Dr Barton between 1987 and 2002 were identified by National Statistics. From 1993 onwards, information about deaths has been stored on a computer system by National Statistics, and those certified by Dr Barton were readily identified. However, prior to 1993 information was stored on paper only, and a hand search of files containing information about deaths notified in districts local to Gosport was required. The information held on computer or paper

systems consists of details recorded by the certifying doctor on the MCCD, and associated information provided to the registrar of births, marriages and deaths by the informant, who is usually a relative of the deceased. In this report, the summaries of the information from these two sources combined are referred to as death notifications. In addition to the name of the deceased, date of death, and certified cause of death, the information available includes the name of the doctor who issued the MCCD, and the place of death.

The sample of records selected for review was taken from the notifications provided by National Statistics. The review sampled cases from 1988 until 2000, from the beginning of Dr Barton's work at the hospital until she left her post of clinical assistant. A 10% sample of the 833 deaths certified by Dr Barton during this period was selected using the random sampling procedure in the Statistical Package for the Social Sciences (SPSS), the principal statistics software employed in this review.

The hospital records of all deceased patients had been retained by Portsmouth Healthcare NHS Trust for all years during which Dr Barton worked at Gosport, although records of patients who died in 1995 or before had been stored on microfiche. The record department of Gosport War Memorial Hospital was asked to provide all the sampled records, and once these had been retrieved, the review was undertaken. The information extracted from each record is shown in Table 2.1. The notes recorded by both doctors and nurses were reviewed, and drug charts were also inspected. In addition, in each case my own observations on the patient's care were recorded, and the cause of death as certified by Dr Barton was noted. Causes of death were grouped into six categories, according to the first cause of death noted on the MCCD. Thus, the category 'cancer' included all deaths in which a type of cancer was given as the first cause of death. Heart conditions included myocardial

infarction, heart failure, ischaemic heart disease, and other heart disorders. Stroke included both cerebral thrombosis and cerebral haemorrhage. Some certificates gave bronchopneumonia as the sole cause of death, and these were placed in a category distinct from deaths certified as due to bronchopneumonia associated with other conditions that included cancer, dementia, or other disorders. The 'other' category included dementia, old age, renal disease, progressive neurological conditions and other medical conditions not included in the five other categories.

Table 2.1. Information extracted from the clinical records

	Information collected from records
1	Age and gender
2	Date of admission
3	Past medical history
4	History of the final illness
5	Administration of opiate medication

Results

The sample consisted of 85 patients. The records of four were held by the police and therefore were excluded from this review. All the remaining 81 records were reviewed. The numbers of records in each year are shown in Table 2.2. The mean age of patients in the sample was 84.5 years (95% confidence interval 82.8-86.1), and in the group not sampled 82.7 years (95% confidence interval 82.2-83.3). The proportion of females was slightly higher in the sample than in the group not in the sample (Table 2.3), although this did not reach statistical significance (Chi Sq 3.26, df 1, p 0.07). There was no difference between the groups of patients included in and excluded from the sample with respect to the numbers of patients certified as dying from different categories of illness (Chi Sq 3.02, df 5, p 0.70) (Table 2.4).

Table 2.2. Numbers of deaths in Gosport War Memorial Hospital certified by Dr Barton in total, and numbers in sample, 1988-2000.

Year	Number of patients in sample	Number of deaths certified by Dr Barton
1988	2	19
1989	4	30
1990	3	38
1991	6	31
1992	2	32
1993	10	94
1994	8	104
1995	7	80
1996	8	84
1997	11	86
1998	7	107
1999	12	92
2000	1	34
Total	81	833

Table 2.3. Numbers (%) of males and females in the sample compared to those not in the sample the (the Table does not include the four cases excluded from the sample).

Gender	Not in sample	In sample	Total
male	337 (45.1)	28 (34.6)	365 (44.0)
female	411 (54.9)	53 (65.4)	464 (56.0)
total	748	81	829

Table 2.4. Numbers (%) of deaths due to different categories of disease, in those patients included in and excluded from the sample.

Category of disease	Not in sample	In sample	Total
Cancer	44 (5.9)	5 (6.2)	49 (5.9)
Heart	85 (11.4)	7 (8.6)	92 (11.1)
Stroke	122 (16.3)	13 (16.0)	135 (16.3)
bronchopneumonia + other conditions	331 (44.3)	33 (40.7)	364 (43.9)
bronchopneumonia only	139 (18.6)	21 (25.9)	160 (19.3)
Other	27 (3.6)	2 (2.5)	29 (3.5)
total	748	81	829

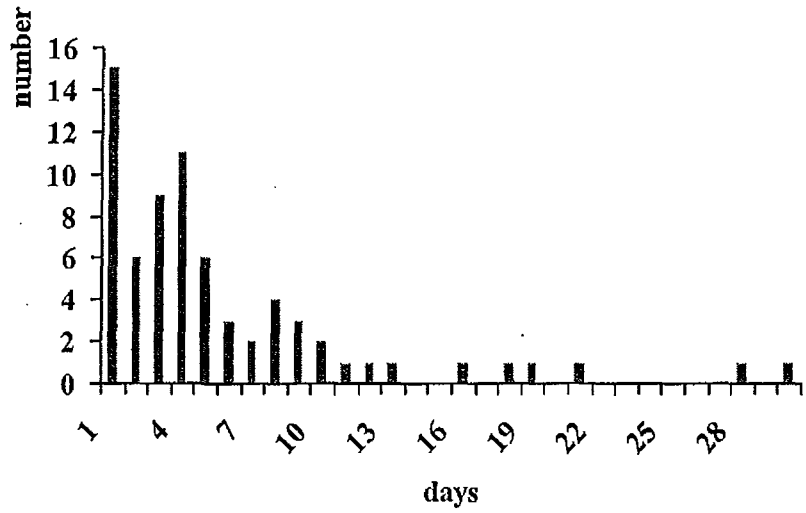
The patients in the sample were almost all elderly; all except two were aged 70 or over (one was aged 69 and one 60). Twenty-one (25.9%) were aged 90 or above (one was aged 100). Typically, patients had been transferred to Gosport following admission to an acute hospital for a major illness, the transfer to Gosport being arranged because the patient would have required more support than could have been provided in a nursing home. In some cases, the aim of transfer to Gosport was rehabilitation, for example, following a stroke or fractured hip. In others, the aim was long term care, as in patients with lasting disabilities following major strokes, or with terminal cancer. Many patients also had other comorbid conditions contributing to the development of dependence on nursing care, including advanced dementia and cardiovascular disease.

Table 2.5. Numbers (%) of patients who received opiate medication before death

	N	%
None	5	6.2
Diamorphine only	21	25.9
Oramorph and diamorphine	38	46.9
Other oral opiates and diamorphine	13	16.0
Other opiates, no diamorphine	4	4.9
Total	81	100.0

Most patients had received an opiate before death (Table 2.5). The most common pattern was initial use of Oramorph, followed by diamorphine subcutaneously. When used in a syringe driver in this way, diamorphine was invariably accompanied by other drugs. In 1988, diamorphine was used in combination with atropine, but in subsequent years it was combined with hyoscine and midazolam. In one case, the duration of opiate medication could not be determined from the records. The other 76 who received opiates were administered the drugs for a median of four days (range 1 – 120 days, inter-quartile range 7 days) (see Figure 2.1).

Figure 2.1. Duration of administration of opiate medication (chart excludes 2 patients at 42 days, 3 at 90 days and 1 at 120 days).



The pattern of use of opiates in these patients generally involved the administration of an oral opiate for pain or distress from whatever cause, followed by the use of subcutaneous diamorphine when the patient became unable to swallow oral medication. This process was usually triggered by a deterioration in health. An example taken from the medical records is as follows:
'further deterioration. Uncomfortable coughing, to have a tiny dose of oramorph regularly JAB' (JAB are Dr Barton's initials) (Case 1210).

Oramorph would also be commenced by other doctors, for example:
Oedema worse, relative feels patient has had enough. Oramorph started. (Signature not clear) (Case 1209).

If the patient deteriorated further, subcutaneous diamorphine would be used, for example:
'Further deterioration in general condition. In pain, confused and frightened. sc analgesia commenced. JAB' (Case 1139).
or:
'patient has deteriorated over weekend, pain relief is a problem. I suggest starts sc analgesia and please make comfortable. I am happy for nursing staff to confirm death. JAB' (Case 708).

The initial dose of diamorphine varied from 5 mg to 80 mg in 24 hours, doses below 20 mg being administered intramuscularly, and doses of 20 mg or more being administered subcutaneously by syringe driver. Of the 60 patients in whom the starting dose of diamorphine could be established, the most common dose was 40mg (50.8%), followed by 20 mg (31.7%) (Table 2.6). Of the 19 who received 20 mg diamorphine in 24 hrs, the dose of oral morphine being administered before

diamorphine was commenced could be identified in seven. The mean total daily dose of oral morphine in these cases was 27.1 mg. Of the 31 who received a starting dose of diamorphine of 40 mg in 24 hours, the daily dose of oral morphine before changing to subcutaneous diamorphine could also be established in seven cases, and the mean morphine dose in these was 44.3 mg. It is generally recommended that to obtain an equivalent level of pain relief, the dose of diamorphine on transfer from oral morphine should be one third of the total daily oral dose (see Chapter One). If this guidance is followed, a starting dose of subcutaneous diamorphine of 20 mg would equate to a daily dose of oral morphine of 60 mg, and a 40 mg dose of diamorphine would equate to a 120 mg dose of oral morphine in 24 hours.

Table 2. 6. Numbers (%) of patients receiving different starting doses of diamorphine

Diamorphine (mg)	N	%
5	1	1.7
10	2	3.3
15	1	1.7
20	19	31.7
30	2	3.3
40	31	50.8
60	1	1.7
80	3	5.0
Total	60	

The use of opiates was not confined to patients with cancer. Only two (15.4%) patients who were certified as having died from strokes did not receive an opiate, and only three (9.1%) of those who were certified as dying from bronchopneumonia associated with other conditions did not receive an opiate (Table 2.7).

Table 2.7. The certified causes of deaths of patients and the numbers (%) who received an opiate.

	Opiates					Total
	none	*diamorphine only*	*oramorph then diamorphine*	*other opiates then diamorphine*	*other opiates*	
cancer	0	1 (20.0)	3 (60.0)	0	1 (20.0)	5
heart	0	2 (28.6)	2 (28.6)	2 (28.6)	1 14.3)	7
stroke	2 (15.4)	3 (23.1)	8 (61.5)	0	0	13
bronchopneumonia with other conditions	3 (9.1)	10 (30.3)	15 (45.5)	5 (15.2)	0	33
bronchopneumonia alone	0	5 (23.8)	9 (42.9)	5 (23.8)	2 (9.5)	21
other conditions	0	0	1 (50.0)	1 (50.0)		2
Total	5 (6.2)	21 (25.9)	38 (46.9)	13 (16.0)	4 (4.9)	81

Typically, a deterioration in a patient's condition would not be investigated in depth. In many cases this would have been appropriate, since the advanced state of illness and impossibility of further curative or rehabilitative treatment had been well established. However, in some cases, the resort to opiate medication might have been, but was not, preceded by some investigation, or trial of analgesics other than opiates. The degree of assessment of pain recommended in the 'Wessex guidelines' was not usually evident in the records, and body maps to highlight areas of pain were not used. For example:

– *'frightened agitated appears in pain suggest transdermal analgesia despite no obvious clinical justification!! Dr Lord to countersign. I am happy for nursing staff to confirm death. JAB'* (Case 785).

In 18 (22.2%) cases the drug chart could not be reviewed because a copy had not been stored on microfiche. Nonetheless, in these cases it was possible to describe the use of opiate medication from entries in the medical and nursing records. Drug charts were almost always completed by Dr Barton. It was notable that in many cases, prescriptions for opiate medication had been entered by Dr Barton on drug charts on the day of the patient's admission, although the medication was not administered until some days or even weeks later. For example, in the case of a patient who had abdominal obstruction and had been admitted to Gosport from an acute hospital, diamorphine was entered onto the drug chart on the day of admission, but not administered until 16 days later (Case 597). Prescriptions for diamorphine typically indicated a range of dose, to enable adjustment without a new prescription being written. In the example just mentioned, the indicated dose was 20-80 milligrams subcutaneously in 24 hours, to be administered with hyoscine and midazolam. It was not unusual for entries in the records by Dr Barton on the day of admission to include the statement '*I am happy for nursing staff to confirm death JAB*' (e.g. Case 530).

The proportion of patients who received an opiate before death did not vary significantly from year to year (Table 2.8). Of the nine deaths that occurred between 1988 and 1990, seven had received an opiate, and it therefore appears that the almost routine use of opiates before death had been established at Gosport hospital long before the initial complaint in 1998.

Table 2.8. Numbers (%) of patients who received an opiate before death, 1988-2000 (Chi Sq 50.0, p not significant).

year	Opiates					Total
	none	*diamorphine*	*oramorph plus diamorphine*	*other plus diamorphine*	*other only*	
1988	1 (50.0)			1 (50.0)		2
1989	1 (25.0)	3 (75.0)				4
1990		2 (66.7)		1 (33.3)		3
1991	1 (20.0)	1 (20.0)	1 (20.0)	2 (40.0)		5
1992			1 (50.0)	1 (50.0)		2
1993		4 (36.4)	3 (27.3)	3 (27.3)	1 (9.1)	11
1994	1 (12.5)	3 (37.5)	4 (50.0)			8
1995		2 (28.6)	5 (71.4)			7
1996		1 (12.5)	6 (75.0)		1 (12.5)	8
1997	1 (9.1)	2 (18.2)	6 (54.5)	2 (18.2)		11
1998		1 (14.3)	3 (42.9)	2 (28.6)	1 (14.3)	7
1999		2 (16.7)	8 (66.7)	1 (8.3)	1 (8.3)	12
2000			1 (100.0)			1
	5 (6.2)	21 (25.9)	38 (46.9)	13 (16.0)	4 (4.9)	81

The medical records were often limited. In 32 (39.5%) of the cases reviewed, the records were judged to be too brief to enable an adequate assessment of care to be made. In particular, they did not always contain information about the decision to initiate opiate medication.

In the review, it was possible to relate information contained in the records to the information reported on death certificates. In 42 (51.9%) cases, the information on certificates was judged to be an incomplete statement of factors contributing to

death. In 16 of these, a recent fracture that had contributed to the patient's condition had not been reported on the death certificate. These included patients who had suffered a fractured hip and undergone operative fixation or partial hip replacement in an acute hospital prior to transfer to Gosport. Indeed, a fracture had not been mentioned on any of the death certificates in the sample. Typically, death in these cases was reported as being caused by bronchopneumonia.

Forty-eight records contained sufficient details to enable a judgement to be made about the appropriateness of care. In 32 (66.7%) of these, care was judged to have been appropriate. There were some concerns about the decision to start opiate medication in the remaining 16 (33.3%). The indications for starting the drugs were either not clearly stated, or if pain was mentioned it had not been investigated, and neither remedial treatment or alternative analgesia had been attempted. For example, the following was written in one set of records in Dr Barton's handwriting: *'marked deterioration over last 24 hrs. Persistent cough relieved by nebulised diamorphine in N/saline. .... Sc analgesia is now appropriate + neb if required'* (Case 587). No investigation of the cough was described nor treatment other than nebulised diamorphine.

Discussion

A number of qualifications about the review of records should be acknowledged. The information was obtained from the records only, and because of the pressure of routine care in a hospital ward, clinicians may often fail to record extensive details about patient care. In some cases, the drug charts that recorded prescribing and administration of opiate medication were not available because they had not been copied onto microfiche. More complete records, or information obtained through interviews of clinical staff or relatives, might have explained some of the findings

that, on the evidence of the records alone, gave rise to some concern. The sample included only patients whose deaths had been certified by Dr Barton. However, the records contained entries from other doctors, and demonstrated that they had made some treatment decisions.

The record review was undertaken to identify broad patterns of care, and therefore included a relatively large number of cases, albeit a sample from over 800 cases. An intensive, prolonged and in depth review of a small number of cases might have reached, in those cases, different conclusions. Nevertheless, despite these reservations, the review does raise questions about the care provided to patients at Gosport War Memorial Hospital.

Features of care

The first aim of the review was to determine whether features associated with the care of patients whose deaths were being investigated by the police could also be found in the sample.

1. All patients were severely ill, having major disabling, or progressive conditions, or illnesses that were unlikely to substantially improve. They were heavily dependent on nursing care, and many had been intensively investigated and treated in acute hospitals before transfer to Gosport.
2. The precise reasons for admission were not always clear from the records, but some patients had certainly been admitted for rehabilitation. The majority of patients, however, had major clinical problems.
3. 93.8% of patients received an opiate, and almost half received Oramorph (Table 2.5). Opiate medication was frequently prescribed on the day of admission, although there was no immediate indication for their use, and they

were sometimes not administered until after several days or weeks. There was little evidence of use of weak or moderate analgesics before resort to oral morphine, opiate medication being used when patients suffered a deterioration in their condition. Further investigation or active treatment were often not undertaken, and alternative analgesics were generally not used first. If pain was a feature of a patient's deterioration, a detailed assessment of the reasons for pain was not usually recorded.

4. Diamorphine was administered to 72 (88.9%) patients, almost always by syringe driver and accompanied with other drugs with sedative properties, most commonly midazolam and hyoscine. Diamorphine was used in all categories of condition (Table 2.7). In those patients in whom the dose of oral morphine could be established, the starting dose of diamorphine tended to be higher than would have been expected. The two potential explanations are that oral opiates were not being administered at sufficient doses to control pain, or that the doses of diamorphine were greater than required.
5. In most cases, opiates were not used for prolonged periods, 47 (61.8%) patients dying within five days of starting treatment.
6. The records were generally brief. On occasions, details were either not recorded, or no entries were made when the patient had been assessed by a doctor, although the consultation was mentioned in the nursing records. The reasons for starting opiate medication were often not adequately recorded, and in 39.5% of cases it was not possible to assess the appropriateness of care.
7. The conservative attitude to treatment identified in the records of the cases being investigated by the police was also evident in the records of the sample. The quotations included above serve to illustrate this finding. The

initial medical assessment of a patient on admission was often concluded with the phrase 'Please make comfortable'.

8. In the case of patients whose deaths had been preceded by a bone fracture (most commonly the hip), Dr Barton did not note the fracture on the medical certificate of cause of death. The Office of National Statistics (ONS) encourages the practice of voluntary referral to the coroner by the certifying doctor of deaths due to accidents (whenever the accident occurred) (Devis and Rooney, 1999). It is conceivable that the local coroner would have undertaken at least some investigation into a number of the deaths that had followed fractures.

The pattern of care

The review included records of patients who died from 1988 to 2000. The findings reveal a distinct pattern dating from 1988. Indeed, the almost routine use of opiates before death appears to date from at least as early 1988, but it is conceivable that this practice was in use before this, and before Dr Barton was appointed as clinical assistant.

The patients admitted to Gosport War Memorial Hospital under the care of the Department of Medicine for Elderly People were old and frail. They had major illnesses and were heavily dependent on nursing care. In managing these patients, the culture at Gosport throughout the period appeared, from the records, to have been conservative with regard to treatment and modest with regard to expectations of improving patient health. It may be summed up in Dr Barton's own words, frequently written in the records: 'Please make comfortable'. This approach may have been entirely correct for many of the severely ill and dependent patients

admitted to Gosport. However, it is possible that in some patients, a more active clinical approach would have extended life.

Opiates were used extensively, and often without recourse to other analgesics, detailed assessment of the cause of pain, agitation or deterioration, or active treatment. The doses of diamorphine appear to have been higher than prior doses of oral morphine would have suggested were required, and most patients died within a few days of starting opiates. These observations might be interpreted as indicating that management of patients with terminal illnesses, in placing so much emphasis on the comfort of the patient, were in advance of those followed elsewhere in the health service. However, they might also be interpreted as indicative of a conservative approach to treatment, and even a premature resort to opiates that in some cases may have shortened life.

The lack of detail recorded in the notes about medical decisions, and contrast between the detailed notes written by the consultants and the short entries of other doctors – sometimes written within a few hours of each other – suggests that the level of supervision and teamwork was poor. The failure of the records to provide a coherent description of a patient's illness and care, the often disjointed nature of entries by different doctors, and the lack of detail about some decisions may have been a consequence of inadequate discussion between members of the clinical team on patient management.

The completion of medical certificates of cause of death was inadequate. In particular, the pattern of not reporting recent fractures was not appropriate.

References

Devis T, Rooney C (1999). Death certification and the epidemiologist. *Health Statistics Quarterly*, Spring, 21-33.

Chapter Three: Deaths at Gosport War Memorial Hospital, 1987-2000: A review of Medical Certificates of Cause of Death (MCCDs) counterfoils

Introduction

Medical certificates of cause of death are supplied in books, each book containing 50 certificates. Each certificate is attached to a counterfoil from which it is detached when it is issued. At Gosport, only one book of MCCDs was in use at any one time, the book being held in an office close to the mortuary. It was hospital policy that MCCDs should be issued from the centrally held book, and the books of counterfoils have been retained for a number of years. Consequently, the counterfoils are likely to represent a reasonably complete record of deaths for which an MCCD was issued, although deaths that were referred to the coroner would have been excluded. This chapter describes the findings from review of these counterfoils.

The counterfoils record selected information that is also entered on the MCCD itself, including the deceased's name, date of death, the place of death, and the cause of death. From early 1988, the counterfoils of the books of certificates in use at Gosport also required the certifying doctor to state the deceased's age.

Method

Information from all the available counterfoils was entered into a database. The specific data items are shown in Table 3.1.

Table 3.1. Information obtained from the MCCD counterfoils.

1	Name
2	Gender
3	Age
4	Date of death
5	Certified cause(s) of death
6	Doctor completing the certificate
7	Place of death

The counterfoils were completed in the certifying doctors handwriting. Dr Barton had a distinctive signature almost invariably written with black ink. Consequently, deaths she had certified could be readily and confidently identified. However, the signatures of the other doctors were generally less distinctive, and consequently it was not possible to reliably identify other doctors. The other doctors would have included general practitioners who had cared for patients admitted to general practitioner beds, and doctors attending patients of the Department of Medicine for Elderly People when Dr Barton was not on duty.

Results

1. Numbers of deaths

The numbers of certificates issued each year by Doctor Barton and other doctors are shown in Table 3.2.

Table 3.2. Numbers (%) of MCCD counterfoils each year, 1987-2000, completed by Dr Barton or other doctors at Gosport.

Year	Other docs	Dr Barton	Total
1987	105 (98.1)	2 (1.9)	107
1988	85 (74.6)	29 (25.4)	114
1989	71 (69.6)	31 (30.4)	102
1990	72 (65.5)	38 (34.5)	110
1991	59 (65.6)	31 (34.4)	90
1992	68 (68.0)	32 (32.0)	100
1993	57 (36.5)	99 (63.5)	156
1994	56 (34.6)	106 (65.4)	162
1995	74 (47.7)	81 (52.3)	155
1996	100 (54.3)	84 (45.7)	184
1997	106 (55.2)	86 (44.8)	192
1998	107 (50.0)	107 (50.0)	214
1999	71 (43.6)	92 (56.4)	163
2000	81 (70.4)	34 (29.6)	115
2001	103 (98.1)	2 (1.9)	105
Total	1214 (58.7)	854 (41.3)	2069

Between 1987 and 2001, Dr Barton completed 854 MCCDs, 41.3% of all those issued at the hospital. The numbers issued by Dr Barton rose from 1988, when she issued 25% of all those issued in the year, to 1994 when she issued 64% of the total. There was a rise in the total numbers coincident with the rise in proportion issued by Dr Barton, and it was not until 2000 when the total number returned to the levels typical of the years 1987-1992. Dr Barton issued two MCCDs in 2001 for patients

who had died in general practitioner beds, the year after the termination of her clinical assistant post.

2. Age and gender of deceased patients

The mean age of Dr Barton's deceased patients was 82.8 years, but for the other doctors the mean was 78.8 (t 9.31, df 1807, p<0.001). The difference in age is probably explained by the admission criteria for the different hospital wards. The gender of the deceased could be identified in 2033 (98.3%) of the 2069 cases, and among Dr Barton's patients 478 (56.8%) were female, in comparison with 623 (52.3%) among the other doctors (Chi Square 3.95, df 1, p 0.047).

3. Certified cause of death

The cause of death, grouped into the six categories as defined in Chapter Two, given by Dr Barton and other doctors are shown in Table 3.3.

Table 3.3: Numbers (%) of deaths certified as due to groups of conditions by Dr Barton and the other doctors (Chi Sq 507.9, df 5, p <0.001).

	Other docs	Dr Barton	
cancer	424 (38.6)	49 (5.8)	473
heart conditions	165 (15.0)	100 (11.8)	265
stroke	106 (9.7)	139 (16.4)	245
bronchopneumonia + other conditions	235 (21.4)	367 (43.3)	602
bronchopneumonia alone	21 (1.9)	162 (19.1)	183
other condition	147 (13.4)	31 (3.7)	178
total	1098	848	1946

Dr Barton's patients were less likely to have been certified as dying primarily because of cancer or heart conditions, but more likely to have died from bronchopneumonia with or without other conditions, or from strokes. Case mix will explain at least some of these differences. Thus, local general practitioners appear to have admitted patients with cancer to Gosport Hospital for terminal care, but Dr Barton was responsible for the care of other groups, including people with Alzheimer's disease or other forms of dementia, and those recovering from strokes or in need of rehabilitation for other reasons.

4. Deceased seen after death, and post-mortems

Dr Barton was more likely to have reported personally seeing the deceased after death (98.6% vs 86.9%, Chi Sq 89.3, df 2, $p<0.001$). Dr Barton reported that in 99.4% of deaths, no post mortem or referral to the coroner occurred; the proportion for the other doctors was 98.4%. These cases will not have included all cases reported to the coroner, since no MCCD would have been issued by the doctor in those cases that the coroner chose to investigate. In such cases, a certificate would be issued by the coroner at the conclusion of the coronial investigation. Therefore, the deaths indicated as referred to the coroner on the counterfoils are likely to include only those in which a discussion took place with the coroner or coroner's officer, and that concluded that an MCCD should be issued by the doctor.

5. Day, calendar quarter and week of death

The date of death was used to identify the day of week of death. In the case of both Dr Barton's patients and the patients whose deaths were certified by other doctors, the pattern was as expected, with approximately equal proportions of deaths occurring on each day of the week (Table 3. 4). A marginally greater proportion of Dr Barton's patients died during the winter (October to March), a factor that might be explained by seasonal factors influencing the types of conditions with which patients

were admitted, or because Dr Barton was more likely to take vacations between April and September (Table 3.5). Table 3.6 shows the distribution of deaths during the year when the certified cause of death was given as bronchopneumonia only. Dr Barton issued a greater number of certificates giving this cause of death, although the temporal distribution was no different to that of the other doctors.

Table 3.4. Numbers (%) of patients certified as dying on each day of the week (Chi Sq 5.1, df 6, not significant).

	doctor		total
	other doctors	Dr Barton	
1	174 (15.7)	113 (13.3)	287
2	147 (13.2)	111 (13.0)	258
3	154 (13.9)	122 (14.3)	276
4	151 (13.6)	137 (16.1)	288
5	139 (12.5)	117 (13.7)	256
6	176 (15.9)	132 (15.5)	308
7	169 (15.2)	119 (14.0)	288
	1110	851	1961

Table 3.5. Numbers (%) of patients certified as dying in each calendar quarter (Chi Sq 11.2, df 3, p < 0.01)

quarter	doctor		total
	Other doctors	Dr Barton	
Jan-Mar	269 (24.1)	235 (27.6)	504
Apr-Jun	288 (25.8)	199 (23.4)	487
Jul-Sep	294 (26.3)	182 (21.4)	476
Oct-Dec	266 (23.8)	236 (27.7)	502
	1117	852	1969

Table 3.6. Numbers (%) of deaths in different quarters certified as due to bronchopneumonia alone (Chi Sq 0.67, df 3, not significant).

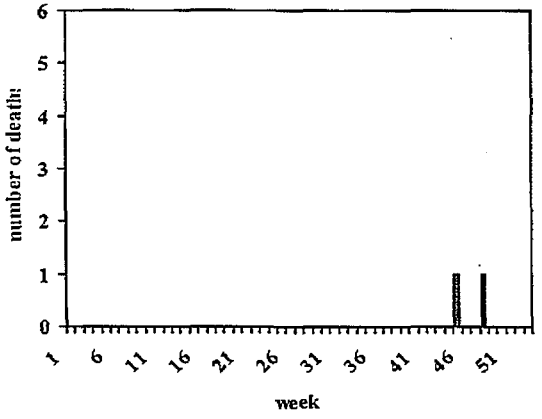
quarter	Doctor		total
	other doctors	Dr Barton	
Jan-Mar	7 (31.8)	51 (31.5)	58
Apr-Jun	6 (27.3)	33 (20.4)	39
Jul-Sep	3 (13.6)	28 (17.3)	31
Oct-Dec	6 (27.3)	50 (30.9)	56
	22	162	184

The distribution of deaths according to week of the year may also be used to identify clusters of deaths, and variations in the numbers of deaths at different times. Table 3.7 shows the mean number of deaths per week certified by Dr Barton from 1988 until July 2000, when she ceased employment at Gosport hospital. The findings demonstrate the increase in the numbers of deaths from 1993, the year in which Dryad and Daedalus wards were opened.

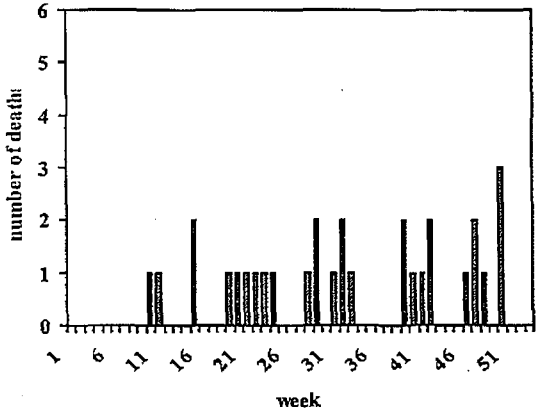
Table 3.7. Mean and standard deviation (SD) of numbers of deaths certified by Dr Barton per week, 1988- 2000.

year	minimum	maximum	number	mean	SD
1988	0	3	29	.53	.77
1989	0	2	31	.58	.69
1990	0	5	38	.72	.97
1991	0	3	31	.58	.89
1992	0	2	32	.60	.77
1993	0	5	99	1.87	1.43
1994	0	6	105	1.98	1.63
1995	0	6	81	1.53	1.31
1996	0	5	84	1.58	1.18
1997	0	6	86	1.62	1.40
1998	0	6	107	2.02	1.57
1999	0	6	92	1.74	1.32
2000	0	4	34	1.31	1.19

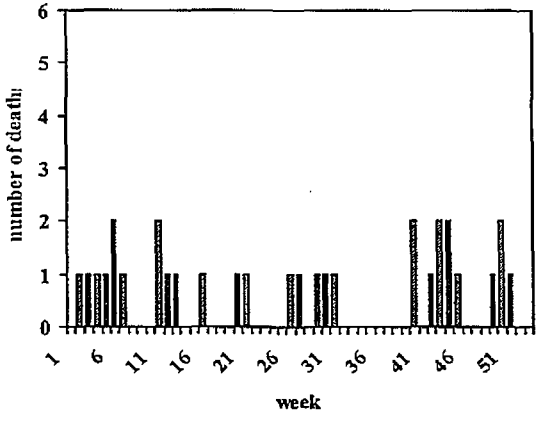
The Figures 3.1 to 3.15 in the following pages show the numbers of deaths certified each week from 1987 to 2001. They demonstrate the rise in the numbers of deaths from 1993 onwards, and suggest a decline in numbers may have occurred during 2000, although Dr Barton worked only until July in that year. The two deaths in 1987 would presumably have been for patients in general practitioner beds under the care of Dr Barton or one of her partners in her general practice. Other than the rise in numbers of deaths from 1993, the Figures do not indicate any clear clusters of deaths or patterns of concern.



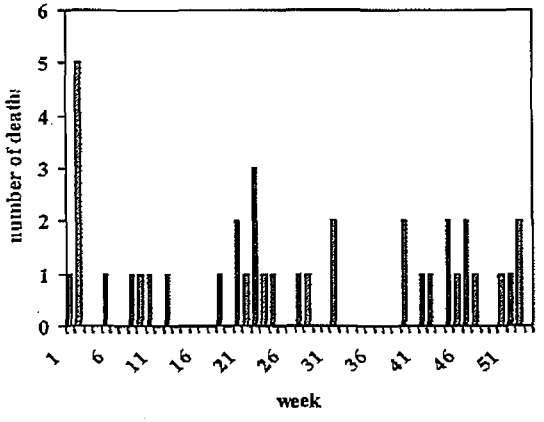
3.1. Deaths in 1987



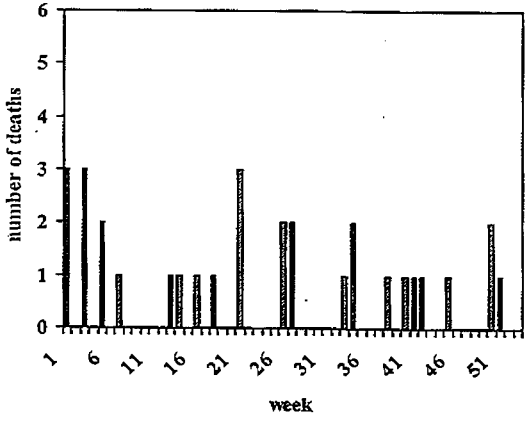
3.2. Deaths in 1988



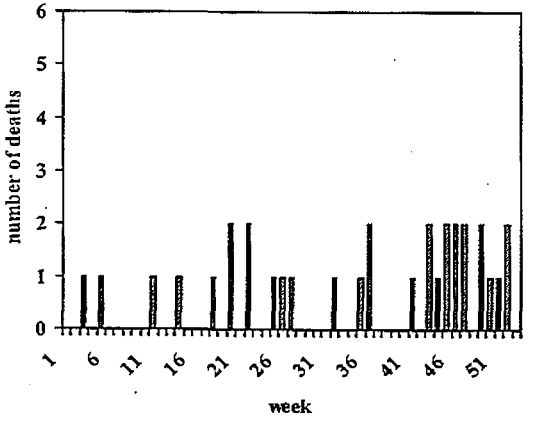
3.3. Deaths in 1989



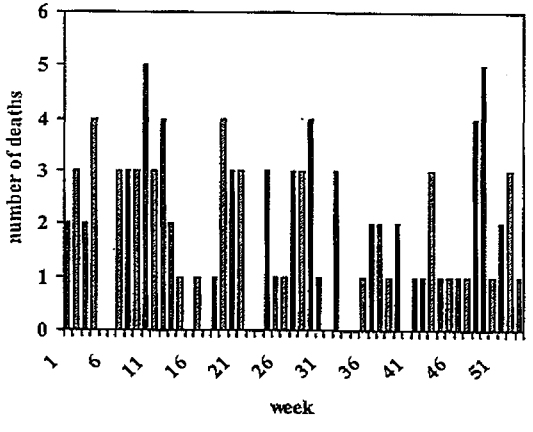
3.4. Deaths in 1990



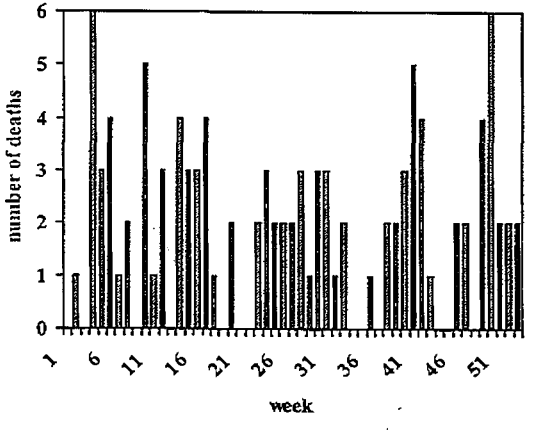
3.5. Deaths in 1991



3.6. Deaths in 1992



3.7. Deaths in 1993



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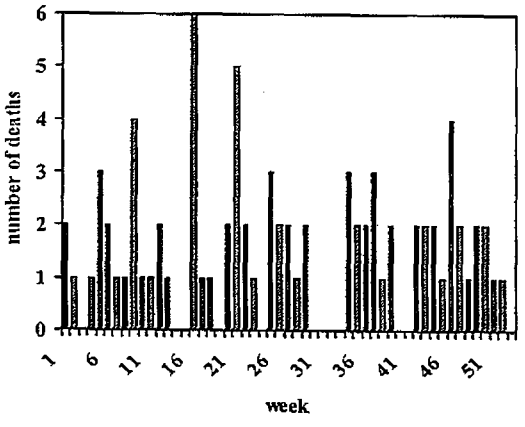

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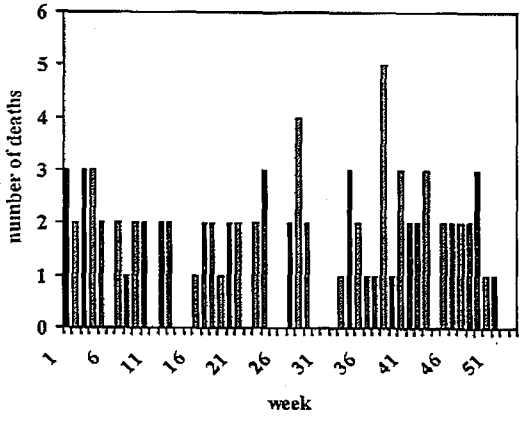

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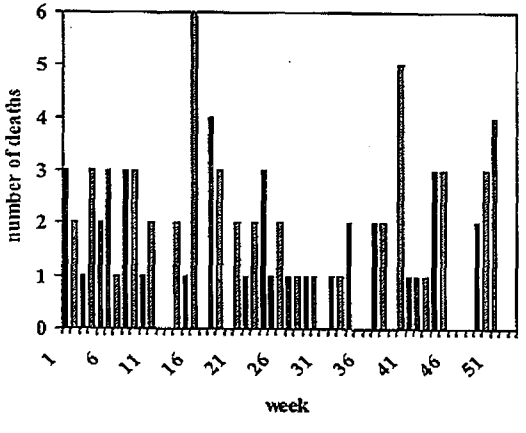

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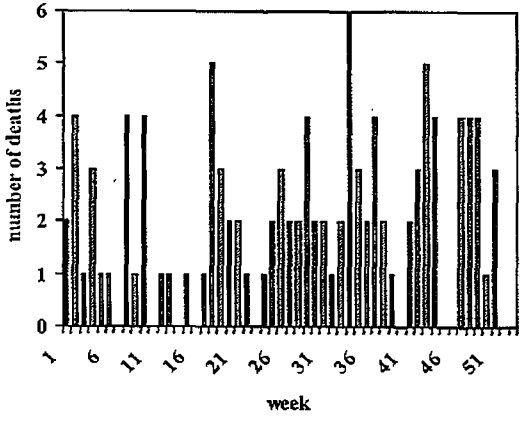

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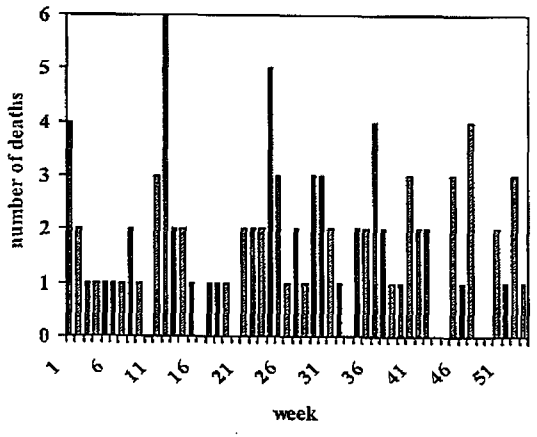
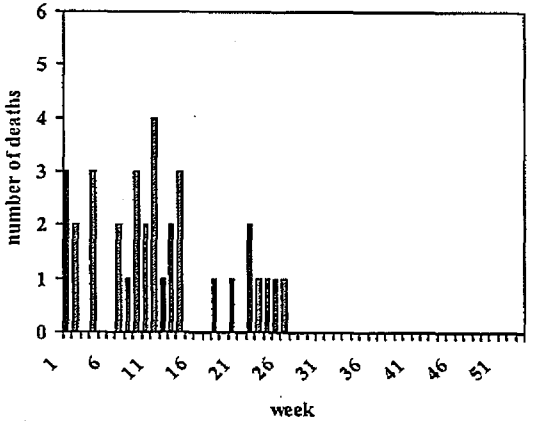
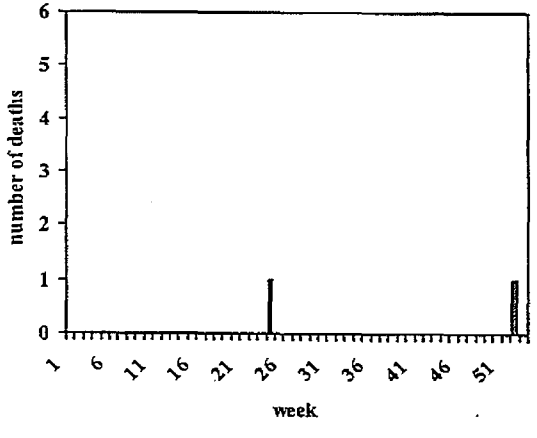


3.13. Deaths in 1999



3.14. Deaths in 2000



3.15. Deaths in 2001

6. Patients on Dr Barton's wards

In some cases, doctors other than Dr Barton issued MCCDs for patients who died on wards specifically served by Dr Barton in her role as clinical assistant in the Department of Medicine for Elderly People. These wards were Redclyffe Annexe, and Dryad and Daedalus wards. Dr Barton also cared for some patients in the male and female wards, but these wards were not exclusive to patients of the Department. The completion of MCCDs by other doctors for patients in Redclyffe Annexe, or Dryad and Daedalus wards, could occur principally when Dr Barton was on leave or not on duty. Therefore, the case mix of these patients would tend to be similar to those whose deaths were certified by Dr Barton.

Tables 3.8 and 3.9 show respectively the certificates issued by the other doctors at the hospital and Dr Barton for deaths on different wards. These data reflect the fact that Dr Barton ceased responsibility for patients in Redclyffe Annexe and took on the new Dryad and Daedalus wards 1993/4.

Table 3.8. Deaths certified by doctors other than Dr Barton on wards at Gosport (Mulberry is a 40 bed assessment unit).

year	place of death								
	Gosport (ward not stated)	*Redclyffe*	*male ward*	*female ward*	*Daedalus ward*	*Dryad ward*	*Sultan ward*	*Mulberry*	*tota*
1987	66	9	9	11					95
1988	61	3	13	5					82
1989	52	3	3	10					68
1990	52	2	9	9					72
1991	37	1	10	11					59
1992	35	1	16	15					67
1993	34	2	3	6	3		8		56
1994	15	5			2		33		55
1995	12				12	5	35	10	74
1996	28	7			10	6	37	11	99
1997	10	3			8	7	45	33	100
1998	23	5			12	11	35	18	93
1999	12	7			6	9	27	10	71
2000	20	5			13	12	22	9	81
2001	59	8			1	4	25	6	103
	523	61	63	67	67	54	267	97	1175

Table 3.9. Deaths certified by Dr Barton on different wards at Gosport.

year	place of death							Total
	Gosport (ward not stated)	*Redclyffe*	*male ward*	*female ward*	*Daedalus ward*	*Dryad ward*	*Sultan ward*	
1987	1	1						2
1988	2	6	11	1				20
1989	1	19	8	1				29
1990		23	13	2				38
1991		18	11	2				31
1992		23	8	1				32
1993		51	7	6	35			99
1994		58	1		42		4	105
1995	1	4			42	33	1	81
1996					48	32	3	83
1997					39	47		86
1998					51	51	5	107
1999					42	49	1	92
2000					15	17	2	34
2001						1	1	2
	5	203	59	13	314	230	17	841

The mean age of patients who died on each ward was different (Table 3.10). Patients in Redclyffe, Daedalus and Dryad wards tended to be older than those in the other wards. Greater proportions of patients who died in Redclyffe, Daedalus and Dryad wards were female than those who died in Sultan ward (Table 3.11).

Table 3.10. Mean age (years) of patients who died in different wards. (N=1799, p <0.005)

Ward	number	mean age	95 % confidence intervals
Gosport hospital, ward not specified	427	78.4	77.4 – 79.4
Redclyffe	250	82.8	81.8 – 83.7
Male ward	109	78.1	76.4 – 79.9
Female ward	68	80.3	77.7 – 82.8
Daedalus	381	82.5	81.8 – 83.2
Dryad	284	83.7	82.9 – 84.5
Sultan	280	77.0	75.6 – 78.4

Table 3.11. Numbers (%) of males and females who died in wards in Gosport hospital.

ward	gender		total
	male	*female*	
Gosport, ward not stated	244 (47.8)	266 (52.2)	510
Redclyffe	68 (26.2)	192 (73.8)	260
male ward	115 (96.6)	4 (3.4)	119
female ward		78 (100.0)	78
Daedalus ward	173 (46.1)	202 (53.9)	375
Dryad Ward	135 (47.7)	148 (52.3)	283
Sultan Ward	142 (51.1)	136 (48.9)	278
total	877 (46.1)	1026 (53.9)	1903

7. Certified cause of death

The certified cause of death could be determined from 2052 (99.2%) of the 2069 counterfoils available. Table 3.12 shows, for all deaths regardless of place of death in Gosport Hospital, the numbers of deaths certified as primarily due to one of six groups of conditions. Dr Barton was more likely to give bronchopneumonia or stroke as the cause of death (Chi sq 529.6, df 5, P< 0.001). A potential explanation is case mix – patients with dementia or stroke would have been admitted to Redclyffe, Dryad and Daedalus wards. Another possibility is excess use of sedative medication, leading to development of bronchopneumonia.

Table 3.12. Cause of death in groups, according to whether Dr Barton or other doctors signed the certificate.

Cause of death	Other doctors	Barton	total
cancer	460 (38.3)	50 (5.9)	510
heart	172 (14.3)	100 (11.8)	272
stroke	112 (9.3)	139 (16.4)	251
bronchopneumonia plus another	263 (21.9)	368 (43.3)	631
bronchopneumonia only	22 (1.8)	162 (19.1)	184
other	173 (14.4)	31 (3.6)	204
	1202	850	2052

It was possible to identify from the counterfoils 946 patients who had died in Daedalus, Dryad and Sultan wards. The admission criteria for these wards were different, and this is reflected in the differences in the certified causes of death among patients who died in these wards (Table 3.13). Since Dr Barton was responsible for patients in Daedalus and Dryad wards, and general practitioners were responsible for patients in Sultan ward, it is possible that the differences observed in the certified causes of deaths between these doctors would be at least partly explained by the different characteristics of the patients they cared for.

Table 3.13. Numbers (%) of deaths certified as due to different causes on Daedalus, Dryad and Sultan wards (Chi Sq 344.8, df 10, p<0.005).

	ward			total
	Daedalus ward	*Dryad ward*	*Sultan ward*	
cancer	21 (5.5)	24 (8.5)	158 (56.0)	203
heart	51 (13.4)	37 (13.0)	36 (12.8)	124
stroke	95 (25.0)	29 (10.2)	10 (3.5)	134
bronchopneumonia plus another	135 (35.5)	103 (36.3)	44 (15.6)	282
bronchopneumonia only	56 (14.7)	65 (22.9)	13 (4.6)	134
other	22 (5.8)	26 (9.2)	21 (7.4)	68
	380	284	282	946

There were also variations in the certified causes of death according to the gender of patients, cancer being less frequently given as the cause of death among males, and bronchopneumonia alone more frequently among females (Table 3.14). However, this difference was not apparent when the analysis was confined to patients whose deaths had been certified by doctors other than Dr Barton (Table 3.15).

Table 3.14. Numbers (%) of male and female patients certified as dying due to certain causes (Chi Sq 19.8, df 5, p<0.001)

cause of death	gender		total
	male	*female*	
cancer	244 (28.0)	241 (23.6)	485
heart	114 (13.1)	137 (13.4)	251
stroke	104 (12.0)	129 (12.6)	233
bronchopneumonia plus another	278 (32.0)	305 (29.9)	583
bronchopneumonia only	57 (6.6)	124 (12.1)	181
other	73 (8.4)	85 (8.3)	158
	870 (100.0)	1021 (54.0)	1891

Table 3.15. Numbers (%) of male and female patients certified by doctors other than Dr Barton as dying due to certain causes (Chi 3.9, df 5, not significant).

cause of death	gender		total
	male	*female*	
cancer	218 (42.7)	219 (39.5)	437
heart	66 (12.9)	91 (16.4)	157
stroke	44 (8.6)	53 (9.5)	97
bronchopneumonia plus another	113 (22.2)	112 (20.2)	225
bronchopneumonia only	9 (1.8)	12 (2.2)	21
other	60 (11.8)	68 (12.3)	128
	510 (100.0)	555 (100.0)	1065

A comparison between certificates issued by Dr Barton and the other doctors restricted to selected wards would reduce the likelihood that case mix would explain any observed differences. From 1987, 745 MCCDs were issued by Dr Barton and 166 by other doctors for patients in Redclyffe Annexe and Daedalus and Dryad wards. The mean age of the patients was similar (Dr Barton 83.0, the other doctors 82.5, not significantly different), as would be expected if the case mix had been the same. Among Dr Barton's patients, 439 (59.5%) were females, and among the patients of the other doctors 103 (57.2%) were females (difference not statistically significant). However, the other doctors gave bronchopneumonia alone as the cause of death in only 3% of cases, but among Dr Barton's patients the proportion was 20% (Chi Square 88.3, df 5, p 0.000) (Table 3.16).

Table 3.16. Causes of death among patients of Redclyffe Annexe, Daedalus and Dryad Wards, 1987-2001, comparing those certified by Dr Barton and other doctors.

cause of death	**ward**					
	Redclyffe		Daedalus ward		Dryad ward	
	other	*Dr Barton*	*other*	*Dr Barton*	*other*	*Dr Barton*
cancer	3 (5.9)	2 (1.0)	6 (9.2)	14 (4.5)	5 (10.0)	18 (7.9)
heart	7 (13.7)	12 (5.9)	11 (16.9)	40 (12.7)	6 (12.0)	31 (13.5)
stroke	8 (15.7)	23 (11.4)	18 (27.7)	77 (24.5)	4 (8.0)	25 (10.9)
bronchopneumonia plus another	23 (45.1)	125 (61.9)	17 (26.2)	118 (37.6)	19 (38.0)	84 (36.7)
bronchopneumonia only		36 (17.8)	1 (1.5)	55 (17.5)	4 (8.00)	58 (25.3)
other	10 (19.6)	4 (2.0)	12 (18.5)	10 (3.2)	12 (24.0)	13 (5.7)
	51	202	65	314	50	229

8. Hospital Episode Statistics

To determine whether there were a greater number of deaths than would have been expected among patients admitted to Gosport under the care of the Department of Medicine for Elderly People, a method is required for estimating the numbers of deaths that would have been expected. Since Gosport hospital is a community hospital, a comparison with other community hospitals would be a logical approach.

Information on admitted patient care delivered by NHS hospitals from 1989 is provided by Hospital Episode Statistics (HES), and HES were requested to provide information for this review. HES employs a coding system, each patient episode being assigned a series of codes that indicate the hospital in which care was provided, the type of speciality concerned, and the diagnosis. The codes are entered into a database in each NHS hospital, and the information is then collated at a national level by the Department of Health.

In order to identify those patients who were cared for in the Department of Medicine for Elderly People in Daedalus and Dryad wards at Gosport, specific codes indicating the speciality, hospital and ward would have been desirable. However, HES at a national level records information by hospital trust, but not necessarily by local hospital or specific ward. Thus, the national data do not allow the ready identification of patients who were cared for in the two wards at Gosport that are the focus of this review. Episode statistics that identified the ward were, however, available at Gosport hospital, but only relating to the years 1998 onwards. Consequently, data about most of the years of interest were not available.

Even if complete data for all the years of interest had been available, the difficulties would not have been resolved. The reason for employing HES data is to enable comparisons between the mortality rates in Gosport hospital with those of similar community hospitals elsewhere who were caring for similar groups of patients over the same period. The level of detail in the central HES data does not, however, permit the identification of a satisfactory group of comparable community hospitals and similar group of patients. For example, even when HES codes are selected that identify patients who have been transferred between hospitals following initial admission because of a stroke, the mortality rate (approximately 30%) is substantially lower than that in Gosport (see Table 4.3). An uncritical acceptance of this finding would lead to the conclusion that patients admitted to Gosport were more likely to die than if they had been admitted elsewhere, whereas in fact the patients who were admitted to Gosport were more severely ill than those in the best comparison group yet identified from the central HES data. The collection of episode statistics directly from a sample of community hospitals would ensure that more detailed information would be obtained. However, since a comparison would only be possible from 1998, and it would be impossible to eliminate the effects of case-mix among patients admitted to different hospitals, it would be impossible to place much confidence on the findings of such a comparison. Consequently, an analysis using HES data has not been undertaken in this review.

Discussion

Two points about the use of counterfoils as a source of data should be discussed first.

1) identification of all deaths

In this analysis of deaths identified from the counterfoils of MCCDs stored at Gosport hospital, some deaths may not be included, for example deaths referred to the coroner; in a few cases the doctor may not have issued the certificate from the Gosport hospital certificate book. However, a comparison with the numbers of certificates for deaths at the hospital completed by Dr Barton and certificates identified by National Statistics shows the number to be virtually identical (Tables 3.1 and 6.1), and therefore the data from counterfoils are likely to be sufficiently complete to permit conclusions to be drawn.

2) completion of counterfoils

The writing of some doctors was difficult to read, and the signatures of many could not be interpreted. However, the counterfoils completed by Dr Barton were easily identified. She had bold and confident handwriting, and used distinctive black ink. Also, occasional counterfoils were not fully completed, although this problem was uncommon and will not have influenced the findings of the analysis. Although Dr Barton usually specified the ward in which patients had died, other doctors often gave less detail and usually only indicated Gosport hospital as the place of death. However, this lack of detail is unlikely to have been systematic, and therefore it is possible to be reasonably confident in the findings of the comparison between deaths in different wards.

Findings

The analysis has identified the following concerns:

1. In her role as clinical assistant in the Department of Medicine for Elderly People, Dr Barton issued a large number of MCCDs between 1987 and 2000. Between 1988 and 1992, the numbers were between 29 and 38 per year, but from 1993 the numbers increased to between 81 and 107 per year, falling to 34 in 2000, the year in which Dr Barton left the hospital in July. Dryad and Daedalus wards

opened in 1993-4, a factor that is likely to explain the increase in numbers of deaths in these years owing to differences in the types of patients admitted to these wards. Patients in Redclyffe Annexe commonly suffered from dementia, but those admitted to Dryad and Daedalus had a wider range of severe clinical problems.

2. The proportion of deaths certified by either Dr Barton or other doctors occurring on each day of the week was more or less the same. In comparison with other doctors, Dr Barton issued a lower proportion of MCCDs during the summer months, but this finding is likely to be explained by annual leave being taken during the summer months.
3. The case mix of patients is likely to explain most of the observed differences between MCCDs issued by Dr Barton and those issued by other doctors. For example, patients under her care tended to be older than patients whose deaths were certified by other doctors.
4. It is notable that the patients admitted to Sultan ward, under the care of their general practitioners, were more likely to have been certified as dying due to cancer. They were also younger than patients who had died in Daedalus and Dryad wards.
5. The effect of case mix is probably reduced in an analysis that compared deaths in Redclyffe Annexe, Daedalus and Dryad wards that had been certified by Dr Barton or by other doctors. In this analysis, the mean age and proportion who were female was similar. However, Dr Barton gave bronchopneumonia alone as the cause of death significantly more frequently than the other doctors. The review of records (Chapter Two) highlighted that patients who had been certified as having died of bronchopneumonia had had other significant conditions, including recent fractures of the hip. Furthermore, a high proportion of these patients had received opiates before death. Consequently, although case mix

almost certainly explains much of the difference between patients in the Department of Medicine for Elderly People managed by Dr Barton and those under the care of other general practitioners, concerns about the use of opiates and the possible contribution they may have made to the deaths of some patients cannot be ruled out.

Chapter Four: Admissions to Dryad Ward

Introduction

The admissions book for Dryad ward has been retained by the hospital, and contained information about all admissions from 1993, the year of first opening of the ward. The information recorded in the book included dates of admission and discharge (or death), the time of day of deaths, some indication of the reasons for admission, and the place the patient had been admitted from. This information was studied in order to identify the characteristics of patients admitted to Dryad ward, and aspects of the care they had received.

It should be noted that Daedalus ward did not have a similar book, although a day-book appears to have been employed. This did not contain information helpful to this review.

Methods

There had been a total of 715 admissions from the opening of the ward in 1993 until the end of 2001. The admissions book recorded the date of admission and the date of discharge or death, and it was therefore possible to calculate the length of admission. Table 4.1 shows the mean length of admissions by year of admission, for the 676 (94.5%) admissions in which the admission and discharge date could be identified. There was some variation between years, with admissions during 1998 having the shortest mean length.

Table 4.1. Mean length (days) of stay on Dryad ward, days, 1993-2001.

year	number of admissions	mean (days)	95% CI for mean		minimum	maximum
			Lower	Upper		
1993	37	148.6	87.6	209.5	4	652
1994	68	41.7	24.7	58.7	1	326
1995	52	88.8	41.9	135.6	1	856
1996	43	56.0	33.6	78.3	1	345
1997	67	33.9	19.3	48.6	1	365
1998	103	36.0	28.1	43.9	0	195
1999	131	42.5	32.4	52.6	0	406
2000	90	65.8	47.4	84.2	1	487
2001	85	67.5	48.5	86.6	4	409
Total	676	57.1	50.0	64.1	0	856

The mean age of patients on admission to Dryad ward is shown in Table 4.2, according to year of admission, for the 708 (99.0%) cases in which the patient's age could be identified. There was no significant difference between years. The admissions book did not record the gender of patients, but gender could be inferred from the names of 712 (99.5%) of the 715 cases. Of these 414 (58.1%) were female.

Table 4.2. Mean age (yrs) at admission to Dryad ward, 1993-2001.

year	number of admissions	mean (yrs)	95% CI for mean		minimum	maximum
			Lower	Upper		
1993	38	82.1	79.7	84.4	66.0	97.0
1994	75	83.7	82.0	85.3	64.4	100.0
1995	56	82.6	80.6	84.5	66.9	99.0
1996	45	83.0	81.0	84.9	69.8	95.2
1997	71	81.8	79.9	83.8	66.3	98.0
1998	105	83.2	81.7	84.6	67.1	100.0
1999	133	83.6	82.3	84.8	65.0	98.2
2000	89	82.7	81.2	84.2	67.0	100.0
2001	96	80.9	79.2	82.6	61.0	100.0
Total	708	82.7	82.1	83.21	61.0	100.0

The Dryad ward admissions book recorded whether the patient died or was discharged. Table 4.4 indicates that the proportion of patients who were discharged

alive was less than 50% until 1999. Between 1993-5, 80% of admitted patients died on the ward.

Table 4.3. Numbers (%) of admissions followed by death or discharge, Dryad ward, 1993-2001.

year	Outcome		Total
	died	discharged	
1993	29 (80.6)	7 (19.4)	36
1994	59 (84.3)	11 (15.7)	70
1995	42 (80.8)	10 (19.2)	52
1996	31 (70.5)	13 (29.5)	44
1997	48 (69.6)	21 (30.4)	69
1998	64 (61.5)	40 (38.5)	104
1999	58 (43.9)	74 (56.1)	132
2000	35 (38.5)	56 (61.5)	91
2001	39 (45.3)	47 (54.7)	86
	405	279	684

The causes of death of patients of Dryad certified by Dr Barton are shown in Table 4.4. These data were taken from the MCCD counterfoils (see Chapter Three).

Table 4.4. Deaths on Dryad ward certified by Dr Barton

Cause of death							Total
	cancer	*heart*	*stroke*	*bronchopneumonia plus another*	*bronchopneumonia only*	*other*	
1995	2	4	2	15	8	1	32
1996	1	3	5	17	5	1	32
1997	2	11	4	23	6	1	47
1998	3	4	6	15	18	5	51
1999	7	6	5	12	15	4	49
2000	3	2	3	2	6	1	17
2001					1		1
	18	30	25	84	59	13	229

The admissions book recorded brief information about the patient's illnesses at the time of admission. On a few occasions, this information included an indication of the reason for admission, for example respite care. Table 4.5 summarizes the findings. Medical/mental problems refer in the Table to either dementia or a mix of medical conditions with the additional problem of confusion or dementia; "post-op" indicates people who have had a recent operation, most commonly surgery following a fractured hip.

Table 4.5. Numbers (%) cases admitted to Dryad ward with different primary problems, 1993-2001.

Year	Diagnostic group							Total
	stroke	*general medical problems*	*medical/ mental problems*	*heart problems*	*Cancer*	*post op*	*respite care/social admission*	
1993	9 (23.7)	19 (50.0)	6 (15.8)	2 (5.3)	2 (5.3)			38
1994	10 (13.5)	31 (41.9)	14 (18.9)	2 (2.7)	3 (4.1)	14 (18.9)		74
1995	7 (12.5)	23 (41.1)	13 (23.2)		7 (12.5)	5 (8.9)	1 (1.8)	56
1996	1 (2.5)	20 (50.0)	10 (25.0)		7 (17.5)	2 (5.0)		40
1997	4 (5.7)	29 (41.4)	16 (22.9)	5 (7.1)	8 (11.4)	8 (11.4)		70
1998	6 (5.8)	42 (40.4)	11 (10.6)	3 (2.9)	9 (8.7)	23 (22.1)	10 (9.6)	104
1999	10 (7.6)	47 (35.9)	10 (7.6)	6 (4.6)	11 (8.4)	38 (29.0)	9 (6.9)	131
2000	8 (9.0)	38 (42.7)	8 (9.0)	2 (2.2)	10 (11.2)	20 (22.5)	3 (3.4)	89
2001	11 (12.4)	30 (33.7)	16 (18.0)	1 (1.1)	8 (9.0)	9 (10.1)	14 (15.7)	89
Total	66	279	104	21	65	119	37	691

General medical problems were the commonest reason for admission in all years, but the proportion of admissions for other problems varied. Stroke was a relatively common reason for admission in 1993, and dementia with or without other medical problems was also relatively common until 1998. The proportion of patients who had been admitted following surgery increased from 1998, as did admissions for respite care.

The admissions book also recorded information about the source of admission. This information is summarised in Table 4.6. Dolphin Day Hospital is the day hospital based in Gosport War Memorial Hospital.

Table 4.6. Sources of admission to Dryad ward, 1993-2001.

year	home	rest/nursing home	acute hospital	Sultan ward	another ward at Gosport	Dolphin day hospital	
1993	4 (10.5)	2 (5.3)	23 (60.5)	8 (21.1)	1 (2.6)		38
1994	8 (10.7)	2 (2.7)	56 (74.7)	8 (10.7)	1 (1.3)		75
1995	6 (10.9)	2 (3.6)	42 (76.4)	3 (5.5)	1 (1.8)	1 (1.8)	55
1996	2 (4.4)	4 (8.9)	36 (80.0)	2 (4.4)	1 (2.2)		45
1997	3 (4.2)		56 (78.9)	7 (9.9)	3 (4.2)	2 (2.8)	71
1998	13 (12.4)		82 (78.1)	4 (3.8)	5 (4.8)	1 (1.0)	105
1999	19 (14.4)	2 (1.5)	103 (78.0)	1 (0.8)	4 (3.0)	3 (2.3)	132
2000	8 (8.8)	1 (1.1)	76 (83.5)	1 (1.1)	4 (4.4)	1 (1.1)	91
2001	23 (24.5)	2 (2.1)	49 (52.1)	8 (8.5)	12 (12.8)		94
Total	86	15	523	42	32	8	706

Most patients admitted to Dryad ward had been transferred from acute hospitals. Only in 2001 did the proportion of admissions directly from home approach 25%, a finding that is likely to be partly explained by the increase in admissions for respite care (Table 4.5).

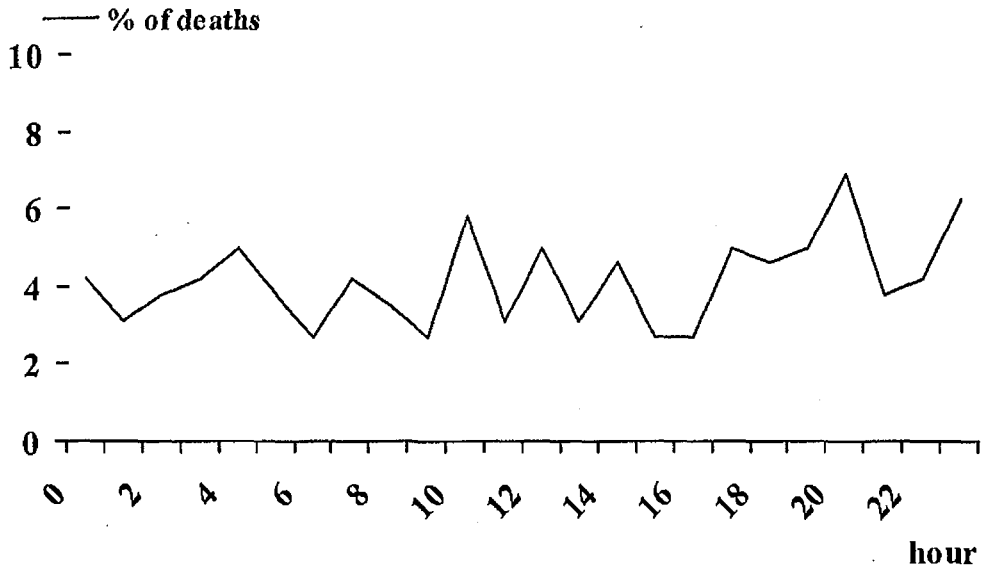
The time of death had been recorded in the admissions book in 260 cases (64.2% of the 405 deaths on the ward). Deaths are reasonably equally distributed among hours of the day (Table 4.7 and Figure 4.1).

Table 4.7. Time of death (data recorded in only cases only).

hour	year of admission									total
	1993	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	
0	1 (5.0)	4 (11.4)		1 (5.9)	1 (3.3)			4 (15.4)		11 (4.2)
1	1 (5.0)	2 (5.7)	2 (6.7)	1 (5.9)		1 (2.3)			1 (4.3)	8 (3.1)
2	1 (5.0)	1 (2.9)	3 (10.0)		1 (3.3)	2 (4.5)	1 (2.9)	1 (3.8)		10 (3.8)
3	1 (5.0)	1 (2.9)			1 (3.3)	2 (4.5)	5 (14.3)	1 (3.8)		11 (4.2)
4		3 (8.6)	2 (6.7)		2 (6.7)	1 (2.3)	3 (8.6)	1 (3.8)	1 (4.3)	13 (5.0)
5	1 (5.0)		1 (3.3)	1 (5.9)	2 (6.7)	2 (4.5)		2 (7.7)	1 (4.3)	10 (3.8)
6			1 (3.3)		2 (6.7)	3 (6.8)			1 (4.3)	7 (2.7)
7	1 (5.0)	2 (5.7)	2 (6.7)	1 (5.9)	3 (10.0)		1 (2.9)	1 (3.8)		11 (4.2)
8		2 (5.7)	1 (3.3)	2 (11.8)	1 (3.3)				3 (13.0)	9 (3.5)
9	1 (5.0)				1 (3.3)	3 (6.8)	1 (2.9)		1 (4.3)	7 (2.7)
10	1 (5.0)	3 (8.6)	1 (3.3)		2 (6.7)	5 (11.4)	2 (2.7)		1 (4.3)	15 (5.8)
11	2 (10.0)		1 (3.3)	1 (5.9)	1 (3.3)	1 (2.3)	1 (2.9)		1 (4.3)	8 (3.1)
12			2 (6.7)	2 (11.8)	4 (13.3)	2 (4.5)		2 (7.7)	1 (4.3)	13 (5.0)
13		3 (8.6)		2 (11.8)	1 (3.3)	2 (4.5)				8 (3.1)
14	2 (10.0)	1 (2.9)			1 (3.3)	3 (6.8)	1 (2.9)	3 (11.5)	1 (4.3)	12 (4.6)
15		1 (2.9)	1 (3.3)		2 (6.7)		2 (5.7)	1 (3.8)		7 (2.7)
16						1 (2.3)	2 (5.7)	2 (7.7)	2 (8.7)	7 (2.7)
17	1 (5.0)	1 (2.9)	2 (6.7)	1 (5.9)	1 (3.3)	2 (4.5)	2 (5.7)	1 (3.8)	2 (8.7)	13 (5.0)
18		2 (5.7)	2 (6.7)	2 (11.8)		1 (2.3)	3 (8.6)	2 (7.7)		12 (4.6)
19	4 (20.0)	1 (2.9)	2 (6.7)	1 (5.9)		1 (2.3)	3 (8.6)		1 (4.3)	13 (5.0)
20	1 (5.0)	2 (5.7)	3 (10.0)	2 (11.8)		1 (2.3)	3 (8.6)	3 (11.5)	3 (13.0)	18 (6.9)
21		1 (2.9)			2 (6.7)	3 (6.8)	2 (5.7)		2 (8.7)	10 (3.8)
22	1 (5.0)	2 (5.7)	2 (6.7)		1 (3.3)	3 (6.8)	1 (2.9)	1 (3.8)		11 (4.2)
23	1 (5.0)	3 (8.6)	2 (6.7)		1 (3.3)	5 (11.4)	2 (5.7)	1 (3.8)	1 (4.3)	16 (6.2)

Total	20	35	30	17	30	44	35	26	23	260

Figure 4.1. The percentage of deaths on Dryad ward, 1993-2001, in each hour of the day (n=260).



Discussion

Some qualifications about the admissions book as a source of date must be noted. There were occasional errors in the book, for example the admissions of some patients had not been entered on the day of admission, and some information was occasionally missing, for example the source of admission. Nevertheless, the book was generally complete, and can be assumed to represent a reasonable description of admissions throughout the period.

The information from the admissions book reveals a changing pattern of cases being admitted to Dryad ward. Most patients were admitted from acute hospitals and with general medical problems, dementia or after surgery. However, from 1998, the proportion with dementia decreased, and there were increases in the proportions of admissions that were for respite care or following surgery. These changes in case

mix are important when interpreting changes in mortality. The proportions of admissions that ended in death declined from 1997. However, the annual number of admissions increased, and consequently the total numbers of deaths did not decrease until 2000. It is not possible to describe in detail the changes in case mix of patients admitted to Daedalus and Sultan wards, but it is almost certain that changes did occur. There may also have been changes in case mix in the period 1988 – 1993 with respect to admissions to Redclyffe Annexe, and the male and female wards. If follows that any comparisons in mortality rates between those in the wards of the Department of Medicine for Elderly People at Gosport or between Gosport and other community hospitals must be interpreted with considerable caution.

More or less similar proportions of patients died in each hour, as would normally be expected. The finding of a predictable distribution of deaths throughout the hours of the day serves to reduce concern about the possibility of sudden death following the administration of lethal drug doses.

Chapter Five: Prescribing of opiate drugs

Introduction

Many of the concerns about deaths at Gosport War Memorial Hospital relate to the use of opiates. The misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 1985 stipulate that registers are kept of the administration of opiate drugs such as diamorphine, morphine and fentanyl. Registers must be bound, and entries must be in chronological order. This Chapter describes an investigation of the information contained in the controlled drug registers retained at Gosport Hospital.

Method

The surviving controlled drugs registers used at the hospital were obtained and reviewed. The relevant registers that were still available are shown in Table 5.1. No data were available from the male ward. Comparisons between wards were possible for some years, although the data were not always complete.

The controlled drug registers contained a record of every dose of opiate drug administered to each patient. It was possible to identify the first and last doses of each drug administered, and the quantity of drug in each dose.

Table 5.1. The periods for which controlled drug registers from different wards were available.

Ward	Dryad	Daedalus	Sultan	Redclyffe	Female ward	Male ward
Period covered by registers	25.6.95 – 5.3.02	6.10.96 – 14.8.02	13.7.94 – 31.10.01	27.2.93 – 28.10.95	30.8.87 – 8.9.94	No register available

Results

1. Numbers of patients who died who received opiates

Information was available from both the MCCD counterfoils (see Chapter Three) and the controlled drug registers, and it was possible to identify those who had received opiates during their final illness by matching counterfoils and register entries. The years 1997-2000 were selected, since the controlled drug register data from Dryad, Daedalus and Sultan were complete for this period. Table 5.2 shows the numbers and proportions of cases given an opiate before death, according to whether the MCCD was signed by Dr Barton or another doctor. A greater proportion of patients of Dr Barton received an opiate (Chi Square = 30.1; df 1, p <0.001).

Table 5.2. Numbers (%) of patients dying 1997-2000 who were prescribed at least one dose of an opiate before death.

Doctor signing MCCD	Opiate prescribed		Total
	yes	*no*	
Dr Barton	211 (74.0%)	74 (26.0%)	285
Another doctor	146 (51.8%)	136 (48.2%)	282
Total	357 (63.0%)	210 (37.0%)	567

Dr Barton was more likely to prescribe an opiate to patients who were certified as dying from bronchopneumonia with other conditions, bronchopneumonia alone, or other conditions (Table 5.3). In the Table, all the certified causes of death have been grouped into the six categories employed in Chapters Two and Three.

Table 5.3. The numbers (%) of patients dying 1997-2000 from groups of conditions who had been prescribed an opiate by Dr Barton or other doctors.

Cause of death	doctor	opiate		total	Sig (df 1)
		yes	*no*		
Cancer	Barton	15 (68.2%)	7 (31.8%)	22	0.2
	Another	78 (80.4%	19 (19.6%)	97	
Heart	Barton	26 (59.1%)	18 (40.9%)	44	0.58
	Another	11 (36.7%)	19 (63.3%)	30	
Stroke	Barton	37 (69.8%)	16 (30.2%)	53	0.19
	Another	16 (55.2%)	13 (44.8%)	29	
bronchopneumonia with other conditions	Barton	64 (76.2%)	20 (23.8%)	84	0.001
	Another	27 (37.5%)	45 (62.5%)	72	
bronchopneumonia only	Barton	57 (83.8%)	11 (16.2%)	68	0.01
	Another	3 (42.9%)	4 (57.1%)	7	
other conditions	Barton	12 (85.7%)	2 (14.3%)	14	0.001
	Another	10 (21.7%)	36 (78.3%)	46	

The analysis in Table 5.3 was repeated for all deaths that occurred in Redclyffe Annexe up to and including 1994. Patients in the Annexe were generally the elderly mentally infirm, and Dr Barton was the responsible doctor at the Annexe until approximately 1994 (see Table 3.9). The findings do not indicate differences in use of opiates between Dr Barton and the other doctors, although none of the other doctors gave bronchopneumonia alone as the cause of death in this period. However, a comparison involving deaths in Redclyffe from 1995 indicates leads to different findings. None of the patients whose deaths were certified by other doctors had received an opiate, although all three of those certified by Dr Barton had (Table 5.5). A test of statistical significance has not been performed since the numbers of cases involved was small. However, there does appear to have been a change in the use of opiates at the end of life at about the time Dr Barton ceased to have principal

Table 5.4. The numbers (%) of patients dying 1993-1994 in Redclyffe Annexe from different causes who were prescribed an opiate by Dr Barton or other doctors.

Cause of death	doctor	opiate		total	sig
		Yes	no		
Cancer	Barton	1 (50.0)	1 (50.0)	2	0.17
	Another		3 (100.0)	3	
Heart	Barton	5 (41.7)	7 (58.3)	12	0.24
	Another	1 (16.7)	5 (83.3)	6	
Stroke	Barton	6 (27.3)	16 (72.7)	22	0.93
	Another	1 (25.0)	3 (75.0)	4	
Bronchopneumonia with other conditions	Barton	41 (33.1)	83 (66.9)	124	0.39
	Another	3 (50.0)	3 (50.0)	6	
Bronchopneumonia Only	Barton	23 (65.7)	12 (34.3)	35	-
	Another	-	-	0	
Other conditions	Barton		10 (100.0)	10	-
	Another		3 (100.0)	3	

Table 5.5. Numbers (%) of patients dying from different causes in Redclyffe Annexe, 1995 or later.

Cause of death		opiate		total
		yes	no	
Heart	other		1 (100.0)	1
	Dr Barton		1 (100.0)	1
Stroke	other		4 (100.0)	4
	Dr Barton	1 (100.0)		1
bronchopneumonia plus another	other		17 (100.0)	17
	Dr Barton	1 (100.0)		1
bronchopneumonia only	other			
	Dr Barton	1 (100.0)		1
	Dr Barton	1 (100.0)		1
Other	other		5 (100.0)	5

responsibility for patients in Redclyffe Annexe. One explanation for this finding is that the type of patients being cared for in the Annexe changed at the same time, but an alternative is that the practice of almost routine use of opiates before death was discontinued.

2. Deaths on Dryad ward

Since information was available about admissions to Dryad ward, including some indication of the reason for admission, and whether the patient was discharged alive or had died on the ward, it has been possible to estimate the proportions of patients admitted with different types of illnesses who received opiates, and whether they died. Those patients who received at least one dose of opiate were included in this analysis.

The findings are summarized in Table 5.6. The illness groups are stroke, general medical problems, medical and mental problems, heart problems, cancer, post-operative cases such as fractured neck of femur, and respite care. Thus, of the 17 patients admitted with strokes between March 1995 and August 1998, 10 died, of whom 8 received an opiate. None of those discharged alive had received an opiate. Some patients in all illness groups received an opiate except for those in the respite care group. Of those who were admitted with strokes, 47% received an opiate, the proportion for general medical problems was 71.7%, medical and mental problems 73.2%, heart problems 71.4%, cancer 66.7 %, and post-operative cases 60.9%.

Some qualifications must be made about these data. First, 10 patients had been recorded as receiving an opiate although the admissions book did not record them

as having been admitted. These patients were omitted from the analysis. The most likely explanation is that these patients were on a different ward, the drugs been transferred between wards. Second, no account has been made of the dose, numbers of doses, type of opiate received or administration route. The data will

Table 5.6. Patients on Dryad ward who received an opiate, March 1995 – August 1998, according to illness group and outcome (died or discharged). N=209.

illness group	had an opiate	Outcome		Total
		died	*discharged*	
stroke	No	2 (22.2)	7 (77.8)	9
	yes	8 (100.0)		8
	total	10 (58.8)	7 (41.2)	17
general medical problems	No	7 (26.9)	19 (73.1)	26
	yes	55 (83.3)	11 (16.7)	66
	total	62 (67.4)	30 (32.6)	92
medical/mental problems	No	3 (27.3)	8 (72.7)	11
	yes	29 (96.7)	1 (3.3)	30
	total	32 (78.0)	9 (22.0)	41
heart problems	No		2 (100.0)	2
	yes	5 (100.0)		5
	Total	5 (71.4)	2 (28.6)	7
cancer	No	5 (62.5)	3 (37.5)	8
	yes	16 (100.0)		16
	Total	21(87.5)	3 (12.5)	24
post op	No	3 (33.3)	6 (66.7)	9
	yes	12 (85.7)	2 (14.3)	14
	Total	15	8	23
respite care/ social admission	No		5 (100.0)	5

Total	5 (100.0)	5

therefore include a number of patients who received only one or two doses, although this would be unlikely to change the general conclusion from the table. Third, it is difficult to judge whether individual patients did have a level of pain that justified the use of opiate medication. Without a case by case review, the appropriateness of opiate medication for each patient cannot be determined.

3. Quantities of opiates prescribed per patient

An analysis was undertaken to compare the total amount of opiate prescribed per patient by Dr Barton and other doctors at Gosport. A random sample of patients who had died, and who had been prescribed an opiate, was identified, from those who had died on Dryad, Daedalus or Sultan wards, and for whom complete data from controlled drug registers were available. A total of 46 patients were included, 21 being patients whose deaths had been certified by Dr Barton, and 25 whose deaths had been certified by other doctors. Seventeen patients had died on Dryad ward, nine on Daedalus ward, and 20 on Sultan ward. The amount of opiate prescribed for a patient was calculated by identifying the number of doses, and quantity of drug in each dose, for each drug administered to each patient. Thus, if a patient had been administered subcutaneous diamorphine 20 mgm per day for three days, the total amount would be 60 mgm.

There was no significant difference in the total amount in mgms of diamorphine recorded as administered during the terminal illness, the mean for Dr Barton's patients being 113 mgms (SD 211 mgms) in comparison with 1300 mgms (SD 3354 mgms) for the other doctors (t-test p 0.13). The mean quantity of oramorph for Dr

Barton's patients was 276 mgms (SD 276 mgms) and for the other doctors 169 mgms (SD 168 mgms) (t-test p 0.6). None of Dr Barton's patients in the sample had received morphine sulphate tables, although seven in the comparison group had. One patient of Dr Barton had received fentanyl, and one patient of the other doctors had received methadone.

Some caution is needed in drawing definitive conclusions from this analysis since it did not involve review of the clinical records, and the sample was small. Nevertheless, the findings do not suggest that Dr Barton's patients had received opiates for prolonged periods.

Discussion

The findings of the review of prescribing of controlled drugs indicate that patients in Gosport Hospital whose deaths were certified by Dr Barton were more likely to have been prescribed an opiate (most commonly diamorphine or oramorph). The excess was most evident among patients who were certified as dying from bronchopneumonia with or without other conditions, or from some other condition that was not cancer or cerebro- or cardio-vascular disease. This finding is a cause for concern, since the use of opiates for pain relief in terminal care is more common in conditions in which pain would be expected, in particular cancer. Furthermore, a high proportion of the initial cases referred to the police by concerned relatives had been certified as dying due to bronchopneumonia. It does appear that the practice of almost routine use of opiates before death in Redclyffe Annexe changed when Dr Barton ceased principal responsibility for patients in the Annexe. This may have been a consequence of a change in the practice followed by the doctors who took

over from Dr Barton, or a change in the mix of patients who were admitted to the Annexe.

The finding that the quantities of opiate prescribed, in the analysis of a random sub-sample, did not indicate that Dr Barton had prescribed opiates over prolonged periods is reassuring. However, this finding does not eliminate the possibility that some patients were given opiates unnecessarily. Therefore, the findings of the analyses reported here are consistent with a practice of prescribing opiates to an inappropriately wide group of older patients.

Chapter Six: Analysis of medical certificates of cause of death (MCCDs)

Introduction

This Chapter presents the findings of an analysis of numbers of deaths in general practice certified by Dr Barton. The aim was to determine whether there were greater numbers of deaths than would have been expected, and therefore reasons for concern about the care of patients in general practice. Although most of the review is concerned with deaths in Gosport hospital, it was necessary to be certain that there were no reasons for concern about deaths in the community.

Methods

The data relate to the deaths certified by Dr Barton and a sample of general practitioners chosen because they were caring for similar groups of patients in Gosport at the same time as Dr Barton. There were nine general practices in Gosport, one of which was the practice of Dr Barton and her partners (referred to as the index practice). Levels of deprivation were classified into four levels. In the index practice 6.9% of registered patients were classified in one of the four levels (0.4% in the highest level of deprivation), but in the first control practice 8.4% (2.5% in the highest level) and in the second control practice 7.9% (0.5% in the highest level) were classified in one the deprivation levels. Thus, the comparison practices had a marginally higher proportion of deprived patients. In the index practice, 15.6% of patients were aged 65 years or over; in the first control practice 11.3% and in the second control practice 18.3% of patients were aged 65 years or over. Consequently, the analysis took account of the differences in the age of patients

between practices, but did not account for deprivation since the differences were small.

The MCCDs were identified by National Statistics (see Chapter Two). Deaths from 1993 onwards certified by any of the general practitioners of the three practices were identified using the computer database maintained by National Statistics. Deaths prior to 1993 have not been stored on computer, and therefore a hand search was required of the notifications in the death register of files completed in the registration districts serving the Gosport area (Gosport, Fareham 1, and Havant). The data from these sources had been provided by registrars from the death certificates completed by the general practitioners and additional information provided by the person reporting the death to the registrar (the informant). In this review, information from each death notification was entered into a database for analysis.

The deaths certified by the general practitioners included those that had occurred at home, in nursing homes, or in hospitals, in particular Gosport War Memorial Hospital.

Results

Table 6.1 presents information about the numbers of deaths certified by the sample of GPs who were partners in one of the three practices included in this analysis. The figures for Dr Barton are similar to those identified from certificate counterfoils held at the hospital (see Table 3.2).

Table 6.1. Annual number of deaths, 1987-2002.

year	certifying doctor																						tota
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Dr B	
1987	8	20	7					6	10	11	13			2	15	12	3	9	11		17	2	14
1988	4	8	4					10	12	10	11				5	8	5	5	6	1	15	28	13
1989	4	11	10					20	9	13	14				6	9	8	8	5	2	9	39	16
1990	20	11	7	5				8	17	13	17				10	13	1	4	4			41	17
1991	16	20	13	9				7	5	12	11				11	10	7	5				37	16
1992	5	10	8	18				9	10	8	13				9	10	3	5				36	14
1993	8	10	13	7	3			8	9	7	11	1			5							97	17
1994	4	8	5	9	4			12	4	5	12				9							106	17
1995	7	12	8	9	2			8	10	18	9	13	9		6							81	19
1996	15	9	11	11	7			10	5	9	5	11	9									86	18
1997	7	6	3	10	5	1		19	13	5	9	6	8									92	18
1998	5	9	7	10	5	8		2	13	9	15	12	14									108	21
1999	7	9	4	10	4	12	8	2	9	13	9	1	7									94	18
2000	3	5	5	7	5	11	4		7	6	13	7										35	10
2001	7	17	9	1	1	13	2	1	5	4	6	8	1									5	8
2002	9	8	4	9	5	8	5	7	5	5	5	10											8
	129	173	118	115	41	53	19	129	143	148	173	69	48	2	76	62	27	36	26	3	41	887	251

Deaths in Gosport hospital

Dr Barton's partners provided cover at Gosport hospital during her absences (due to vacations and other reasons). Figures 3.1 to 3.15 reveal periods of one or more weeks in which Dr Barton did not issue a certificate for a patient who had died in Gosport hospital, and one explanation for these weeks is that she was on vacation. A comparison of death certification rates by her partners, relating to patients on Daedalus and Dryad wards during those periods of absence, with certification rates by Dr Barton on the same wards when she was present would be of particular interest. A high death rate when Dr Barton was present and a lower rate when she was on leave would raise questions about the impact of her clinical practice on mortality rates.

However, some difficulties of interpretation might remain since mortality during her absences could in part reflect effects of her practice when present, possibly leading to attenuation of observable differences. Also, the delay of the admission of

seriously ill patients until Dr Barton's return may serve as an explanation for differences in deaths rates between normal and holiday periods. Unfortunately, it has proved impossible to obtain information about the doctors' rota for Daedalus and Dryad wards and the analysis reported below differs from a straightforward comparison in two respects:

a) Since individual wards cannot be consistently identified from the place of death details on the certificates, the analysis relates to deaths from all wards at Gosport certified by Dr Barton or her partners. These include deaths of patients in Sultan ward who would have been under the care of their general practitioner as well as deaths in Dryad and Daedalus wards, under the care of the Department of Medicine for Elderly People.
b) Since records of Dr Barton's rota are no longer available, an indirect method of inferring (some of) these periods of absence has been used, as described below, but the validity of this method cannot be verified directly.

Absence of Dr Barton has been inferred from prolonged periods between consecutive deaths certified by her. Such periods could of course occur by chance even when Dr Barton is present. A variety of period lengths has been investigated. The principal results below are based on periods of at least 14 consecutive days, since use of shorter periods are more prone to error, such as uncertainty over the exact start and end dates.

Rates of certification by Dr Barton, except during those periods in which there was at least 14 days between successive certifications by her, were compared with rates of certification by the seven other practice partners in those same 14+ day periods. Incidence ratios (and 95% confidence intervals) were: 1.67 (0.88-3.59) in 1998, 3.78 (1.91-8.52) in 1999, and 1.25 (0.49-4.11) in 2000. If the three 1998-2000 years were considered together, the incidence ratio was 2.24 (1.47-3.55).

In interpreting these ratios, it is helpful to consider the magnitude and direction of possible biases. End-estimate bias in the 14-day intervals is unlikely to exceed 15% (two end days in 14 days); they could operate in either direction (that is increasing or decreasing the true estimate). If Dr Barton had been absent for periods shorter than 14 days, this will lead to under estimation of her rates. If the 14+ day periods are chance occurrences not corresponding to her absence, her rates will be overestimated, by up to 30%. If, as noted earlier, Dr Barton's practice while present impacted on her partners' certification rates during her absence, the incidence ratio might be reduced.

Taking these factors into account, it is difficult to draw secure conclusions. The incidence ratio in 1999 was markedly raised, and this finding may point to a method for exploring further any potential impact of Dr Barton's clinical practice on mortality rates. It has not been possible to obtain reliable information about holiday periods in this review, but this may be possible in the continuing police investigation, in which case the pilot analysis included here should be repeated using valid holiday data.

Deaths at home or in nursing or residential homes

Table 6.2 presents information relating to deaths at home, or in residential or nursing homes, certified by the same group of GPs. Since Dr Barton was required to care for patients in Gosport War Memorial Hospital, she may be expected to have undertaken a reduced workload in the general practice. The findings indicate that Dr Barton issued fewer certificates than most of the other GPs, although some (probably part-timers, or doctors leaving general practice between 1993-5) issued fewer. This finding is reassuring, since it reduces concern about care given to patients in the community. It is notable that Dr Barton issued no certificates in 2002.

Table 6.2. Annual number of deaths at home or in residential/nursing homes certified by GPs, 1987-2002.

year	certifying doctor																						total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Dr B	
1987	4	13	7					4	6	7	10			2	10	9	3	5	4		10	2	96
1988	1	6	2					9	10	6	8				3	5	4	5	6	1	10	9	85
1989	3	7	7					20	6	5	11				5	6	8	6	3	2	9	9	107
1990	12	6	5	3				7	15	9	11				7	7	1	4	3			3	93
1991	15	15	10	7				7	4	9	9				10	5	7	4				5	107
1992	2	6	6	10				7	8	5	11				6	6	2	4				4	77
1993	5	7	10	5	1			6	7	5	8	1			5							3	63
1994	1	5	4	7	4			9	3	3	10				5							2	53
1995	4	9	6	7	2			8	6	8	7	10	2		3							1	73
1996	10	5	6	8	5			7	3	3	4	6	1									2	60
1997	5	1	1	10	1			15	9	2	6	3	3									6	62
1998	5	7	6	9	1	6		1	8	4	6	9	4									1	67
1999	6	6	3	7	4	10	7		5	4	6	1	5									2	66
2000	2	3	4	4	4	11	2		5	5	7	6										1	54
2001	6	13	8	1	1	11	2	1	2	3	5	7	1									3	64
2002	9	7	3	7	1	7	5	3	4	4	4	7											61
	90	116	88	85	24	45	16	104	101	82	123	50	16	2	54	38	25	28	16	3	29	53	1188

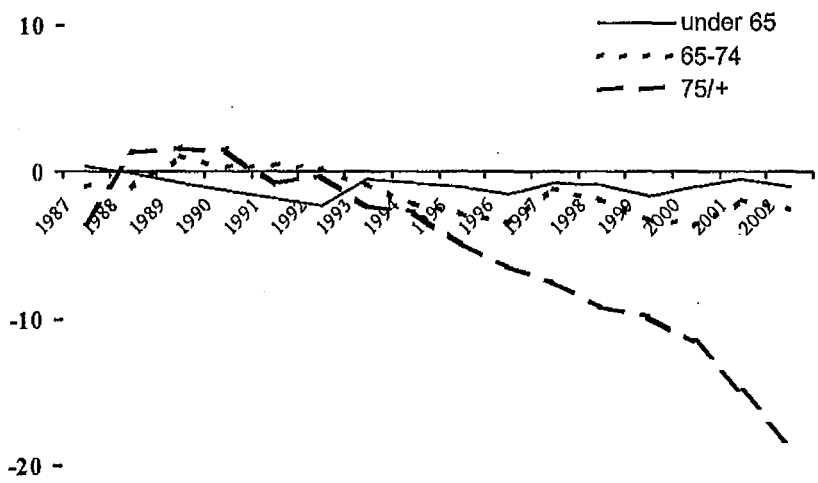
Although Table 6.2 provides some reassurance, a more detailed analysis is required that takes into account the numbers of patients registered with the included general practices. This additional information would enable calculation of the rate of deaths in the three practices, and provide a more meaningful comparison between Dr Barton and other doctors. Information about the numbers of patients registered with each general practitioner was obtained from the Hampshire and Isle of Wight Practitioners and Patient Services. Although the Agency was able to supply information from 1987 onwards about the numbers of patients in three age bands (0-64 years, 65-74 year, and 75 years and over), details on the numbers who were male and female were available only from 1996.

The number of patients registered with a general practitioner is not necessarily an accurate reflection of the number of patients the doctor directly cares for. Within a general practice, some doctors may undertake work outside the practice (as did Dr Barton) and therefore not care for so many patients in the practice. A doctor may

choose to work part-time for other reasons. Therefore, the numbers of patients registered with the doctor were not used in estimating mortality rates. Since detailed information about the work patterns of the general practitioners in the comparison practices was not available, the numbers of patients cared for by each general practitioner was taken to be an equal share of the total practice list size. For example, using this method, in a practice of five doctors and with a total of 10,000 registered patients, the numbers cared for by a single doctor would be assumed to be 2000.

Deaths among males and females combined up to 1995 are shown in Table 6.3 to 6.5, and deaths among males and females separately from 1996 to 2002 are shown in Tables 6.6 to 6.10. Each Table displays the numbers of deaths certified by doctors in the comparison practice, the numbers certified in Dr Barton's practice (the index practice), and the numbers certified by Dr Barton. The Tables also show the numbers of patients registered with the comparison and index practices, and the estimated number under the care of Dr Barton. These data are used to calculate the number of certificates that would have been expected to have been certified by Dr Barton based on the comparison practices, and the difference between the expected number and the number she did in fact certify. In all but two of the Tables, the total of the difference between the numbers expected and observed is less than zero. The cumulative difference between the expected and observed numbers of deaths in the three age bands is displayed in Figure 6.1.

Figure 6.1. The cumulative difference between the observed and expected numbers of MCCDs issued by Dr Barton, 1987-2002. (Deaths occurring at home, or in residential or nursing homes).



By 2002, the total difference between the observed and expected certificates issued by Dr Barton was –0.99 for patients aged 0-64, -2.54 for those aged 65 to 74, and -18.53 for those aged 75 and over. These figures provide further reassurance about the care given to patients in general practice.

Table 6.3. Deaths and death rates/1000 patients under the age of 65 1987-1995 (males and females).

year	Patients in control practices	Deaths in control practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected deaths	Observed – expected, Dr Barton
1987	15376	5	8644	10	.33	1.16	1729	1	.57	.43
1988	15457	5	8569	7	.32	.82	1714	0	.55	-.55
1989	15673	5	8665	3	.32	.35	1733	0	.55	-.55
1990	15490	5	8634	7	.32	.81	1727	0	.55	-.55
1991	13192	4	8644	5	.30	.58	1729	0	.52	-.52
1992	13009	4	8578	2	.31	.23	1716	0	.53	-.53
1993	12933	2	8535	4	.15	.47	1707	2	.26	1.74
1994	13055	1	10819	2	.08	.18	1803	0	.14	-.14
1995	13244	2	10745	4	.15	.37	1791	0	.27	-.27
Total observed - expected										-.94

Table 6.4. Deaths and death rates/1000 patients age 65 - 74 1987-1995 (males and females).

year	Patients in control practices	Deaths in control practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1987	1271	8	783	6	6.29	7.66	157	0	.98	-.98
1988	1315	8	788	9	6.08	11.42	158	1	.96	0.04
1989	1326	8	788	8	6.03	10.15	158	3	.95	2.05
1990	1331	7	785	7	5.25	8.92	157	0	.82	-.82
1991	1176	14	800	6	11.90	7.50	160	2	1.90	0.10
1992	1144	9	805	6	7.87	7.45	161	1	1.27	-.27
1993	1145	7	779	6	6.11	7.70	156	0	.95	-.95
1994	1157	9	986	2	7.78	2.03	164	0	1.28	-1.28
1995	1147	5	993	8	4.36	8.06	166	0	.72	-.72
Total observed - expected										-2.83

Table 6.5. Deaths and death rates/1000 patients age 75 and above 1987 – 1995 (males and females).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1987	1231	38	688	28	30.86	40.70	138	1	4.26	-3.26
1988	1231	31	687	25	25.18	36.39	137	8	3.45	4.55
1989	1234	52	677	31	42.14	45.79	135	6	5.69	0.31
1990	1227	29	667	38	23.63	56.97	133	3	3.14	-.14
1991	1138	46	640	31	40.42	48.44	128	3	5.17	-2.17
1992	1125	23	616	32	20.44	51.95	123	3	2.51	.49
1993	1087	27	622	19	24.84	30.55	124	1	3.08	-2.08
1994	1091	20	753	19	18.33	25.23	126	2	2.31	-.31
1995	1120	28	771	25	25.00	32.43	129	1	3.23	-2.23
Total observed - expected										-4.84

Table 6.6. Deaths and death rates/1000 patients age below 65 1996-2002 (females).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	6978	2	5307	0	.29	0	885	0	.26	-.26
1997	6983	0	5259	2	0	.38	877	0	0	0
1998	7078	1	5094	3	.14	.59	849	0	.12	-.12
1999	7233	2	4981	0	.28	0	830	0	.23	-.23
2000	7311	1	4964	2	.14	.40	827	1	.12	.88
2001	7379	3	4903	1	.41	.20	817	0	.33	-.33
2002	7407	2	4935	2	.27	.41	823	0	.22	-.22
Total observed - expected										-.28

Table 6.7. Deaths and death rates/1000 patients age below 65, 1996 - 2002 (males).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	6426	2	5244	1	.31	.19	874	0	.27	-.27
1997	6475	2	5238	2	.31	.38	873	1	.27	.73
1998	6509	0	5127	1	0	.20	855	0	0	0
1999	6665	4	5058	2	.60	.40	843	0	.51	-.51
2000	6839	2	5048	3	.29	.59	841	0	0.24	-.24
2001	7040	1	5005	2	.14	.40	834	1	.12	0.88
2002	7011	3	5003	0	.43	0	834	0	.36	-.36
Total observed - expected										0.23

Table 6.8. Deaths and death rates/1000 patients age 65 to 74, 1996-2002 (females).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	626	0	521	1	0	1.92	87	0	0	0
1997	620	2	508	0	3.23	0	85	0	.27	-.27
1998	618	3	498	0	4.85	0	83	0	.40	-.40
1999	634	3	508	1	4.73	1.97	85	0	.40	-.40
2000	668	1	533	3	1.50	5.63	89	0	.13	-.13
2001	685	0	535	2	0	3.74	89	2	0	2
2002	699	3	543	0	4.29	0	91	0	.39	-.39
Total observed - expected										.41

Table 6.9. Deaths and death rates/1000 patients age 65 – 74, 1996-2002 (males).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	529	4	461	4	7.56	8.68	77	0	.58	-.58
1997	526	3	472	5	5.70	10.59	79	3	.45	2.55
1998	543	3	457	2	5.52	4.38	76	0	.42	-.42
1999	538	6	450	0	11.15	0	75	0	.84	-.84
2000	552	3	469	2	5.43	4.26	78	0	.42	-.42
2001	577	1	474	0	1.73	0	79	0	.14	-.14
2002	593	2	478	2	3.37	4.18	80	0	.27	-.27
Total observed - expected										-.12

Table 6.10. Deaths and death rates/1000 patients age 75 and above, 1996-2002 (females).

year	Patients in control practices	Deaths in index practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	752	25	471	9	33.24	19.11	79	2	2.63	-.63
1997	731	17	494	15	23.26	30.36	82	2	1.91	.09
1998	730	15	511	13	20.55	25.44	85	0	1.75	-1.75
1999	742	14	491	11	18.87	22.40	82	2	1.55	.45
2000	736	9	492	8	12.23	16.26	82	0	1.00	-1.00
2001	779	22	505	9	28.24	17.82	84	0	2.37	-2.37
2002	770	24	508	7	31.17	13.78	85	0	2.65	-2.65
Total observed - expected										-7.86

Table 6.11. Deaths and death rates/1000 patients age 75 and above, 1996 - 2002 (males).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	371	8	279	3	21.56	10.75	47	0	1.01	-1.01
1997	389	9	273	4	23.14	14.65	46	0	1.06	-1.06
1998	387	7	283	14	18.09	49.47	47	1	.85	.15
1999	408	9	281	8	22.06	28.47	47	0	1.04	-1.04
2000	415	8	280	10	19.28	35.71	47	0	.91	-.91
2001	448	9	293	5	20.09	17.06	49	0	.98	-.98
2002	461	8	308	8	17.35	25.97	51	0	.88	-.88
Total observed - expected										-5.88

Table 6.12. Numbers (%) of patients certified by Dr Barton or other general practitioners dying at home or in residential or nursing homes.

place of death	doctor		total
	Dr Barton	other GPs	
own home	28 (52.8)	533 (47.0)	561 (47.2)
residential or nursing home	25 (47.2)	602 (53.0)	627 (52.8)
	53	1135	1188

There was no significant difference in the proportion of patients who died at home or in residential or nursing homes between Dr Barton and the other general practitioners (Table 6.12). Of the 53 patients of Dr Barton who died at home or in residential or nursing homes, 41 (77.4%) were females in comparison with 648 (57.1%) of the 1135 certified by the other general practitioners (Chi Sq 8.5, $p<0.003$).

Table 6.13. Numbers (%) of patients certified as dying from different conditions (Chi 17.6, df 5, p <0.004).

cause of death	doctor		total
	Dr Barton	other GPs	
cancer	7 (13.2)	248 (21.9)	255 (21.5)
heart	23 (43.4)	336 (29.6)	359 (30.2)
stroke	2 (3.8)	115 (10.1)	117 (9.8)
bronchopneumonia plus	15 (28.3)	219 (19.3)	234 (19.7)
bronchopneumonia alone	5 (9.4)	51 (4.5)	56 (4.7)
other	1 (1.9)	166 (14.6)	167 (14.1)
	53	1135	1188
	53	1135	1188

The mean age of the patients whose deaths were certified by Dr Barton was 76.4 years, and among the patients of the other general practitioners the mean age was 79.6 (not significantly different). Dr Barton certified a greater proportion of cases as due to heart conditions (Table 6.13), although it should be noted that the numbers of cases involved were small.

Discussion

The analyses reported in this Chapter were based on death notifications identified by National Statistics. The number of deaths certified by Dr Barton in Gosport hospital as indicated by these notifications was similar to that identified by the counterfoils of books of MCCDs, and it is reasonable to conclude that information about almost all deaths has been identified.

The findings indicate that the numbers of deaths certified by Dr Barton for patients who died at home or in residential or nursing homes was less than would have been expected if she had cared for the same number of patients as her partners. Since she undertook sessions in Gosport hospital, it is unlikely that she did in fact care for the same numbers of patients as her partners, but the proportion is difficult to estimate without the provision of information from the practice. Since a police investigation is underway, direct contact with the practice was judged to be inappropriate. Therefore, it has been assumed that each partner in the practice was responsible for more or less the same number of patients.

The analysis indicated that the numbers of deaths certified by Dr Barton was less than would have been expected in comparison with the other general practitioners. If Dr Barton had cared for fewer patients than her colleagues, a lower number of certificates would have been expected, and the finding almost certainly reflects the

fact the Dr Barton was indeed responsible for fewer patients than the other general practitioners. Nevertheless, the finding does provide reassurance about care of patients in general practice.

In an additional analysis, an estimate of any effect of holidays and other absences on mortality rates in Daedalus and Dryad wards was attempted. However, the assumptions required in this analysis make the findings of little direct value. Since no information about actual vacations and other periods of absence was available, it is impossible to be confident that the periods in which no certificates were issued occurred because Dr Barton was absent, or whether there were in fact, no deaths to be certified in those weeks. However, if more information about periods of absence can be obtained in the police investigation, this analysis should be repeated.

Chapter Seven: Conclusions

In this audit or review, information has been obtained from a variety of sources about the care delivered to patients of the Department of Medicine for Elderly People at Gosport War Memorial Hospital, including death notifications stored by National Statistics, the counterfoils of medical certificates of cause of death, clinical records, controlled drug registers, and ward admissions books. Whilst there are inevitable reservations about the completeness of these sources, when viewed together they enable conclusions to be reached. In this Chapter, the reservations about the data used in the review are summarised, the findings are outlined, and conclusions are presented. Relevant recommendations are also made.

The sources of information

It has not been possible to undertake a comparison of mortality rates between Gosport and other community hospitals because centrally held Hospital Episode Statistics data do have sufficiently detailed provider codes to identify groups of patients similar to those admitted to Gosport. However, whilst such an analysis would be desirable, I would not expect that the findings would significantly alter the conclusions of this review.

The notifications of deaths provided by National Statistics were a reliable source of information about the numbers of deaths certified by Dr Barton and the comparison general practitioners. Therefore, conclusions based on this information can be regarded as safe. It should be noted, however, that notifications would not have included information about cases certified by coroners. The data provided by National Statistics corroborate the numbers of deaths identified from the counterfoils of MCCDS that had been stored at Gosport hospital. Consequently, the findings from

the analysis of the counterfoils can also be regarded as reliable, although the lack of information about cases investigated by the coroner must be noted again.

The data contained in the controlled drugs registers are likely to have been reasonably accurate and complete, although it is not possible to verify this through comparison with another source. The administration of controlled drug registers must be recorded in registers, and the registers at Gosport did appear to have been maintained correctly. Ward admission books are not required to be maintained to such a standard, and the policy on admission books varied in different wards. Only Dryad ward's book was found to be a satisfactory source of information. The admission books are therefore the source of information about which there should be most caution. Nevertheless, significant weaknesses in the information in the books were not detected during the review, and they probably do represent a reasonable record of the admissions of patients to the ward.

Summary of findings

The investigation of a random sample of records indicated that:

- Patients admitted to Gosport hospital were elderly, had severe clinical problems, and had commonly been transferred from acute hospitals after prolonged in-patient stays. Although some were admitted for rehabilitation, most were believed to be unlikely to improve sufficiently to permit discharge to a nursing home.
- Of the 81 patients in the sample, 76 (94%) had received an opiate before death, of whom 72 (89%) had received diamorphine.
- When administered by syringe driver, diamorphine was invariably accompanied by other medication, most commonly hyoscine and midazolam.

- The mean starting dose of diamorphine was greater than would have been expected if the rule of thumb of giving one third of the total daily dose of morphine had been followed.
- Opiates were used for patients with all types of conditions, including strokes, heart conditions, and end stage dementia.
- There was little evidence of the three analgesia steps recommended in palliative care (non-opiate, then weak opiate, then strong opiate).
- Opiates were commonly prescribed on admission, although not administered until some days or even weeks later.
- Some records failed to indicate that an acute deterioration in a patient's condition had been followed by a careful assessment to determine the cause. Opiates may have been administered prematurely in such cases.
- The records commonly did not report detailed assessments of the cause of the patient's pain.
- The pattern of early use of opiate medication was evident from 1988.
- The records did not contain full details of care. Only 48 (59.3%) contained sufficient information to enable a judgement to be made about the appropriateness of care. In 16 of these, I had some concerns about the indications for starting opiates, the investigation of pain, or in the choice of analgesic.
- Dr Barton did not report recent fractures, including fractured hips, on MCCDs. These cases were commonly reported as having died from bronchopneumonia.

The counterfoils of MCCDs stored at Gosport hospital indicated that:

- Dr Barton had issued 854 certificates from 1987.

- The number of certificates was between 30 and 40 per year between 1988 and 1992, when Dr Barton was responsible for patients in Redclyffe Annexe and some in the male and female wards. The numbers increased to between 80 and 107 per year between 1993 and 1999 when Dr Barton became responsible for patients in Daedalus and Dryad wards.
- Dr Barton issued between nil and six MCCDs per week. There were no clear clusters of deaths.
- Dr Barton was more likely than other doctors to give bronchopneumonia with other conditions or bronchopneumonia only as the cause of death.

The investigation of Dryad ward's admissions books indicated that:

- Of the 684 patients admitted between 1993 and 2001, 405 (59.2%) died in the ward.
- The mean age of the people admitted was 82.7, and around three quarters had been transferred from an acute hospital.
- There was a change in the patients admitted to the ward from around 1997. After that year, there was an increase in the proportion of patients who had been admitted for respite care, and by 1999, the proportion of patients who died had decreased.
- The proportions of patients who died in each hour of the day were as would normally be expected.

The investigation of controlled drugs registers indicated that:

- Patients in whom the MCCDs had been issued by Dr Barton were more likely to have received an opiate before death.

- The greater use of opiates was found in relation to all causes of death except cancer, although when this analysis was confined to patients in Redclyffe Annexe, there were no significant differences between Dr Barton and other doctors.
- Dr Barton did not prescribe opiates to individual patients for longer periods of time than other doctors.

The investigation of MCCDs indicated that:

- The counterfoils stored at Gosport hospital were an accurate record of the deaths in the hospital.
- There was no evidence that more than the expected number of deaths had been certified by Dr Barton. In fact, the number was less than expected if Dr Barton had undertaken an equal share of the workload in general practice.
- A greater proportion of MCCDs issued by Dr Barton were for female patients, and were more likely to have been certified as dying from heart conditions. These findings are probably incidental and are not reason for concern.

Conclusions

Patients admitted to Gosport were elderly and with severe clinical problems. Most had been transferred from acute hospital settings after a period of intensive management, at the end of which it had been concluded that further intensive management would have little or no benefit. Patients were transferred to Gosport either for rehabilitation or for continuing care (defined by CHI as 'a long period of treatment for patients whose recovery will be limited').

In this group of very ill and dependent patients, a practice of liberal use of opiate medication can be discerned from the findings of the review. Patients who

experienced pain, and in whom death was judged to be a likely outcome in the short term, were given opiates. Alternative management with other analgesics or detailed assessment of the cause of pain or distress was generally ruled out. This practice may be described as the almost routine use of opiates before death. The practice was followed irrespective of the principal clinical condition. Patients whose main problems were dementia, strokes, bronchopneumonia or neurological problems all received opiates. A potential explanation is that care was as in advance of care elsewhere in the NHS at the time. General concerns have been raised about the end stage care of people with dementia and other problems, in particular the finding that many such patients have not received adequate analgesia, although they have received antibiotics or other treatments intended to be curative.

However, the proportion of patients at Gosport who did receive opiates before death is remarkably high, and it is difficult to accept that the practice of almost routine use of opiates before death, dating from 1988 or earlier, merely represents clinical practice in advance of practice elsewhere. The practice may be summed up in the words found in many clinical records – 'please make comfortable'. This phrase also points to a prevailing attitude or culture of limited hope and expectations towards the potential recovery of patients in Gosport. But in some patients, a different attitude that might be phrased 'determined rehabilitation' could well have led to a different outcome.

The review of records has raised concerns about the degree of assessment of patients whose condition deteriorated, and the level of consideration given to decisions to commence opiates. Consequently, it is difficult not to conclude that some patients were given opiates should have received other treatment. Only a detailed investigation of individual cases, in which the accounts of witnesses as well

as documentary evidence are considered, can conclude whether lives were shortened by the almost routine use of opiates before death, but I would expect such case by case investigations to conclude that in some cases, the early resort to opiates will be found to have shortened life. I would also expect that in a smaller number of cases, the practice will be found to have shortened the lives of people who would have had a good chance of surviving to be discharged from hospital.

From the evidence considered in this review, it is not possible to determine how the practice of almost routine use of opiates at Gosport originated. Whilst much of the review has focused on the work of Dr Barton, this is because she issued the MCCDs and made most of the entries in the clinical records. However, this should not be taken as meaning that she was the origin of the practice, she may merely have been implementing it. Indeed, the practice may have been introduced before Dr Barton began work in Gosport as a clinical assistant in 1988.

Recommendations

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.

4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to suspect that some patients at the end of life do not receive adequate analgesia.
5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

rom: Code A
ent: 19 Mar 2008 08:46
o: Peter Swain Code A
ubject: Dr Barton

ttachments: Barton GMC Case Protocol stage 5 form.doc
eter,

advance of your meeting with Sarah today, I enclose the minutes from the last Adjudication telephone onference concerning Dr Barton. You will note that the defence have some concerns about the hearing ate, although it is currently maintained.

Code A

rom: Ellson, Sarah Code A
ent: 27 Mar 2008 11:45
o: Code A ; Hall, Tamsin
ubject: RE: Dr Barton
orry to cut across - I agree 2 hours will be fine.

iven Tamsin's work to get some nurses "on board" for our case we will need to be mindful of how we onduct this meeting - we cannot be seen to pass on matters confidential to the GMC case particularly it might undermine the confidence of some of our witnesses. On the other hand it is worth knowing ow the NMC intend to proceed.

Ve should be aware that such a meeting will be minuted by both NMC and GMC and whilst onfidential for the time being could ultimately be the subject of an FOI request.

arah Ellson | Partner
or Field Fisher Waterhouse LLP
Code A

---

rom: Code A
ent: Thursday, March 27, 2008 11:42 AM
o: Hall, Tamsin
c: Ellson, Sarah
ubject: RE: Dr Barton

hanks, do you think that two hours is sufficient to reserve a room for?

---

rom: Hall, Tamsin Code A
ent: 27 Mar 2008 11:37
o: Code A ; Ellson, Sarah
ubject: RE: Dr Barton

li Juliet

es, I am free on 16 May. A 9:30 start would be good for us, and the GMC offices would be an excellent ocation for us.

have met with quite a few of the nurse witnesses in the case and they are, understandably, concerned bout potential NMC action.

egards

amsin

amsin Hall | Solicitor
ır Field Fisher Waterhouse LLP
Code A

Code A

---

rom: Code A
ent: Thursday, March 27, 2008 9:12 AM
o: Ellson, Sarah; Hall, Tamsin
ubject: RE: Dr Barton

arah,

's unclear what the purpose of the meeting is from the NMWC point of view, so it maybe best to have you oth present as you suggest.

amsin - could you let me know if are also free on 16 May and if so what time you would like the meeting) start, so that I can check if we have any rooms available.

hanks Code A

---

ro Ellson, Sarah Code A
ent: 26 Mar 2008 16:17
o: Code A ; Hall, Tamsin
ubject: RE: Dr Barton

Code A

presume we want a face to face meeting in London in which case the two most suitable dates or me would be Friday 25 April in the morning - I could be down from 9am but have another neeting in the office at 12:30, or Friday 16 May at any time (I will be down the day before and o not have to return to Manchester).

this is a fairly high level meeting about the principles of working together etc you may only eed me to attend but if we want to get into the detail it would be helpful to have Tamsin with s, in which case the 16 May date be best (Tamsin will need to confirm).

arah Ellson | Partner
or Field Fisher Waterhouse LLP
Code A

onsider the environment, think before you print!

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
/eb www.ffw.com **CDE**823

rom: Code A
ent: Wednesday, March 26, 2008 4:04 PM
o: Ellson, Sarah; Hall, Tamsin
ubject: Dr Barton

arah,

ark Mallinson from the Nursing and Midwifery Council just rang me to advise that their lawyer laire Strickland would like to meet to discuss the case.

laire is currently available on the following dates;

pril

7, 22, 23, 25 and 28

lay

, 6, 7, 12, 15, 16, 20, 27 and 30.

lease let me know your availability and times, I'm not available on May 1, 9 or 12.

uliet

ieneral Medical Council

t James Building, 79 Oxford Street Manchester. M1 6FQ

:egents Place, 350 Euston Road, London. NW1 3JN

'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
'ax: 0845 357 9001

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:egents Place, 350 Euston Road, London. NW1 3JN

'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

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'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
ax: 0845 357 9001

rom: Hall, Tamsin Code A
ent: 02 Apr 2008 17:37
o: Code A
c: Watson, Adele
ubject: Meeting with counsel next week / Black latest reports

ttachments: DOCS_7226650_1.DOC; DOCS_7209340_1.DOC

i Juliet

lease find attached the draft reports on Stevens and Purnell I have received from Black.

nave arranged to meet with Ben and Tom next week to discuss these on a preliminary asis and sort out some more administrative details regarding witnesses. I was not nticipating that you attend as it is not a con as such - we think we will probably need to sit own later in the month with Professor Black and it would be useful for you to attend that. I ant[illegible] meet with Ben face to face and pore over the witness evidence we have gathered to ee if we can come up with a more definitive list of who we need to call. This should enable s to plan more effectively for the telecon later in April and be able to provide the defence ith a more realistic time estimate.

have now visited the Healthcare Commission - and they have sent me copies of their ocuments. It is currently being copied and will be sent out shortly.

am now away on holiday until 9 April so please call Adele if you have any queries.

egards

amsin

am[illegible]n Hall | Solicitor
or Field Fisher Waterhouse LLP
Code A

Code A

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
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/e use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with quivalent standing and qualifications.

Jean STEVENS
DOB: Code A
Died: 22/05/1999

SUMMARY OF CONCLUSIONS

Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with severe left hemiplegia , probable myocardial infarction and continued myocardial ischemia.

She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

There is some evidence of poor medical practice in Haslar.

Documentation and management of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records, and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT.

(The numbers in brackets refer to the page of evidence. For the three volumes: number / 1, number / 2 and number / 3)

3.1. Jean Stevens was a 72 year old lady at the time of her death in the Gosport War Memorial Hospital on 22 May 1999. She had a long past medical history including diverticular disease diagnosed in 1982 (24/1), appendisectomy in 1967, various arthritic pains, atrial fibrilation from 1994 (854/2), asthma needing inhalers and a gastric ulcer in 1994 (753/2).

3.2. However as a result of abdominal pain she undergoes a Sigmoid colectomy in 1995. This is complicated by what is eventually found to be an colo-vaginal fistula and she undergoes a further laparotomy (135-36/1) after which she is very ill and needs a period of time in the intensive care unit. However, she does eventually return home although continues to get chronic abdominal pain with normal investigations (113/1) including a normal CT (121/1) and is finally referred to the pain clinic for her chronic abdominal pain although she does not receive the appointment before her final admission to Hasler.

3.3. 26th April 1999 she is admitted acutely to Hasler Hospital through the A&E department for both the onset of a left hemiplegia together with constant chest pain (114-117/1). The medical notes document her stormy admission (174-205/1). On 28th April she has chest pain with both EGC and cardiac enzyme abnormalities (179/1) suggesting an acute myocardial infarction and is admitted to the coronary care unit. Subsequently she has probable aspiration pneumonia on 30th April (183/1) and possibly a further MI, certainly with more chest pain on 5th May (192/1).

3.4. Nursing notes confirm her serious condition. On 5th and 6th May she is agitated and distressed needing doses of Diamorphine. On 6th May she is seen by Dr Lord (194/1) who finds her extremely unwell and certainly not fit for rehabilitation or transfer to the Gosport War Memorial Hospital. She has more chest pain on 10th May (197/1) and the family are seen on 12th May and the poor prognosis is explained (200/1). On 12th May she is reviewed by Dr Tandy (67/1) who notes she has a dense flaccid hemiplegia and very dysarthric speech although she can obey simple commands. She is tolerating naso-gastric feeding but because of her recent chest pain was certainly not stable for transfer yet.

3.5. The nursing notes said that she was stressed and agitated on 15th May (95/1) and required subcutaneous Diamorphine, however, on 16th May (98/1) she slept well without it. On 17th May she is very demanding and continually disturbing other patients with calling out. On 18th May she has general aches and pains despite regular Co-codamol, although on 19th May (91/1) she is settled and slept all night. Her blood tests confirm her poor health with a very low albumin of 23 and a raised white cell count of 16 (201/1) on 13th May. She remains pyrexial on 17th May with crepitations at her left base and an albumin of 22 and a white cell count of 14 (203/1).

3.6. She is transferred after discussion with the Gosport War Memorial Hospital (GWMH). But the transfer letter written on the 19th (69/1)

fails to mention that she is receiving regular Co-dydramol, although it does state she is on Diamorphine 5 mgs subcutaneous PRN for pain.

3.7. The drug chart from Haslar appears on pages (71-72/1) and (550-560/2). She is written up for Diamorphine 2.5mg IV 4hourly PRN on the 1st May, changed to 5mg SC PRN from the 13th May and receives 12 doses in total between the 5th of May and the 16th May. She is also written up for Co-codamol 2 tablets QDS on the 26th April and receives regular doses until the 29th April. Co-dydramol is started on the 17th May and continues until the 19th. According to the drug chart no drugs of any sort are given on the morning of the 20th May, the day she is transferred.

3.8. The medical receiving notes on 20th May (20/3) comprise a brief summary starting with "transfer to Daedalus Ward 555K". It documents that she had a left dense hemiplegia, her past medical history and her current Barthel. Her examination is recorded. So there is no other medical note and the next note is a nursing note on 22nd May verifying death by a nurse. I do not understand the 555K note.

3.9. The nursing cardex records her transfer at 1340 on 20th May. It records her NG feeding and slurred speech but Mrs Stevens appeared quite alert and aware of her surroundings (26/3). A Barthel is recorded at 1 (32/3), a Waterlow of 25 (30/3) and an abbreviated mental test score of 4 out of 10 (33/3). The nursing contact sheet starts on 21st May (34/3) at 1130. It is possible that the contacts sheet for the 20th May is missing. This sheet records that "now on regular (4 hourly Oramorphine 10 mgs in 5 mls)". At 1800 she has been "uncomfortable despite 4 hourly Diamorphine. Husband seen and care discussed, very upset, agreed to commence syringe driver at an equivalent dose to Oramorphine with Midazolam, aware of poor outlook but anxious that medication given should not shorten her life. At 1945 commenced syringe driver". On 22nd May condition deteriorating, very bubbly, on Hyoscine 800 mgs added to 20 mgs of Diamorphine and 20 mgs Midazolam. With Hyoscine increased to 1600 is very bubbly at 1020 (35/3).

3.10. The handling profile (42/3) under the client risk factor 'pain' states "abdominal pain". The nursing care plan of 20th May (58/3) documents problems with the nasal gastric tube and the night care plan (60/3) states that on 20th May, Oramorphine 2.5 mls given as per cardex, complaining of pain in stomach and arm.

3.11. The drug chart has Oramorphine in 10 mgs in 5 mls, oral 5 mgs 4 hourly enough to start on 21st May, however, only two doses are given at 1000 and 1400 and the other doses are omitted. It also has

Oramorphine 10 mgs in 5 mls for 10 mls nocte to start on 21st May also written as a regular prescription but again this is never given. Oramorphine 10 mgs in 5 mls orally 2.5 – 5 mls 4 hourly as required is written up on 20th May, 5 mgs are given on 4 doses as documented in Table 1. Diamorphine 20 – 200 mgs S/C in 24 hours is written up on 20th May on the as required part of the drug chart and started at 1920 on 21st May, 0830 on 22nd May and restarted again with the increase of dose of Hyoscine at 1030 on 22nd May. Midazolam 20 – 80 mgs subcut in 24 hours in written up on 20th May as required and 20 mgs is started at 1920 on 21st May at 0800 on 22nd May and again restarted at 20 mgs at 1030 on 22nd May.

TABLE 1

Drug	Prescribed as	Prescriber	Given Doses
Diamorphine 2.5 mg IV PRN 01/05 changed to: 5mg SC PRN 13/05	As required	?	05/05 x1 06/05 x2 08/05 x2 09/05 x1 10/05 x1 12/05 x1 13/05 x1 15/05 x2 16/05 x1
Oramorphine 10 mgs in 5 mls For 10mls nocte to start 21/05	Regular	BARTON	Never given
Oramorphine 10 mgs in 5 mls Oral 5 mls 4 hourly to start 21/05	Regular	BARTON	21/05 1000 10mgs 21/5 1400 10mgs (other doses not given)
Oramorphine	As required	BARTON	20/05 1430 5 mgs

10 mgs in 5 mls Oral 2.5 – 5 mls 20/05 4 hourly	(PRN)		20/05 1830 5 mgs 20/05 2245 5 mgs 21/05 0735 5 mgs
Diamorphine 20 – 200 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 1920 20 mgs 22/05 0830 20 mgs 22/05 1030 20 mgs
Midazolam 20 – 80 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 1900 20 mgs 22/05 0800 20 mgs 22/05 1030 20 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Jean Stevens, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Stevens was 72 at the time of her final admission to the Gosport War Memorial Hospital although she had long standing cardiac and gastrointestinal problems and had been very seriously ill needing intensive care during 1995. She also had chronic unexplained abdominal pain and with recent negative investigations she had been referred to a chronic pain clinic for management.

4.3. However, her acute admission was with a severe and dense left sided stroke on 26th April. She had also had constant chest pain that day and when she had further chest pain on 28th April, it seems likely that she had a definite myocardial infarction simultaneously with her stroke. She then suffered from probable

aspiration pneumonia and was extremely ill for several days including having further chest pain.

4.4. Nursing and medical notes document that the family is seen and indeed the medical staff think that it is likely that she is going to die. Certainly she is restless and distressed and in my view probably clinically unstable certainly until 17th May as she still had abnormal signs in her chest, pyrexial and had a raised white count with a very low albumin. There is to be no doubt that her prognosis was extremely poor both from the likelihood of surviving or even getting significant improvement from her stroke.

4.5. During her admission to Hasler she is written up on the PRN side of the drug chart for 2.5 ms IV then 5 mgs SC PRN of Diamorphine. This would be a standard regime for people suffering myocardial infarction with recurrent cardiac pain. The drug is given on a number of occasions in Haslar sometimes for pain and sometimes for non-specific distress, judging from the nursing cardex. It would be perfectly appropriate to use this dose of Diamorphine if she was getting recurrent pain as it would not be possible to intervene in other ways because of her stroke. It seems likely that a clinical management decision (not recorded) was made on the 17th May to stop using Diamorphine and restart a regular oral analgesic, Co-dydramol, given via the NG tube. No further doses of Diamorphine are given in Haslar after 00.10 early on the morning of the 16th May.

4.6. She is seen on two occasions by Geriatricians, who both think she was unstable at that time and not yet suitable for transfer. I would strongly agree. Indeed there is then a further a discussion before it is agreed that she will go to the GWMH. In my view she was likely to be still unstable and it will have been clinically prudent to keep her for another week in Haslar. There can be no doubt that she is getting continued pain. She is written up for 6 hourly Co-dydramol which she received 4 times a day for the 2 days before her transfer to GWMH.

4.7. The drug chart appears to show poor prescribing practice at Haslar as the dose of Diamorphine is not written in words as well as figures nor is the total dose to be given written on the drug chart. There is no evidence she was given her regular medication, including oral analgesia, on the morning of her transfer and the Co-dydramol is not mentioned on the transfer letter.

4.8. There is a summary of the clinical problems functional status upon arrival at GWMH but it is not clear from the notes whether the

patient was examined, and if she was, the examination was not recorded. There is no medical assessment on whether or not she is pain, and if she is in pain why she is pain, nor of her clinical status upon arrival in particularly as she had been so ill recently. In my view this is poor clinical practice.

4.9. She is not written up for the Co-dydramol that she was on regularly at Haslar although it was not mentioned in the transfer letter. On the PRN part of the drug chart doses of Oramorphine are written up orally and a large range of Diamorphine and Midazolam is written up as required There is no documentation in the medical notes at Gosport War Memorial Hospital as to why these drugs were written up upon admission without apparently a clinical assessment of her pain or clinical status. Nor is there any explanation of why no other analgesics apart from strong opiates were prescribed. One note in the nursing cardex refers to abdominal pain which of course may have been the same pain that she had for many years prior to her admission. In general the Diamorphine she had received at Hasler had been for chest pain and further angina. There is no evidence in the medical or nursing cardex that she has any acute cardiac problems or angina in GWMH. In my view this management was poor clinical practice

4.10. She receives her first dose of Oramorphine at 1430, only 45 minutes after the nursing cardex records her arrival and then receives a further 3 doses until the morning of 21st. It is not clear whether it was a nursing or medical decision to actually give the Oramorphine.

4.11. On 21st May a decision is made that she is dying and she should be for symptom control with a syringe driver. Including the two doses given on the morning of 21st May she had received in total 40 mgs of Oramorphine in a 24 hour period. In these circumstances and assuming the patient was still distressed then it would be reasonable to start with 20 mgs of Diamorphine in a syringe driver over 24 hours. However, in my view it is unacceptable clinical practice to give the doses of Oramorphine in the first 24 hours after her arrival and start the syringe driver without making and recording a clinical assessment in the medical notes.

4.12. There are significant irregularities with the drug charts. Oramorphine has been written up on the regular side of the drug chart but not actually prescribed with no note to say why. A large range of Diamorphine is written up on the PRN part of the drug

chart before it is required and it is not written in words or figures nor is the total dose written.

4.13. Midazolam is a sedative which can be suitable for very restless patients and is usually given initially in a dose of 20 mgs in 24 hours although some people believe the dose should be much lower (5 – 20 mgs in older people, in particular the most frail). There is nothing in the notes to explain why it was thought that both Midazolam and Diamorphine were required in this patient. In my view the regular doses of Oramorphine and then the syringe driver together with the 20 mgs of Midazolam would have given a risk of over sedation for example causing respiratory depression in this lady who already had severe heart, lung and neurological disease.

5. OPINION

5.1. Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with a severe left hemiplegia, probable myocardial infarction and continued myocardial ischemia.

5.2. She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

5.3. There is some evidence of poor medical practice in Haslar. In particular:

- Use of the drug chart in Hasler with the failure to write controlled doses of drugs in word and figures as well as the total dosages to be given.
- The apparent failure to give her regular medication, including oral analgesia, on the morning of her transfer to the GWMH.
- The failure to document the regular Co-dydramol in the transfer letter.
- The early transfer of a patient who had been seriously ill and clinically unstable to the short period before transfer.

5.4. Documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- Lack of a documented medical assessment on admission.
- Lack of any recorded assessment of her clinical condition and in particular her source of pain.

- Starting regular opioid analgesia within an hour of admission and a syringe driver within 24 hours of admission ,without any medical records of justification for either regular strong opioid analgesia or a syringe driver .
- The failure to prescribe any analgesia other than the strong opiate analgesia on admission to the GWMH.
- The lack of a written justification requiring both Diamorphine and Midazolam in the syringe driver.

5.5. The use of the drug chart in the Gosport War Memorial Hospital is also significantly in deficient. In particular:

- The failure to give regularly the drugs prescribed on the regular side of the drug chart without explanation in medical or nursing notes.
- Prescription of a large range of a controlled drug in the "as required" side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I

subsequently consider that the report requires any correction or qualification.

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

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature: _____ Date: _____

rom: Code A
ent: 03 Apr 2008 15:28
o: Code A
c: Code A Tamsin Hall ffw (formerly Tomlinson) Code A
ubject: Meeting
ear Mark,

urther to our telephone conversation today thank you for confirming that Claire is able to attend the eeting to discuss the Gosport War Memorial Case on the 16th.

ne details of the meeting are:

ate: 16 May 2008
me; 9.30 to 11.30
enue: GMC, Room 2.18, Second Floor, 350 Euston Road, Regents Place, London NW1 3JN

lea ask Claire to report to our ground floor reception when she arrives.

will be attending the meeting as well as our Solicitors, Sarah Ellson and Tasmin Hall.

would be grateful if you would let me know if anyone else from the NMC will accompany Claire.

lease acknowledge receipt of this email.

/ith kind regards
Code A

'rom: Code A
ent: 21 Apr 2008 16:30
'o: 'Hall, Tamsin'
:c: Code A
ubject: RE: Ltr to Ian Barker MDU 21.04.08.DOC
amsin,

hank you for the draft letter and comments.

ı respect of Jean Stevens and Edna Purnell the final decision rests with Peter as to how to proceed and ıe may decide that despite Professor Black's criticms in the Stevens case we do not need to add further llegations in order to prove our case or he may decide that it should be added, in light of this I have ıade an amendment to your paragraph below.

Please find enclosed with this letter the expert reports of Professor Black regarding patients ean Stevens and Edna Purnell. We also enclose the generic report of Professor Black.

Ve have disclosed Professor Black's report concerning Jean Stevens and Edna Purnell to the ;MC and await their instructions, which we hope to receive later this week.

~~Ve have advised the GMC to include Jean Stevens within the charges.~~
~~he Draft Notice of Hearing is currently with the GMC for amendment to include these charges.~~ Please nd enclosed with this letter, by way of disclosure, the witness statement of Mr Ernest Stevens. We do nc urrently have any other witness statements regarding Mrs Stevens.

will discuss with Peter on Wednesday:

. How to proceed with the Stevens and Purnell cases

. Whether we want to risk the hearing going part heard

. Who should sign off letters to the families.

suspect that the defence will require a further telecon due to outstanding matters such as finalised ′itness statements and our pharmacist's report.

Code A

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rom: Hall, Tamsin Code A
ent: 21 Apr 2008 15:54
o: Code A
ubject: Ltr to Ian Barker MDU 21.04.08.DOC

s promised, here is my draft letter to the defence.

particularly wanted to check you are happy with the section I have left in italics regarding Jean tevens.

lso, please note that we do have a lot of witnesses to get through. We are hoping that the efence will agree much of the evidence and some of the witnesses will not take too long on the and. However, we do have some concerns about the 8 week listing potentially which I wanted flag up now.

/e don't think that we need to alter the listing at this stage but will need to keep an eye on this. s we have 'booked' Counsel and the expert it would perhaps be preferable to take the risk of oing part-heard so as not to lose the September start. I would be grateful for your thoughts.

lso, need to discuss with you notifying the families of the patients as to whether their cases ill be proceeding. I wondered if you would like the letters to go out from Field Fisher /aterhouse or from the GMC? (Either way I am, of course, happy to draft the letters)

hanks for looking at this letter, I would like to send it over to the defence this evening.

amsin

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP
Code A

Code A

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E/Committee/PCC/Listings/GMC Case Protocol stage 5 form

GMC Case Protocol - Stage 5 Telephone Conference

Attendees:
Sarah Ellson & Tamsin Hall, Field Fisher Waterhouse
Ian Barker, Medical Defence Union
Code A GMC Investigation Officer
Rebecca Faulkner, GMC Adjudication Team

Case: Dr Barton

Conference date:4 March 2008 @ 10:00am

Areas to be covered

	Action	Outcome
1.	Stage 3 actions complete? If no, please record below actions and timescale for completion Draft notice was disclosed on 3 March. All used material and expert reports in the possession of the GMC has also been disclosed. However a significant amount of documentation is still awaited by Defence (including boxes- possibly 25- of unused material, also production, police & witness statements, and further expert reports). Defence state,without prejudice, due to the slippage in timescales, their preparation time is reduced and whilst they will endeavour to meet the current hearing schedule, it may not prove possible. Parties are in agreement to maintain the set hearing date, but to keep matters under close review. A further telecon has been arranged for **10:00am on 22 April** for parties to check progress. It is hoped that by this stage GMC will be able to confirm whether the additional cases will be included. Parties agreed to discuss a date for the disclosure of unused material (including a substantive reply by GMC) outside of the conference.	No
2.	Any outstanding procedural or legal issues? If so, please record below As above	As above
3.	Are you aware of any health issues regarding the doctor, which may affect the planned hearing date for this case	TBC
4.	Confirm hearing date	8 Sep- 31 Oct 08
5.	Confirm time estimate Non sit day on 8 October (at panellist request) Agreed by parties.	39 days

6.	Confirm location of hearing	London
7.	Check whether there will witnesses giving evidence via video link up. If so check where they will be giving evidence from i.e Country or location in UK	TBC
8.	Check whether facilities are required i.e: Video player / tape player etc	TBC

rom: Code A
ent: 14 Apr 2008 12:52
o: Code A
c: Code A
ubject: RE: Meeting

nportance: High
ear Mark,

s Sarah and Tamsin will be travelling from Manchester for this meeting, I would be grateful if you would cknowledge receipt of the email below.

/ith thanks
Code A

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ro Code A
ent: 03 Apr 2008 15:28
o: Code A
c: Code A
ubject: Meeting

ear Mark,

urther to our telephone conversation today thank you for confirming that Claire is able to attend the ieeting to discuss the Gosport War Memorial Case on the 16th.

he details of the meeting are:

ate: 16 May 2008
ime: 9.30 to 11.30
en GMC, Room 2.18, Second Floor, 350 Euston Road, Regents Place, London NW1 3JN

lease ask Code A to report to our ground floor reception when she arrives.

will be attending the meeting as well as our Solicitors, Sarah Ellson and Tasmin Hall.

would be grateful if you would let me know if anyone else from the NMC will accompany Code A

lease acknowledge receipt of this email.

/ith kind regards
Code A

GMC

V

Dr Barton

Advice re: Patient Edna Purnell

1. I have been asked to consider whether it is appropriate to include in the Notice of Inquiry allegations relating to the treatment of this patient.

2. I have reviewed the documentation sent to me which included the statement and exhibits of Mr Michael Wilson. Unfortunately some of the even pages of the report by the Health Service Ombudsman have not been copied, however given the conclusions of that report I do not think it necessary to read the report in its entirety before forming the view which I have. I have also received the hospital notes and the report of Professor Black.

3. Having read the relevant material I do not think it appropriate to include charges relating to this patient for the following reasons:

4. The patient was, before her discharge from the Haslar Hospital, thoroughly assessed by Dr Lord who does not paint an optimistic picture in relation to this ninety-one year old patient.

5. Although there is no clear note of a medical assessment upon her arrival at GWMH there is clear documentation in the nursing notes of pain being expressed by the patient.

6. On the 17th November following an angry exchange with the patient's son, there were two full reviews of the patient's treatment by the consultants Dr Brodie and Dr Ried. The patient's management was also discussed with Dr Lord. The notes reveal that the patient was distressed when moved and the prognosis was very poor. According to Professor Black that means that the patient was believed likely to die soon. Symptom control and

support were said to be paramount and Professor Black agrees that that was the appropriate management at that stage of the patient's life.

7. There was further decline noted in the patient's health and on 23rd November when reviewed by Dr Lord the patient was groaning in apparent pain when lightly handled.

8. On the 24th November when Dr Barton prescribes opiates by syringe driver to be started, that was, in Professor Black's expert opinion, appropriate management for the patient.

9. Although the dose of Midazolam prescribed by Dr Barton was high, and risked over-sedation, the patient was by then terminally ill and in the last few days of her life.

10. There is some criticism of the care provided at GWMH such: i) as lack of documentation of initial assessment; ii) the use of strong analgesics when possibly weaker ones would have done the job; iii) the absence of notes in relation to the Midazolam increase. These criticisms are only partially directed at Dr Barton given that two other consultants were also involved in assessing the patient's needs at a relatively early stage in her admission.

11. Given that two other doctor's were closely involved in this patient's care and that Professor Black describes the use of the syringe driver as appropriate in this case, in all of the circumstances my view is that there is insufficient material upon which to base appropriate charges against Dr Barton and I have not therefore drafted any.

Tom Kark

QEB Hollis Whiteman Chambers

Temple, London EC4Y 9BS

11th April 2008

Patient L (Jean Stevens)

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

ii) On 20 May 1999 you prescribed:

a) Oramorphine 10 mgs in 5 mls;

b) Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis;

c) Midazolam with a dose range of 20 to 80 mgs to be administered SC;

iii) You further prescribed Oramorphine 10 mgs in 5 mls as a regular prescription to start on 21 May 1999;

iv) Doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient in 21 and 22 May 1999.

b) You did not properly assess Patient L on admission. This was

i) inadequate;

ii) not in the best interests of the patient;

c) In relation to your prescription for drugs described in paragraph 1 a) ii) and/or iii):

i) There was insufficient clinical justification for such prescriptions;

ii) The dose range of Diamorphine was too wide;

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

d) Your actions in prescribing the drugs described in paragraph 1a) ii) and or iii) were:

i) Inappropriate;

ii) Potentially hazardous;

iii) Not in the best interests of patient L.

ADD PATIENT L TO ALLEGATION RE: INSUFFICENT RECORD KEEPING.

Edna PURNELL
DOB: Code A
Died: 03/12/1998

SUMMARY OF CONCLUSIONS

Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

There is some evidence of poor medical practice in the Gosport War Memorial Hospital

The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient

1. INSTRUCTIONS

To examine the medical records, the statement of Mr Michael Wilson and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT.

The numbers in brackets refer to the page of evidence.

3.1. Edna Purnell was a 91 year old lady at the time of her death in the Gosport War Memorial Hospital on 3rd December 1998.

3.2. Her long standing problems included palpitations, anxiety, vaginal prolapse, herpes zoster, previous right Colles fracture, transient ischaemic episodes and cervical spondylosis (70). She was also noted to have aortic valve disease (118).

3.3. However, her main problem was a dementing illness. Possible early evidence in October 1995 (47) definite evidence by November 1995 (45). Subsequently seen by the psycho-geriatric team on a domiciliary visit in January 1996, a formal diagnosis of dementia of moderate severity is made (37) which is followed up by the psycho-geriatric team and it is clear by October 1997 that she is failing at home (31). Following a probable stroke in October 1997 (21) she moves to Addenbrookes Residential Home and the community psychiatric nurse notes her to be settled in May 1998 (14).

3.4. She is admitted to the Haslar Hospital on 25 October having had a fall and suffered a fractured right neck of femur (58). Unfortunately none of the Hasler notes were available in the medical records provided to me. The only information is her nursing discharge letter (58, 60) and part of her drug chart in the statement of Mr Michael Wilson. The nursing letter states post operatively her condition was very poor and that she remained not for active resuscitation. It also states that she had suffered with senile dementia and required full assistance with washing, feeding although her oral intake had been reasonable with encouragement. Despite the best efforts she had sustained pressure sores on her heels. The letter states that "Mrs Purnell is a challenging patient and wish you every success in her care".

3.5. The drug charts in Haslar notes note that 10 mgs of Morphine were given intramuscularly on 26th October. They also note that Diclofenac was given orally on 30th and 31st October and that soluble Co-codamol (a weak oral opioid) was given up until 5th November. However, as I only have the as required prescription part of that drug chart I cannot comment on whether other oral analgesia was being given on a regular basis.

3.6. Dr Lord visits Mrs Purnell at Haslar on 5th November. The letter documents recent fracture, post operative oedema, poor mobility, faecal and urinary incontinence (with a catheter)and bilateral pressure sores. As a result of her assessment she states that the son and daughter-in-law were present and that she explained to them rehabilitation was going to be very difficult given the mental state and pressure sores, but she would be given a "gentle rehabilitation" in an NHS continuing care bed for a month initially. She might well need a nursing home subsequently.

3.7. On the 11th November she is transferred to Gosport War Memorial Hospital. A problem list is recorded in the medical notes (125) although it is not clear if she is medically examined. She is extremely dependent as documented in the nursing notes (161) and a Barthel of 2 out of 20 (185).

3.8. On the 12th November in the medical notes she " is in pain despite Co-codamol (unreadable word) Oramorphine". The nursing cardex confirms the pain (161) stating "has been complaining of great deal of pain". On 15th November there is an unreadable medical record stating that she is for Diazepam.

3.9. The nursing records document that Mr Wilson has concerns about possible opiate sedation on 14th and there was a discussion about her prognosis and the needs to control her pain. She continues to complain of pain on 15th November (160).

3.10. The nursing and medical notes are extremely detailed on 17th November following a visit to the ward by Mr Wilson who raises concerns about his mother's medical care which leads to a confrontational situation. Mrs Purnell is examined in detail by a Dr Brodie, who finds her semi-conscious with arms and legs flexed and appears in distress when moved. The doctor finds her in distress which need analgesia although her son is not happy for her to receive analgesia. The doctor appropriately discusses her with the consultant, Dr Lord who agrees the plan and for subcutaneous fluids. Another consultant is covering so comes in to assess the patient (Dr Reid) (126 – 127). Dr Reid is also quite clear having assessed her that she is in pain and distress and this must be relieved. He also reports some recent swallowing difficulties, however she continues to receive oral medication until the 22nd November.

3.11. On 18th November (127) she is less well and there is evidence of Cheyne-Stoking respiration and subcutaneous fluids needs to be continued. The assessment is that her prognosis is extremely poor. There appears to be considerable difficulty contacting the son. On 19th she remains poorly but on 20th she is recorded as being comfortable with Oramorphine.

3.12. On 23rd November she is groaning and in pain and frowns when lightly handled. She was taking liquids, Oramorphine and Diazepam the day before. The management plan is to continue sub-cut fluids where appropriate, to use Oramorphine/Diamorphine, Diazepam or Midazolam to keep comfortable and if more than one injection of Diamorphine is required for a syringe driver. The consultant's view is that she is now obviously dying and the management should continue to be to keep her free of pain and distress (140).

3.13. Further medical records confirm further deterioration on 28th November and the 1st December. The record on 28th stating that Mrs Purnell was now on sub-cut analgesia. Death is recorded on 3rd December by a RGN and the final note written subsequently on 18th December states the cause of death was bronchopneumonia and

senile dementia (139). This chronology is also confirmed in the nursing notes. The nursing notes states that on 24th November she was seen by Dr Barton (154) because her condition was deteriorating, she was distressed and reluctant with oral medication that the syringe driver should start. On 25th she continued to deteriorate and it occurred until 27th when her subcutaneous fluids were discontinued. The nursing notes continued to record her deterioration each day with the syringe driver being re-charged. The nursing notes say that Diamorphine was increased to 30 mgs on 1st December (165) although the drug chart says 40 mgs. On the 2nd December she is bubbly and 40 mgs a day of Diamorphine is recorded in the syringe driver. Death is verified at 1130 on 3rd December (166).

3.14. The Gosport War Memorial drug charts are slightly confusing in that there appear to be 3 front sheets (147, 148 and 149). It is possible that an extra front sheet was simply added to a previous drug chart as the space for the "as required" prescription drug box becomes full.

3.15. In summary, two tablets of Co-codamol are prescribed at 0830 on 12th November (which had been written up on admission) thereafter Oramorphine at 10 mgs and 5 mls at a dose of 2.5 – 5 mls is given starting on 12th November when three doses are given and then one or two doses most days until 24th November. There is no particular pattern for the timing of this although on 8 days there is a dose given late at night.

3.16. Diclofenac suppositories are written up on 17th November on a PRN basis but do not appear to be prescribed. Diamorphine is written up on a PRN basis SC/IM by Dr Lord on 23rd November but does not appear to have been prescribed. Diamorphine 20 – 200 mgs sub-cut in 24 hours, Hyoscine 200 – 800 micrograms sub-cut in 24 hours and Midazolam 20 – 80 mgs sub-cut in 24 hours are all written up on the PRN side of the drug chart on 19th November but do not appear to have been given. On the regular side of the drug chart Diamorphine 20 – 200 mgs sub-cut in 24 hours, Midazolam 20 – 80 mgs sub-cut in 24 hours and Hyoscine 200 – 800 micrograms sub-cut in 24 hours are all written up on 24th November. 20 mgs of Diamorphine is prescribed each day until 1st December when 40 mgs is prescribed until she dies. Midazolam 20 mgs is prescribed on 24th November and then 40 mgs each day until the day she dies. Hyoscine 200 micro grams is given on 2nd December and 400 on 3rd December.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Co-codamol 1 – 2	11/11	As required (PRN)	?	12/11 0830
Oramorphine 10 mgs in 5 mls Oral 2.5 – 5 mls	12/11	As required (PRN)	AK	*12/11 1405 5 mgs 1830 5 mgs 2234 10 mgs *13/11 1025 10 mgs 2225 10 mgs 14/11 1030 10 mgs *15/11 0050 10 mgs *16/11 2215 10 mgs *18/11 0105 10 mgs 2015 10 mgs *19/11 2316 10 mgs 20/11 1155 10 mgs 1800 5 mgs *21/11 2315 10 mgs *22/11 0630 10 mgs 2240 10 mgs 24/11 0920 10 mgs * = *Late evening dose on that date*
Diamorphine SC/IM 2.5 mgs – 5 mgs	23/11	As required (PRN)	LORD	-----
Diamorphine	19/11	As required	BARTON	-----

20 – 200 mgs SC in 24 hours		(PRN)		
Midazolam 20 – 80 mgs SC in 24 hours	19/11	As required (PRN)	BARTON	-----
Diamorphine 20 – 200 mgs SC in 24 hours	24/11	Regular	BARTON	24 – 30 Nov 20 mgs daily 1 – 3 Dec 40 mgs daily
Midazolam	24/11	Regular	BARTON	24 Nov 20 mgs daily 25 Nov – 3 Dec 40 mgs daily

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Edna Purnell, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Edna Purnell was a very elderly lady with multiple medical problems although moderately severe dementia was the main functional problem leading to residential care. There is debate in the notes whether this was Alzheimer's or vascular dementia, indeed it is not uncommon for elderly people to have both.

4.3. She was admitted to the Haslar Hospital having had a fall and a fractured neck of femur on 25th October. She was already known to have osteoporosis having previously had a Colles fracture. Unfortunately the prognosis of patients with dementia and a fractured neck of femur is extremely poor, very few return to their previous functional state and an in-hospital mortality rate at 25% is not uncommon. Those that remain immobile and incontinent immediately after the operation have by far the highest mobility

and mortality. Although the notes from Haslar are missing, the nursing summary documents that she remains totally dependent, develops bed sores and is seen as "a very challenging problem". Her dependency is also confirmed by the Barthel of 2 recorded upon admission to the Gosport War Memorial Hospital (GWMH).

4.4. She is thoroughly assessed by Dr Lord in Haslar who also sees the relatives at that time. The letter makes it clear that rehabilitation was going to be very difficult and Dr Lord expects her to remain severely dependent. She has already indicated at this early stage the likelihood of a nursing home placement. Dr Lord does not expect the patient to improve but is giving the family time to come terms with her changed status.

4.5. On admission to GWMH her problems are assessed but it is not clear whether she is medically examined. If she is not I would regard this as poor practice as it fails to give an accurate base line in the notes for future management of her medical problems.

4.6. It is then clearly document in both the medical and nursing notes that she is in considerable pain on 12th November despite the appropriate use of oral co-codamol. There is no medical examination recorded in the notes or any explanation as to where this pain is coming from. If the (incomplete) medical cardex from Haslar is correct she has not received analgesia for 6 days so what has changed? Is the pain coming from her pressure sores, which is very likely, has some other medical condition occurred, for example dislocating her hip during the transfer or some other post-operative complication? Failure to adequately examine the patient to explain her symptoms is poor medical practice. The use of oral strong opioid analgesia after weak opioid analgesia has failed is perfectly appropriate and the doses used are well within recognised standard dosages. However there is no explanation in the notes of why oral weak opioid analgesia is not continued on a regular basis using the stronger opioid analgesia for breakthrough pain. Without explanation I would consider this poor medical practice.

4.7. Mrs Purnell makes no improvement during her time at GWMH and indeed appears to enter a period of slow decline. In Table 1 demonstrates she requires a dose of analgesia most nights to manage her symptoms and allows her to sleep. The causes of decline are often multi-factorial. Her failure to get over the anaesthesia, a possible further vascular event causing swallowing difficulties, poor nutrition, pressure sores from dependency and hypostatic pneumonia. In the presence of multiple other

pathology and old age, a relentless downhill course is not uncommon and it often becomes appropriate to manage symptoms and any distress.

4.8. A crisis occurs on 17th when there is a conflict on the ward between the son and the nursing staff although there had been previous discussions on the 14th. As a result of this there is a very detailed clinical examination undertaken by a Dr Brodie which documents she is semi-conscious, has got arms and legs flexed and appears to be in distress when moved. He appropriately discusses her with Dr Lord and starts subcutaneous fluids. She is then reviewed by another consultant, Dr Reid, in detail who assesses the situation and makes it quite clear that the prognosis is very poor (a statement often put in notes to indicate the consultant believes the patient will die shortly) and that symptom control and support is paramount. I would agree with the assessment and management at this stage.

4.9. Medical and nursing notes then document slow further decline in Mrs Purnell's clinical condition up until 23rd November and she is reviewed by a consultant, Dr Lord. There are detailed notes that she is groaning and in pain and frowns when lightly handled. A clear plan of management is set out in particular if she cannot take medication orally then she should have a syringe driver. I would agree with this management.

4.10. The medication for the syringe driver is written up by Dr Barton on 24th November and starts the same day although there is no record in the medical notes of who actually decided the starting dose in the syringe driver. However in my view a syringe driver was appropriate management at this stage in Mrs Purnell's care. She is started on 20 mgs of Diamorphine in 24 hours together with 20 mgs of Midazolam. As Mrs Purnell had received between 10 and 20 mgs of Oramorphine most days for the previous 12 days I believe this was within the appropriate range of doses to use. Midazolam was also started at 20 mgs in 24 hours. Midazolam is a sedative which can be suitable for very restless patients and is usually initially given in a dose of 20 mgs in 24 hours although some believe the dose should be much lower (5 – 20 mgs) in older people in particular the most frail. She was also on regular oral diazepam at this stage. There is nothing specific in the notes to explain why it was thought that both Midazolam and Diamorphine were required or why a dose of 40 mgs of Midazolam after the first 24 hours was needed. There is a potential risk of over sedation in the last few days although I am certain this lady was terminally ill.

4.11. The use of drug chart is poor. Diamorphine and Midazolam are written up on the PRN part of the drug chart on 19th November but although they are not prescribed there is no documentation in the notes as to why this occurred. A very large dose range is written up on the regular side of the drug chart when a new prescription should have been written for each change in dosage. The dosages of the controlled drugs were not written in words and figures nor was the total dosage to be given made clear in the prescription.

5. OPINION

5.1. Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

5.2. It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

5.3. There is some evidence of poor medical practice in the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical examination on admission.
- The poor assessment of pain and the reason for it on the 12th November.
- The failure to use, or document why not, regular weaker oral analgesia was not used after the 12th November
- The absence of documentation of who made the final decision to choose the dose of diamorphine and midazolam on 24th November and why the dose of midazolam was increased to 40 mgs on 25th November.

5.4. The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient. In particular:

- The prescription of a large range of a controlled drug and both the "daily review prescriptions" and the regular sides of the drug chart.
- The failure to re-write the dose of drugs when changed on the regular side of the drug chart

- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature:_____ Date:_____

Strictly Private & Confidential

FAO Ian Barker
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Our ref: TET/GML/00492-15579/7343749 v1
Your ref:

21 April 2008

Dear Sirs

General Medical Council - Dr Jane Barton

We write prior to the further Stage 5 telephone conference scheduled for Tuesday 22 April 2008.

As previously promised, we have been forwarding all finalised witness statements to you as soon as we have received them from the witnesses.

There are a number of witness statements still awaiting finalisation and we will forward these to you as soon as possible. We would like to state, however, that we do not anticipate that any of the evidence will vary substantively from the evidence contained within the police statements that you already have and the statements will be production statements.

We have met with Counsel and have formulated a provisional list of the witnesses whom we anticipate we will be likely to call.

These are:-

Leslie Pittock – Pt A

1. Dr Victoria Banks (Consultant in Old age psychiatry at Mulberry Ward)

Elsie Lavender - Pt B

2. Alan Lavender (Son)

3. Elizabeth Thomas (Physiotherapist) (See note below)

Eva Page - Pt C

4. Bernard Page (Son)

Alice Wilkie – Pt D

5. Mrs Jackson (daughter)

Gladys Richards – Pt E

6. Gillian McKenzie (daughter)

7. Lesley O'Brien (Previously Richards/O'Brien – daughter)

8. Michael Edmonson (nurse at Haslar)

Ruby Lake – Pt F

9. Diane Mussell (daughter)

10. Pauline Robinson (daughter)

11. Dr Timothy Coltman (Dr at Haslar)

Arthur Cunningham – Pt G

12. Charles Stewart-Farthing (Step-son)

13. Shirley Selwood (friend)

Robert Wilson

14. Ian Wilson (Son)

15. Gillian Kimbley (wife)

16. Dr Ravindrane (was SpR at QAH – now consultant) (Also evidence about Pt G)

Enid Spurgin – Pt I

17. Carl Jewell

Geoffrey Packman – Pt J

18. Betty Packman (wife)

19. Victoria Packman (daughter)

Elsie Devine – Pt K

20. Ann Reeves (daughter)

21. James Reeves (grandson)

22. Dr Ian Reckless (house physician QAH)

Jean Stevens – Pt L (to be included)

23. Ernest Stevens (husband)

24. June Bailey (daughter)

Nurses

25. Carol Ball (Generic)

26. Lynne Barrett (Generic, Pittock, Devine, Lake, Wilson, Spurgin)

27. Margaret Couchman (Lavender, Richards)

28. Tina Douglas (Generic, Pittock, Lake)

29. Sylvia Giffin (Dec'd) (Generic, Richards)

30. Shirley Hallmann (Generic, Lake, Cunningham, Wilson, Packman)

31. Gillian Hamblin (Generic, Devine, Pittock, Cunningham, Wilson, Spurgin, Packman)

32. Sheilagh Joines (Generic, Lavender)

33. Anita Tubbritt (Generic, Devine, Lake, Spurgin, Packman, Richards)

34. Beverley Turnbull (Generic, Devine, Lake, Spurgin, Packman, Richards)

35. Fiona Walker (Generic, Lavender, Pittock, Cunningham)

Miscellaneous

36. Richard Samuel (PCT)

37. DS Roy Stephenson or other member from Hampshire Police

Experts

38. Professor David Black

39. Pharmacy expert (to be confirmed)

Please note that we have not yet made a decision regarding whether or not we will be likely to call Dr Ian Reid, Dr Althea Lord or Dr Jane Tandy. We have met with/interviewed over the telephone all of these consultants and will disclose their draft statements to you shortly.

We are optimistic that you will be in a position to agree the evidence, in part or whole, of a number of the above witnesses. We would be grateful for your early confirmation that this is indeed the case.

We would like to put you on notice that we intend to make an application to read the evidence of Nurse Sylvia Giffin. Unfortunately, since she was interviewed, Mrs Giffin has passed away. We would be grateful for your indication if you are likely to have any objections to this application.

We also would like to put you on notice that we have currently been unable to trace the physiotherapist Elizabeth Thomas. We are making our best endeavours to trace her but fear that we will also have to make an application for her police witness statement to be read.

Please let us know if you would like us to call any of the other witnesses whom we have previously disclosed witness statements to you.

It is our hope that through as much collaboration as possible regarding witnesses we will be able to ensure the smooth running of the hearing in September 2008.

With this in mind, if you have any objections to any of the above witnesses then your early notification would be much appreciated.

Please find enclosed with this letter the expert reports of Professor Black regarding patients Jean Stevens and Edna Purnell. We also enclose the generic report of Professor Black.

We have advised the GMC to include Jean Stevens within the charges.

The Draft Notice of Hearing is currently with the GMC for amendment to include these charges. Please find enclosed with this letter, by way of disclosure, the witness statement of Mr Ernest Stevens. We do not currently have any other witness statements regarding Mrs Stevens.

We would also like to put you on notice that we intend to instruct an expert pharmacist to clarify the generic position regarding prescribing at the relevant period. We have not yet instructed this expert and will, of course, disclose any such report to you as soon as we are in receipt. Please note that we will not be instructing this expert to examine the medical records or comment specifically on any of the charges. This will be a "reference" source of evidence.

We look forward to discussing matters with you further at the Stage 5 telephone conference.

Please do not hesitate to contact Tamsin Hall if you have any comments regarding the above.

Yours faithfully

Field Fisher Waterhouse LLP

Encs

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Dr Bryony Hooper Medicolegal Adviser
LLM BM MRCGP MFPHM DRCOG

MPS

By post and fax Code A

Code A
Fitness to Practise Directorate
General Medical Council
5th Floor, St James's Buildings
79 Oxford Street
Manchester M1 6FQ

Your Reference: TW/C1-5325180
Our Reference: BH/ba/167386/8
Please quote our reference when contacting MPS

21 April 2008

Dear Code A

MPS Member: Dr Michael Davies

I write on behalf of Dr Michael Davies, in relation to your letter to Dr Davies dated 27 November 2007. In that letter, you have stated that the panel has asked that when it reviews Dr Davies' case, the panel would wish to have information from professional colleagues and persons of standing regarding Dr Davies' conduct since the last hearing. You therefore asked for names and addresses to be provided so that the GMC may write to them to request this information.

I apologise for the tardy reply on this point. This was due to a delay in passing on information from Dr Davies to the GMC.

I include below the names of three colleagues of Dr Davies, who would be happy to be contacted by the General Medical Council to provide information regarding Dr Davies' conduct since his last fitness to practise hearing. As time is very short before the forthcoming hearing on 25 April 2008, it may be helpful to point out that Dr Elizabeth Ashley intends to attend the hearing and will be available to give evidence. I have taken the liberty of contacting the other two persons named, and asked them to provide any information of relevance to the GMC at their earliest convenience.

Yours sincerely

Code A
Dr Bryony Hooper
Medicolegal Adviser

Secretary Code A
Direct Telephone
Direct Facsimile
Email
Encs.
cc: **Mr Ian Sadler, RadcliffesLeBrasseur**

MPS

LIST OF NAME

1. Dr Elizabeth Ashley
   Consultant Anaesthetist
   University College Hospitals and the Heart Hospital

   Dr Ashley is also a college tutor.

Code A

2. Dr Andrew Smith
   Consultant Anaesthetist and Department Chair
   University College Hospitals

Code A

3. Dr Ernie Grundy
   Consultant Anaesthetist and Head of School
   UCL Hospital Trust

Code A

Edna PURNELL
DOB: Code A
Died: 03/12/1998

SUMMARY OF CONCLUSIONS

Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

There is some evidence of poor medical practice in the Gosport War Memorial Hospital

The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient

1. INSTRUCTIONS

To examine the medical records, the statement of Code A and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT. The numbers in brackets refer to the page of evidence.

3.1. Edna Purnell was a 91 year old lady at the time of her death in the Gosport War Memorial Hospital on 3rd December 1998.

3.2. Her long standing problems included palpitations, anxiety, vaginal prolapse, herpes zoster, previous right Colles fracture, transient ischaemic episodes and cervical spondylosis (70). She was also noted to have aortic valve disease (118).

3.3. However, her main problem was a dementing illness. Possible early evidence in October 1995 (47) definite evidence by November 1995 (45). Subsequently seen by the psycho-geriatric team on a domiciliary visit in January 1996, a formal diagnosis of dementia of moderate severity is made (37) which is followed up by the psycho-geriatric team and it is clear by October 1997 that she is failing at home (31). Following a probable stroke in October 1997 (21) she moves to Addenbrookes Residential Home and the community psychiatric nurse notes her to be settled in May 1998 (14).

3.4. She is admitted to the Haslar Hospital on 25 October having had a fall and suffered a fractured right neck of femur (58). Unfortunately none of the Hasler notes were available in the medical records provided to me. The only information is her nursing discharge letter (58, 60) and part of her drug chart in the statement of Code A Code A The nursing letter states post operatively her condition was very poor and that she remained not for active resuscitation. It also states that she had suffered with senile dementia and required full assistance with washing, feeding although her oral intake had been reasonable with encouragement. Despite the best efforts she had sustained pressure sores on her heels. The letter states that "Mrs Purnell is a challenging patient and wish you every success in her care".

3.5. The drug charts in Haslar notes note that 10 mgs of Morphine were given intramuscularly on 26th October. They also note that Diclofenac was given orally on 30th and 31st October and that soluble Co-codamol (a weak oral opioid) was given up until 5th November. However, as I only have the as required prescription part of that drug chart I cannot comment on whether other oral analgesia was being given on a regular basis.

3.6. Dr Lord visits Mrs Purnell at Haslar on 5th November. The letter documents recent fracture, post operative oedema, poor mobility, faecal and urinary incontinence (with a catheter)and bilateral pressure sores. As a result of her assessment she states that the son and daughter-in-law were present and that she explained to them rehabilitation was going to be very difficult given the mental state and pressure sores, but she would be given a "gentle rehabilitation" in an NHS continuing care bed for a month initially. She might well need a nursing home subsequently.

3.7. On the 11th November she is transferred to Gosport War Memorial Hospital. A problem list is recorded in the medical notes (125) although it is not clear if she is medically examined. She is extremely dependent as documented in the nursing notes (161) and a Barthel of 2 out of 20 (185).

3.8. On the 12th November in the medical notes she " is in pain despite Co-codamol (unreadable word) Oramorphine". The nursing cardex confirms the pain (161) stating "has been complaining of great deal of pain". On 15th November there is an unreadable medical record stating that she is for Diazepam.

3.9. The nursing records document that Code A has concerns about possible opiate sedation on 14th and there was a discussion about her prognosis and the needs to control her pain. She continues to complain of pain on 15th November (160).

3.10. The nursing and medical notes are extremely detailed on 17th November following a visit to the ward by Code A who raises concerns about his mother's medical care which leads to a confrontational situation. Mrs Purnell is examined in detail by a Dr Brodie, who finds her semi-conscious with arms and legs flexed and appears in distress when moved. The doctor finds her in distress which need analgesia although her son is not happy for her to receive analgesia. The doctor appropriately discusses her with the consultant, Dr Lord who agrees the plan and for subcutaneous fluids. Another consultant is covering so comes in to assess the patient (Dr Reid) (126 – 127). Dr Reid is also quite clear having assessed her that she is in pain and distress and this must be relieved. He also reports some recent swallowing difficulties, however she continues to receive oral medication until the 22nd November.

3.11. On 18th November (127) she is less well and there is evidence of Cheyne-Stoking respiration and subcutaneous fluids needs to be continued. The assessment is that her prognosis is extremely poor. There appears to be considerable difficulty contacting the son. On 19th she remains poorly but on 20th she is recorded as being comfortable with Oramorphine.

3.12. On 23rd November she is groaning and in pain and frowns when lightly handled. She was taking liquids, Oramorphine and Diazepam the day before. The management plan is to continue sub-cut fluids where appropriate, to use Oramorphine/Diamorphine, Diazepam or Midazolam to keep comfortable and if more than one injection of Diamorphine is required for a syringe driver. The consultant's view is that she is now obviously dying and the management should continue to be to keep her free of pain and distress (140).

3.13. Further medical records confirm further deterioration on 28th November and the 1st December. The record on 28th stating that Mrs Purnell was now on sub-cut analgesia. Death is recorded on 3rd December by a RGN and the final note written subsequently on 18th December states the cause of death was bronchopneumonia and

senile dementia (139). This chronology is also confirmed in the nursing notes. The nursing notes states that on 24th November she was seen by Dr Barton (154) because her condition was deteriorating, she was distressed and reluctant with oral medication that the syringe driver should start. On 25th she continued to deteriorate and it occurred until 27th when her subcutaneous fluids were discontinued. The nursing notes continued to record her deterioration each day with the syringe driver being re-charged. The nursing notes say that Diamorphine was increased to 30 mgs on 1st December (165) although the drug chart says 40 mgs. On the 2nd December she is bubbly and 40 mgs a day of Diamorphine is recorded in the syringe driver. Death is verified at 1130 on 3rd December (166).

3.14. The Gosport War Memorial drug charts are slightly confusing in that there appear to be 3 front sheets (147, 148 and 149). It is possible that an extra front sheet was simply added to a previous drug chart as the space for the "as required" prescription drug box becomes full.

3.15. In summary, two tablets of Co-codamol are prescribed at 0830 on 12th November (which had been written up on admission) thereafter Oramorphine at 10 mgs and 5 mls at a dose of 2.5 – 5 mls is given starting on 12th November when three doses are given and then one or two doses most days until 24th November. There is no particular pattern for the timing of this although on 8 days there is a dose given late at night.

3.16. Diclofenac suppositories are written up on 17th November on a PRN basis but do not appear to be prescribed. Diamorphine is written up on a PRN basis SC/IM by Dr Lord on 23rd November but does not appear to have been prescribed. Diamorphine 20 – 200 mgs sub-cut in 24 hours, Hyoscine 200 – 800 micrograms sub-cut in 24 hours and Midazolam 20 – 80 mgs sub-cut in 24 hours are all written up on the PRN side of the drug chart on 19th November but do not appear to have been given. On the regular side of the drug chart Diamorphine 20 – 200 mgs sub-cut in 24 hours, Midazolam 20 – 80 mgs sub-cut in 24 hours and Hyoscine 200 – 800 micrograms sub-cut in 24 hours are all written up on 24th November. 20 mgs of Diamorphine is prescribed each day until 1st December when 40 mgs is prescribed until she dies. Midazolam 20 mgs is prescribed on 24th November and then 40 mgs each day until the day she dies. Hyoscine 200 micro grams is given on 2nd December and 400 on 3rd December.

TABLE 1

Drug	Date Prescribed	Prescribed as	Prescriber	Given
Co-codamol 1 – 2	11/11	As required (PRN)	?	12/11 0830
Oramorphine 10 mgs in 5 mls Oral 2.5 – 5 mls	12/11	As required (PRN)	AK	*12/11 1405 5 mgs 1830 5 mgs 2234 10 mgs *13/11 1025 10 mgs 2225 10 mgs 14/11 1030 10 mgs *15/11 0050 10 mgs *16/11 2215 10 mgs *18/11 0105 10 mgs 2015 10 mgs *19/11 2316 10 mgs 20/11 1155 10 mgs 1800 5 mgs *21/11 2315 10 mgs *22/11 0630 10 mgs 2240 10 mgs 24/11 0920 10 mgs ** = Late evening dose on that date*
Diamorphine SC/IM 2.5 mgs – 5 mgs	23/11	As required (PRN)	LORD	-----
Diamorphine	19/11	As required	BARTON	-----

20 – 200 mgs SC in 24 hours		(PRN)		
Midazolam 20 – 80 mgs SC in 24 hours	19/11	As required (PRN)	BARTON	-----
Diamorphine 20 – 200 mgs SC in 24 hours	24/11	Regular	BARTON	24 – 30 Nov 20 mgs daily 1 – 3 Dec 40 mgs daily
Midazolam	24/11	Regular	BARTON	24 Nov 20 mgs daily 25 Nov – 3 Dec 40 mgs daily

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Edna Purnell, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Edna Purnell was a very elderly lady with multiple medical problems although moderately severe dementia was the main functional problem leading to residential care. There is debate in the notes whether this was Alzheimer's or vascular dementia, indeed it is not uncommon for elderly people to have both.

4.3. She was admitted to the Haslar Hospital having had a fall and a fractured neck of femur on 25th October. She was already known to have osteoporosis having previously had a Colles fracture. Unfortunately the prognosis of patients with dementia and a fractured neck of femur is extremely poor, very few return to their previous functional state and an in-hospital mortality rate at 25% is not uncommon. Those that remain immobile and incontinent immediately after the operation have by far the highest mobility

and mortality. Although the notes from Haslar are missing, the nursing summary documents that she remains totally dependent, develops bed sores and is seen as "a very challenging problem". Her dependency is also confirmed by the Barthel of 2 recorded upon admission to the Gosport War Memorial Hospital (GWMH).

4.4. She is thoroughly assessed by Dr Lord in Haslar who also sees the relatives at that time. The letter makes it clear that rehabilitation was going to be very difficult and Dr Lord expects her to remain severely dependent. She has already indicated at this early stage the likelihood of a nursing home placement. Dr Lord does not expect the patient to improve but is giving the family time to come terms with her changed status.

4.5. On admission to GWMH her problems are assessed but it is not clear whether she is medically examined. If she is not I would regard this as poor practice as it fails to give an accurate base line in the notes for future management of her medical problems.

4.6. It is then clearly document in both the medical and nursing notes that she is in considerable pain on 12th November despite the appropriate use of oral co-codamol. There is no medical examination recorded in the notes or any explanation as to where this pain is coming from. If the (incomplete) medical cardex from Haslar is correct she has not received analgesia for 6 days so what has changed? Is the pain coming from her pressure sores, which is very likely, has some other medical condition occurred, for example dislocating her hip during the transfer or some other post-operative complication? Failure to adequately examine the patient to explain her symptoms is poor medical practice. The use of oral strong opioid analgesia after weak opioid analgesia has failed is perfectly appropriate and the doses used are well within recognised standard dosages. However there is no explanation in the notes of why oral weak opioid analgesia is not continued on a regular basis using the stronger opioid analgesia for breakthrough pain. Without explanation I would consider this poor medical practice.

4.7. Mrs Purnell makes no improvement during her time at GWMH and indeed appears to enter a period of slow decline. In Table 1 demonstrates she requires a dose of analgesia most nights to manage her symptoms and allows her to sleep. The causes of decline are often multi-factorial. Her failure to get over the anaesthesia, a possible further vascular event causing swallowing difficulties, poor nutrition, pressure sores from dependency and hypostatic pneumonia. In the presence of multiple other

pathology and old age, a relentless downhill course is not uncommon and it often becomes appropriate to manage symptoms and any distress.

4.8. A crisis occurs on 17th when there is a conflict on the ward between the son and the nursing staff although there had been previous discussions on the 14th. As a result of this there is a very detailed clinical examination undertaken by a Dr Brodie which documents she is semi-conscious, has got arms and legs flexed and appears to be in distress when moved. He appropriately discusses her with Dr Lord and starts subcutaneous fluids. She is then reviewed by another consultant, Dr Reid, in detail who assesses the situation and makes it quite clear that the prognosis is very poor (a statement often put in notes to indicate the consultant believes the patient will die shortly) and that symptom control and support is paramount. I would agree with the assessment and management at this stage.

4.9. Medical and nursing notes then document slow further decline in Mrs Purnell's clinical condition up until 23rd November and she is reviewed by a consultant, Dr Lord. There are detailed notes that she is groaning and in pain and frowns when lightly handled. A clear plan of management is set out in particular if she cannot take medication orally then she should have a syringe driver. I would agree with this management.

4.10. The medication for the syringe driver is written up by Dr Barton on 24th November and starts the same day although there is no record in the medical notes of who actually decided the starting dose in the syringe driver. However in my view a syringe driver was appropriate management at this stage in Mrs Purnell's care. She is started on 20 mgs of Diamorphine in 24 hours together with 20 mgs of Midazolam. As Mrs Purnell had received between 10 and 20 mgs of Oramorphine most days for the previous 12 days I believe this was within the appropriate range of doses to use. Midazolam was also started at 20 mgs in 24 hours. Midazolam is a sedative which can be suitable for very restless patients and is usually initially given in a dose of 20 mgs in 24 hours although some believe the dose should be much lower (5 – 20 mgs) in older people in particular the most frail. She was also on regular oral diazepam at this stage. There is nothing specific in the notes to explain why it was thought that both Midazolam and Diamorphine were required or why a dose of 40 mgs of Midazolam after the first 24 hours was needed. There is a potential risk of over sedation in the last few days although I am certain this lady was terminally ill.

4.11. The use of drug chart is poor. Diamorphine and Midazolam are written up on the PRN part of the drug chart on 19th November but although they are not prescribed there is no documentation in the notes as to why this occurred. A very large dose range is written up on the regular side of the drug chart when a new prescription should have been written for each change in dosage. The dosages of the controlled drugs were not written in words and figures nor was the total dosage to be given made clear in the prescription.

5. OPINION

5.1. Edna Purnell, a 91 year old lady with moderately severe dementing illness who suffered a fracture neck of femur which she never properly recovered medically or functionally and subsequently deteriorated and died in the Gosport War Memorial Hospital. The post mortem showed bronco pneumonia which is the common end point pathological process found at post mortem after prolonged debilitating illness.

5.2. It was appropriate to transfer her to the Gosport War Memorial Hospital where many aspects of her care and the approach to symptom management of someone who was terminally ill were appropriate.

5.3. There is some evidence of poor medical practice in the Gosport War Memorial Hospital. In particular:

- The lack of a documented medical examination on admission.
- The poor assessment of pain and the reason for it on the 12th November.
- The failure to use, or document why not, regular weaker oral analgesia was not used after the 12th November
- The absence of documentation of who made the final decision to choose the dose of diamorphine and midazolam on 24th November and why the dose of midazolam was increased to 40 mgs on 25th November.

5.4. The use of the drug chart in the Gosport War Memorial Hospital is significantly deficient. In particular:

- The prescription of a large range of a controlled drug and both the "daily review prescriptions" and the regular sides of the drug chart.
- The failure to re-write the dose of drugs when changed on the regular side of the drug chart

- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.
9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity.
10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature: _____ Date: _____

REPORT FOR THE GENERAL MEDICAL COUNCIL ON ASPECTS OF CARE AT GOSPORT WAR MEMORIAL HOSPITAL

Instructions

To prepare a generic report for the General Medical Council covering principles of medical care and matters specific to the Gosport War Memorial Hospital in relation to the individual cases and separate individual reports that have been provided to the GMC.

1. Principles of Medical Care

1.1 Pain Relief

Pain is a complex phenomena that is a subjective, personal experience, only known to the person who suffers. Experience of pain may occur at several levels:

- Sensory dimension, the intensity, location and character.
- The affective dimension; the emotional component of pain and how it is perceived.
- Impact; disabling effect of the pain on the person's ability to function and participate in society.

1.1.1 Analgesic Ladder for pain

The relief of pain is therefore part of a comprehensive pattern of care. However, whatever the cause or the effect on the patient the Analgesic Ladder has for many years been the main stay of the approach to analgesia [1, 2]. It is a very simple concept that the choice of drug should be based on the severity of the pain not the stage of the disease. Drugs should be given at standard doses, at regular intervals in a step wise fashion. Thus for mild pain, non-opioid analgesics such as Paracetamol or a non-steroidal anti-inflammatory agent (e.g. Diclofenac) is used. If this non-opioid is not effective or the patient is in moderate pain, a moderate opioid (e.g. Codeine or Dihydrocodeine, often in combination with a non-opioid drug, such as Paracetamol with Codeine in Co-Codamol) is used. If the patient is in severe pain or the pain has not settled or the pain management for moderate pain has not worked, strong opioid analgesia (e.g. morphine) should be used ideally on an oral basis in the first instance.

1.1.2 Assessment of pain

Comprehensive assessment of pain involves:

a) Direct enquiry or observation for signs of pain. It is important to use alternative descriptions such as sore, hurting or aching. Patients with severe cognitive impairment, communication difficulties or language or cultural barriers present further complexities. There may be other observational signs associated with pain including crying, distress, aggression, moaning, calling out, pacing, rocking, various facial expressions and autonomic changes such as sweating, altered breathing patterns and tachycardia.

b) A description of the pain in terms of its sensory and affective and impact should be obtained and high quality services will often use a standardised scale to assist in assessment.

c) A full physical examination should then be undertaken to identify the cause of the pain.

d) Where a cause can be identified the cause should be treated and if it is not identifiable then it is appropriate to treat the symptoms.

e) The patient should then be reassessed to evaluate the effects of treatment.

1.1.3 Principles of administration of pain relief

This involves the Analgesic Ladder. As well as:

- Using the oral route if possible.
- Providing therapeutic doses of an analgesia regularly.
- Titrating the dose of the drug to the individual's analgesic requirement.
- Providing effective analgesia for breakthrough pain.
- Assessing pain control regularly.
- Assessing and treating the psychosocial dimensions of chronic pain.
- Paying attention to bowel function in particular use of laxatives with opioids.
- Providing appropriate adjuvant therapy (e.g. Bisphosphonates for bone pain, Tricyclic Antidepressants for neuropathic pain, non-steroidals for inflammatory pain).
- Keeping the patient and family fully informed.

1.1.4 Use of opioids

In a patient starting at level 3 of the analgesic ladder for the first time a dose of 5 – 10 mgs, four hourly, of Morphine is usual, given orally. Also prescribe Morphine at one sixth of the 24 hour dose for breakthrough or incidental pain.

- Titrate the dose against the individual's level of pain and side effect profile.
- When indicated, increase the dose by 20 - 50%, or by the amount of breakthrough Morphine used in the previous 24 hours.
- When pain is controlled convert to a sustained release formulation in an equivalent dose.
- Prescribe a regular laxative unless contraindicated.
- For injection Diamorphine is preferred as it is more soluble and can be given in smaller volume. In converting an oral dose of Morphine to a subcutaneous dose of Diamorphine, the BNF states that the equivalent intramuscular or subcutaneous dose of Diamorphine is approximately a third of the oral dose [3]. However, the Wessex Protocol states "conversion from oral Morphine to subcutaneous Diamorphine (total daily dose) varies between 2:1 and 3:1 allowing some flexibility depending on the requirement for increased or decreased opioid effect".

1.1.5 Syringe Drivers

Syringe drivers allow a continuous subcutaneous infusion which can provide good control of symptoms with little discomfort or inconvenience to the patient. Indications include:

- Patient unable to take medicines by mouth for example due to vomiting or coma.
- There is malignant bowel obstruction where further surgery is not possible.
- Where the patient does not wish to take a regular medication by mouth.
- The Wessex Protocol also states "the last 24 / 48 hours of life".

The most common causes of problems with syringe drivers are putting the wrong dosage in the driver, problems with the driver either going too fast or too slow and poor training of staff.

1.1.6 Opioid toxicity and side effects

a) Drowsiness and sedation. Most commonly within the first few days of opioid usage. Severe overdosage may lead to coma and slowing of respiration to the point of respiratory failure.

b) Nausea and vomiting. Nausea is particularly common in those taking oral Morphine. It can be helped with the co-prescription of either Metoclopramide or Haloperidol.

c) Constipation. Develops in almost all patients who should be treated routinely with laxatives.

d) A dry mouth is often troublesome.

Individuals can vary enormously in their tolerability of Opioids. Opioid toxicity may also present as agitation, hallucinations, increased confusion leading to interpretation as uncontrolled pain, and when further opioids are given leading to sedation, lack of fluid intake and further toxicity. This syndrome is sometimes misdiagnosed as terminal agitation.[4]

Patients with both renal impairment and hepatic impairment are both extremely sensitive to opioids.

1.1.7 The use of Midazolam with Diamorphine

Research has shown that a high proportion of patients are distressed in the last week of life. Agitation and restlessness is particularly common. In a terminally restless patient there should be a proper attempt to determine the etiology of the distress. Where this is pain, appropriate analgesia is the first approach. However, if this does not relieve the agitation and distress it is appropriate to add further drugs to manage the symptoms of terminal restlessness. Haloperidol is particularly helpful in cases of agitation, and Midazolam for restlessness. Both can be put subcutaneously in a syringe

driver and can be mixed with Diamorphine where required. Midazolam also has the advantage that it raises the seizure threshold. The BNF[3] states that it should be given in a dose of 20 – 100 mgs per 24 hours, the Wessex Protocol state 10 – 100 mgs per 24 hours[2] although others believe that in older people a lower dose of 5 – 20 mgs per 24 hours is normally sufficient[5]. Thus pain by itself is not a reason to add Midazolam. If excessive doses of Midazolam are used with excessive doses of opioid analgesia it would significantly increase the risk of over sedation, respiratory failure, coma and potentially hasten death.

1.1.8 Principles of prescribing in old age

The British National Formulary[3] sets out important issues around old people particularly the very old and frail.

a) Appropriate prescribing to people receiving multiple drugs - this greatly increases the risks of drug interactions, adverse interactions and poor compliance.
b) Forms of medication in the frail - an older patient may have difficulty swallowing and there may be problems with fluid intake.
c) Manifestations of disease – problems of normal age may be mistaken to disease such as age related muscle weakness being confused with neurological disease.
d) Sensitivity – the nervous system of older people is particularly sensitive to many commonly used drugs and the BNF mentions opioid analgesics and Benzodiazepines (such as Midazolam).
e) Pharmacokinetics – the most important affects of age is the reduction in renal clearance and therefore atoxic drug metabolites may accumulate with greater preponderancy with adverse effects. Liver metabolism of some drugs is also reduced in old age.

The key principles are:

- Use as few drugs as possible, use dosages substantially lower than for younger patients, often 50% of adult dose, review regularly, simplify regimes, explain clearly. Doctors should use the BNF to check dosages and drug interactions.

2. Medical Assessment and Records

2.1 Assessment and Records

Doctors have a responsibility to make the care of the patient their first concern. The attributes of good clinical care are set out in the GMC's document Good Medical Practice[6]. This states that good clinical care must include:

- Adequate assessment of the patient's condition based on the history and clinical signs including, where necessary, an appropriate examination.
- Providing or arranging investigations or treatments where necessary.
- Referring the patient to another practitioner, when indicated.

It also states that in providing care you must:

- Recognise the limits of your professional competence.
- Be willing to consult colleagues.
- Be competent when making diagnoses and when giving or arranging treatment.
- Keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed.
- Keep colleagues well informed sharing the care of patients.

A failure to meet these standards puts the patient at risk:

- Without assessment there can be no proper treatment and would be a clear failing in duty of care to the patient.
- Without recording assessments there are risks to the patient of:
    - Missing and forgetting important matters.
    - No base line on which to document, understand and assess changes in condition.
    - No information for other members of staff whether medical or other members of the health care team to understand the problems and base their own management upon it.
    - No audit trail when decisions are questioned or challenged.

2.2. Use of Drug Charts

On hospital drug charts there are broadly speaking 4 ways to prescribe a drug each with its own section.

- Drugs may be given as a single dose. This is usually on the front of the chart which should state the dose, the route of administration and the time and date of that administration. It would be normal for the nursing (or medical) staff to give the medication at the time and date specified and if not to make a record of why that failed to happen.

- Drugs may be prescribed on a regular basis at the same time and dosages each day. There is often a column where the timing of dosages should be included. The drugs should always be given by the nursing (or medical) staff at the time and at the dose indicated. If it is not given at the time or dose indicated there should be a record made on the drug chart or in the notes as to why this happened. If the dose and/or the timings of the drugs are to be changed the whole prescription should have a line put through it, it should be dated and initialled and a new regular prescription written up on a different line.

- Many medications are prescribed on an "as required" basis (PRN which abbreviates *pro re nata: 'as the occasion arises; when necessary'*). The nursing staff or sometimes the patient may then use their judgement when these drugs are given. It would be normal to specify the dose and the minimum dose interval. It is common practice to give a small dose range. For example, Paracetamol one or two tablets at 6 hourly PRN. This part of the drug chart is most commonly used for sleeping tablets, mild analgesia, laxatives and anti-emetics, but may be condition specific. For example a small dose range of Diamorphine 2.5-5mg is often written up in patients admitted with acute myocardial infarction or unstable angina. This

reflects the need for rapid analgesia but allows some judgement as to the actual dose required particularly if a previous dose has not worked while further medical attention is obtained. As indicated earlier breakthrough doses of analgesics PRN may also be written up when a regular opioid has been started on the regular side of the drug chart.

- The final part of the drug chart is for infusions and fluid management.

Prescribing requires:

- The drug, the dose, the strength, the route of administration and the frequency to be written up for all prescriptions.
- Avoid multiple route prescribing for a single prescription (e.g. IV and oral).
- When changing the dosage you should draw a line through the prescription, date and initial, and then re-write a new prescription.
- The law for controlled drugs states that a prescription must be signed and dated and must always state:
    - the name and address of the patient
    - the form and strength of the preparation
    - either the total quantity (in both word and figures) of the preparation, or the number (in both words and figures) of dosage units, as appropriate, to be supplied in any other case the total quantity (in both words and figures) of the controlled drug to be supplied.
    - the dose

- In a guideline for responsibility on prescribing [7] the Department of Health has advised that the legal responsibility for prescribing lies with the doctor who signs the prescription.
- It is good practice to review the drug chart of every patient as part of a normal ward round. This would also be the case when new drugs are to be prescribed or there is a change in the patient's condition.

Comment

Where these guidelines and instructions are not followed patient care and safety may be compromised due to:

- Confusion as to whether the drugs are to be given regularly or irregularly.
- Important doses of required drug medication being missed.
- Confusion and misunderstanding over the appropriate dose of drug to use and when it should be used.
- A risk of treating patients symptomatically when medical reassessment of a patient's condition would be more appropriate.

In particular I can find no justification for writing up drugs for a possible syringe driver on a PRN part of a drug chart with a very large dosage range in many cases (20 – 200 mgs of Diamorphine). The reasons for this are:

- A decision to start a syringe driver is an important clinical decision that should always require the patient to be seen and reassessed.
- Syringe driver medication should always be written up on the regular side of the drug chart and the prescription should be re-written each time the dosage is changed.

- It might be appropriate for single PRN doses of an oral or parental opioid to be made available on the PRN side of the drug chart with a very small dosage range in those cases where the medical assessment had already noted pain or other symptoms that might not be managed in a short period of time while awaiting further medical attention. 24 hour medical attention was available for all patients at GWMH.
- There is a theoretical risk that a high and clinically inappropriate dose of drugs could be mistakenly started at any time without further medical review or assessment.

2.3 Limits of clinical competence

The GMC Guidelines above state that in providing care the clinician must:

- Recognise the limits of their professional competence.
- Be willing to consult colleagues.

All patients on Dryad and Daedalus Ward had a named consultant Geriatrician responsible for their care. However, the day to day responsibility was devolved to the clinical assistant, a General Practitioner. There is no doubt that many of the patients had complex multiple pathology and were challenging clinical and management problems. The type of complexity faced in managing older people at GWMH included:

- Being prepared to look for a medical reason for change in status or symptomatology. For example a recent onset of confusion may indicate an undiagnosed and untreated urinary tract infection.
- High technology interventions and diagnostics were not available on the Gosport War Memorial Hospital site. Yet such interventions are often crucial in the modern management of patients. It would have been a significant decision to have to arrange for a patient to return to a DGH for an investigation or in-patient care. Such decisions should normally be subject to discussion between the clinical assistant and the consultant in charge of the patient or the consultant on call.
- In patients with multiple pathology where there has been active treatment so far but a further significant clinical events happens. Whether to continue to actively treat, investigate or to make a decision regarding palliative and terminal care can often be complex and emotional. A multi-disciplinary approach involvement of a senior clinician, usually the consultant in charge of the patient's care, would be normal good practice.

3. Matters specific to the Gosport War Memorial Hospital

3.1. The position of a Clinical Assistant

Clinical assistant posts are part-time hospital posts that were initially intended for GPs who wished to work in hospital and were appointed under paragraph 94 of Terms and Conditions of Service[8]. GP clinical assistants can do no more than 9 notional half days. There are no clearly defined terms and condition of service. The role is a career grade role, not a training role and may be permanent. They are usually responsible to a named consultant. Clinical assistants may have had variable experience before being appointed to a post but there is no minimal standard set. It is the employing

organisation that would be responsible for ensuring any clinical assessment had the appropriate skills and training to undertake the task set out in the job description.

3.2 The Job Description

The job description[9] is undated but confirms that the clinical assistant is responsible for a maximum of 46 patients. The job description makes clear there is:

- There is 24 hour medical cover and to be available on call as necessary.
- To ensure that all new patients are seen promptly after admission.
- To be responsible for writing up the case notes and ensuring that follow up notes are kept up to date and reviewed regularly.
- To take part in the weekly consultant ward round.

However there is no comment on the medical cover to be provided if the post holder is unavailable out of hours or for longer periods of leave such as holiday.

There is some confusion in the job summary as it states that it is to provide 24 hour cover to the long stay patients but then goes on to state that patients are "slow stream" or "slow stream rehabilitation".

References

1. World Health Organisation: Cancer Pain Relief and Palliative Care. WHO, Geneva, 1990.
2. Palliative Care Handbook: Guidelines on Clinical Management. 3rd Edition, Salisbury Palliative Care Services (also known as "Wessex Protocols"), May 1995.
3. British National Formulary.
4. ABC of Palliative Care: Principles of Control of Cancer Pain. BMJ: 332; 1022-1024, 2006.
5. Welsh J, Fallon M, Keeley P W. Chapter 23, Brocklehurst Text Book of Medicine 6th Ed. 2002
6. Good Medical Practice. The GMC, October 1995.
7. DoH Circular EL (91) 127.
8. Terms and Conditions of Service, paragraph 94.
9. Job Description for the post of Clinical Assistant to the Geriatric Division in Gosport War Memorial Hospital.

GMC Case Protocol - Stage 5 Telephone Conference

Attendees:
Sarah Ellson Field Fisher Waterhouse
Ian Barker, Medical Defence Union
Code A GMC Investigation Officer
Rebecca Faulkner, GMC Adjudication Team

Apologies: Tamsin Hall, Field Fisher Waterhouse, unable to attend owing to ill health

Case: Dr Barton

Conference date: 22 April 2008 @ 10:00

	Action	Outcome
1.	Stage 3 actions complete? Details have been sent to Defence of 2 extra patients and the reports have been completed. GMC anticipate confirming to Defence by the end of the week if either or both of the additional cases will be included, along with finalised charges. The majority of other evidence is up to date, awaiting finalisation are production statements, and 2 statements (Tandy and Reed) and that of a family member. The interviews have been carried out. Defence position remains largely the same as at the last telecon of 4 March 08. The large volume of material and extended preparation period for the GMC – noted without prejudice – has compressed Defence preparation time. Defence note that they will move forward as best they can, and suggested a further conference to keep matters closely under review. All parties agreed, and a further conference is scheduled for **5 June 08 at 10:00.** An earlier conference can be scheduled should Defence require it.	No
2.	Any outstanding procedural or legal issues? Defence sought clarification on the calling of a Pharmacy expert – GMC noted that this was more in the spirit of a 'text book of drugs available at the time' rather than a whole new case. Defence also questioned when he could expect 3 further particular statements – GMC will be in contact via email with 48 hours on this point.	Yes
3.	Are you aware of any health issues regarding the doctor, which may affect the planned hearing date for this case	TBC
4.	Confirm hearing date A non sit day occurs at panellist request on 8 Oct. GMC stated that any more than 1 non sit day would be prejudicial to the completion of the case. Parties will keep this under review, and if necessary can look at listing for	8 Sep – 31 Oct 08

	additional time.	
5.	Confirm time estimate	39 Days
6.	Confirm location of hearing	London
7.	Check whether there will witnesses giving evidence via video link up. If so check where they will be giving evidence from i.e Country or location in UK	TBC
8.	Check whether facilities are required i.e: Video player / tape player etc	TBC

GMC Case Protocol - Stage 5 Telephone Conference

Case: **PPC referral:**

Conference date:

Areas to be covered

	Action	Outcome
1.	Stage 3 actions complete? If no, please record below actions and timescale for completion	Yes / No (please circle)
2.	Any outstanding procedural or legal issues? If so, please record below	Yes / No (please circle)
3.	Are you aware of any health issues regarding the doctor, which may affect the planned hearing date for this case	
4.	Confirm hearing date	Date:
5.	Confirm time estimate	Days:
6.	Confirm location of hearing	Location:
7.	Check whether there will witnesses giving evidence via video link up. If so check where they will be giving evidence from i.e Country or location in UK **Any details here**	Yes / No
8.	Check whether facilities are required i.e: Video player / tape player etc	Yes / No

Annex F

GMC Pre-adjudication case management procedure

BT MeetMe telephone conferencing – A step-by-step guide

Participant passcode:

MeetMe telephone no: **Code A**

1. Date and time of telephone conference must be agreed in advance.

2. At the agreed time, ring the MeetMe telephone number - **Code A** Code A

3. You will be prompted to enter the participant passcode.

4. Enter **Code A** and then a #.

5. You may be prompted to give your name. Please do so, if asked, and accept the subsequent recording.

6. Wait for the telephone conference to start.

Points to note

- The telephone conference cannot begin until the GMC Adjudication Management Section listings officer (as Chair) has joined it.

- The cost to participants (doctor and/or legal representatives and GMC solicitors) will be that of a normal telephone call. All call costs will be borne by the GMC.

- It is important to call in at the agreed time so that we are efficient with time and money.

- Participants can use additional features during the telephone conference:

  *0 Signals BT co-ordinator for assistance;

  *4 Automatic volume equalisation (adjusts the volume of your line);

  *6 Mutes/unmutes your telephone line (useful for noisy connections).

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Field Fisher Waterhouse LLP
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28 APR 2008

For attention of Ms T Hall

Your Ref: ALW/00492-15579/7365557 v1

28 April 2008

Dear Ms Hall

Gosport War Memorial Hospital Inquests/Dr Jane Barton:

I refer to your letter dated 23 April and our telephone conversation of 28 April.

I confirm that I intend in the very near future to open Inquests into the deaths of ten people who died at Gosport War Memorial Hospital:

Mr Arthur Cunningham
Mr Geoffrey Packman
Mrs Ruby Lake
Mrs Sheila Gregory
Mr Robert Wilson
Mrs Enid Spurgin
Mrs Helena Service
Mr Leslie Pittock
Mrs Elsie Lavender
Mrs Elsie Devine

For logistical reasons, the Inquests will be conducted by Mr A M Bradley, HM Coroner for North Hampshire, acting as my Deputy. Mr Bradley intends to conduct all the Inquests simultaneously and at present estimates about a month in court to do this. It seems very unlikely, given the complex arrangements that will need to be made, for the Inquests to take place any earlier than the Autumn.

Of course, neither Mr Bradley nor I would wish to prejudice in any way the GMC's hearing on Dr Barton. I am copying your letter to him so that we can all liaise on a more definite hearing date for the Inquests.

Yours sincerely

Code A

David C Horsley

Code A

cc Mr A Bradley

'rom: Hall, Tamsin Code A
ent: 16 Apr 2008 18:08
'o: Code A
:c: Ellson, Sarah; Watson, Adele
ubject: Barton - update - Jean Stevens and Edna Purnell

ıttachments: DOCS_7320801_1.DOC; DOCS_7320808_1.DOC; DOCS_7226650_1.DOC;)OCS_7209340_1.DOC; DOCS_7275186_1 (2).DOC

li Code A

'lease find attached:

1. Advice from counsel re Edna Purnell
2. Report from Professor Black re Edna Purnell
3. Draft charges re Jean Stevens
4. Report from Professor Black re Jean Stevens
5. Generic report from Professor Black

ıs you will see, Counsel's advice (with which I agree) is that Edna Purnell should not be dded to the charges. In essence, whilst EP's treatment at GWMH was poor the criticisms an only partially be directed at Dr Barton and Professor Black describes the use of the yringe driver as appropriate in this case.

)n the other hand, Professor Black's report and our collective opinion is that the Jean ;teven's case is strong and should be added to the charges. To that end Counsel has rafted a preliminary charge for inclusion within the DNOH (please note that I have enclosed as he has drafted it and will need to tweak it to ensure that it is consistent with the rest of ıe document and with the GMC preferred style).

'om has asked me to let you know that he and Ben are currently going back through the lOH (as currently drafted) as he wants to cross reference with Black's reports to check that ve have reflected Black's evidence accurately and there may be further changes he wishes) make.

met with Tom and Ben on Friday and we went through the witnesses that we wish to call. 'here are a few more production statements which I will need to draft but I will be in a osition to indicate to the defence whom we will wish to call in a preliminary list before the ;lecon on Tuesday.

'lease let me know your views on the attached.

:egards

'amsin

ımsin Hall | Solicitor
r Field Fisher Waterhouse LLP
Code A

obile Code A

onsider the environment, think before you print!

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GMC

V

Dr Barton

Advice re: Patient Edna Purnell

1. I have been asked to consider whether it is appropriate to include in the Notice of Inquiry allegations relating to the treatment of this patient.

2. I have reviewed the documentation sent to me which included the statement and exhibits of Code A. Unfortunately some of the even pages of the report by the Health Service Ombudsman have not been copied, however given the conclusions of that report I do not think it necessary to read the report in its entirety before forming the view which I have. I have also received the hospital notes and the report of Professor Black.

3. Having read the relevant material I do not think it appropriate to include charges relating to this patient for the following reasons:

4. The patient was, before her discharge from the Haslar Hospital, thoroughly assessed by Dr Lord who does not paint an optimistic picture in relation to this ninety-one year old patient.

5. Although there is no clear note of a medical assessment upon her arrival at GWMH there is clear documentation in the nursing notes of pain being expressed by the patient.

6. On the 17th November following an angry exchange with the patient's son, there were two full reviews of the patient's treatment by the consultants Dr Brodie and Dr Ried. The patient's management was also discussed with Dr Lord. The notes reveal that the patient was distressed when moved and the prognosis was very poor. According to Professor Black that means that the patient was believed likely to die soon. Symptom control and

support were said to be paramount and Professor Black agrees that that was the appropriate management at that stage of the patient's life.

7. There was further decline noted in the patient's health and on 23rd November when reviewed by Dr Lord the patient was groaning in apparent pain when lightly handled.

8. On the 24th November when Dr Barton prescribes opiates by syringe driver to be started, that was, in Professor Black's expert opinion, appropriate management for the patient.

9. Although the dose of Midazolam prescribed by Dr Barton was high, and risked over-sedation, the patient was by then terminally ill and in the last few days of her life.

10. There is some criticism of the care provided at GWMH such: i) as lack of documentation of initial assessment; ii) the use of strong analgesics when possibly weaker ones would have done the job; iii) the absence of notes in relation to the Midazolam increase. These criticisms are only partially directed at Dr Barton given that two other consultants were also involved in assessing the patient's needs at a relatively early stage in her admission.

11. Given that two other doctor's were closely involved in this patient's care and that Professor Black describes the use of the syringe driver as appropriate in this case, in all of the circumstances my view is that there is insufficient material upon which to base appropriate charges against Dr Barton and I have not therefore drafted any.

Tom Kark

QEB Hollis Whiteman Chambers

Temple, London EC4Y 9BS

11th April 2008

Patient L (Jean Stevens)

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

ii) On 20 May 1999 you prescribed:

a) Oramorphine 10 mgs in 5 mls;

b) Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis;

c) Midazolam with a dose range of 20 to 80 mgs to be administered SC;

iii) You further prescribed Oramorphine 10 mgs in 5 mls as a regular prescription to start on 21 May 1999;

iv) Doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient in 21 and 22 May 1999.

b) You did not properly assess Patient L on admission. This was

i) inadequate;

ii) not in the best interests of the patient;

c) In relation to your prescription for drugs described in paragraph 1 a) ii) and/or iii):

i) There was insufficient clinical justification for such prescriptions;

ii) The dose range of Diamorphine was too wide;

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

d) Your actions in prescribing the drugs described in paragraph 1a) ii) and or iii) were:

i) Inappropriate;

ii) Potentially hazardous;

iii) Not in the best interests of patient L.

ADD PATIENT L TO ALLEGATION RE: INSUFFICENT RECORD KEEPING.

Jean STEVENS
DOB: Code A
Died: 22/05/1999

SUMMARY OF CONCLUSIONS

Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with severe left hemiplegia , probable myocardial infarction and continued myocardial ischemia.

She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

There is some evidence of poor medical practice in Haslar.

Documentation and management of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records, and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT.

(The numbers in brackets refer to the page of evidence. For the three volumes: number / 1, number / 2 and number / 3)

3.1. Jean Stevens was a 72 year old lady at the time of her death in the Gosport War Memorial Hospital on 22 May 1999. She had a long past medical history including diverticular disease diagnosed in 1982 (24/1), appendisectomy in 1967, various arthritic pains, atrial fibrilation from 1994 (854/2), asthma needing inhalers and a gastric ulcer in 1994 (753/2).

3.2. However as a result of abdominal pain she undergoes a Sigmoid colectomy in 1995. This is complicated by what is eventually found to be an colo-vaginal fistula and she undergoes a further laparotomy (135-36/1) after which she is very ill and needs a period of time in the intensive care unit. However, she does eventually return home although continues to get chronic abdominal pain with normal investigations (113/1) including a normal CT (121/1) and is finally referred to the pain clinic for her chronic abdominal pain although she does not receive the appointment before her final admission to Hasler.

3.3. 26th April 1999 she is admitted acutely to Hasler Hospital through the A&E department for both the onset of a left hemiplegia together with constant chest pain (114-117/1). The medical notes document her stormy admission (174-205/1). On 28th April she has chest pain with both EGC and cardiac enzyme abnormalities (179/1) suggesting an acute myocardial infarction and is admitted to the coronary care unit. Subsequently she has probable aspiration pneumonia on 30th April (183/1) and possibly a further MI, certainly with more chest pain on 5th May (192/1).

3.4. Nursing notes confirm her serious condition. On 5th and 6th May she is agitated and distressed needing doses of Diamorphine. On 6th May she is seen by Dr Lord (194/1) who finds her extremely unwell and certainly not fit for rehabilitation or transfer to the Gosport War Memorial Hospital. She has more chest pain on 10th May (197/1) and the family are seen on 12th May and the poor prognosis is explained (200/1). On 12th May she is reviewed by Dr Tandy (67/1) who notes she has a dense flaccid hemiplegia and very dysarthric speech although she can obey simple commands. She is tolerating naso-gastric feeding but because of her recent chest pain was certainly not stable for transfer yet.

3.5. The nursing notes said that she was stressed and agitated on 15th May (95/1) and required subcutaneous Diamorphine, however, on 16th May (98/1) she slept well without it. On 17th May she is very demanding and continually disturbing other patients with calling out. On 18th May she has general aches and pains despite regular Co-codamol, although on 19th May (91/1) she is settled and slept all night. Her blood tests confirm her poor health with a very low albumin of 23 and a raised white cell count of 16 (201/1) on 13th May. She remains pyrexial on 17th May with crepitations at her left base and an albumin of 22 and a white cell count of 14 (203/1).

3.6. She is transferred after discussion with the Gosport War Memorial Hospital (GWMH). But the transfer letter written on the 19th (69/1)

fails to mention that she is receiving regular Co-dydramol, although it does state she is on Diamorphine 5 mgs subcutaneous PRN for pain.

3.7. The drug chart from Haslar appears on pages (71-72/1) and (550-560/2). She is written up for Diamorphine 2.5mg IV 4hourly PRN on the 1st May, changed to 5mg SC PRN from the 13th May and receives 12 doses in total between the 5th of May and the 16th May. She is also written up for Co-codamol 2 tablets QDS on the 26th April and receives regular doses until the 29th April. Co-dydramol is started on the 17th May and continues until the 19th. According to the drug chart no drugs of any sort are given on the morning of the 20th May, the day she is transferred.

3.8. The medical receiving notes on 20th May (20/3) comprise a brief summary starting with "transfer to Daedalus Ward 555K". It documents that she had a left dense hemiplegia, her past medical history and her current Barthel. Her examination is recorded. So there is no other medical note and the next note is a nursing note on 22nd May verifying death by a nurse. I do not understand the 555K note.

3.9. The nursing cardex records her transfer at 1340 on 20th May. It records her NG feeding and slurred speech but Mrs Stevens appeared quite alert and aware of her surroundings (26/3). A Barthel is recorded at 1 (32/3), a Waterlow of 25 (30/3) and an abbreviated mental test score of 4 out of 10 (33/3). The nursing contact sheet starts on 21st May (34/3) at 1130. It is possible that the contacts sheet for the 20th May is missing. This sheet records that "now on regular (4 hourly Oramorphine 10 mgs in 5 mls)". At 1800 she has been "uncomfortable despite 4 hourly Diamorphine. Husband seen and care discussed, very upset, agreed to commence syringe driver at an equivalent dose to Oramorphine with Midazolam, aware of poor outlook but anxious that medication given should not shorten her life. At 1945 commenced syringe driver". On 22nd May condition deteriorating, very bubbly, on Hyoscine 800 mgs added to 20 mgs of Diamorphine and 20 mgs Midazolam. With Hyoscine increased to 1600 is very bubbly at 1020 (35/3).

3.10. The handling profile (42/3) under the client risk factor 'pain' states "abdominal pain". The nursing care plan of 20th May (58/3) documents problems with the nasal gastric tube and the night care plan (60/3) states that on 20th May, Oramorphine 2.5 mls given as per cardex, complaining of pain in stomach and arm.

3.11. The drug chart has Oramorphine in 10 mgs in 5 mls, oral 5 mgs 4 hourly enough to start on 21st May, however, only two doses are given at 1000 and 1400 and the other doses are omitted. It also has

Oramorphine 10 mgs in 5 mls for 10 mls nocte to start on 21st May also written as a regular prescription but again this is never given. Oramorphine 10 mgs in 5 mls orally 2.5 – 5 mls 4 hourly as required is written up on 20th May, 5 mgs are given on 4 doses as documented in Table 1. Diamorphine 20 – 200 mgs S/C in 24 hours is written up on 20th May on the as required part of the drug chart and started at 1920 on 21st May, 0830 on 22nd May and restarted again with the increase of dose of Hyoscine at 1030 on 22nd May. Midazolam 20 – 80 mgs subcut in 24 hours in written up on 20th May as required and 20 mgs is started at 1920 on 21st May at 0800 on 22nd May and again restarted at 20 mgs at 1030 on 22nd May.

TABLE 1

Drug	Prescribed as	Prescriber	Given Doses
Diamorphine 2.5 mg IV PRN 01/05 changed to: 5mg SC PRN 13/05	As required	?	05/05 x1 06/05 x2 08/05 x2 09/05 x1 10/05 x1 12/05 x1 13/05 x1 15/05 x2 16/05 x1
Oramorphine 10 mgs in 5 mls For 10mls nocte to start 21/05	Regular	BARTON	Never given
Oramorphine 10 mgs in 5 mls Oral 5 mls 4 hourly to start 21/05	Regular	BARTON	21/05 1000 10mgs 21/5 1400 10mgs (other doses not given)
Oramorphine	As required	BARTON	20/05 1430 5 mgs

10 mgs in 5 mls Oral 2.5 – 5 mls 20/05 4 hourly	(PRN)		20/05 20/05 21/05	1830 2245 0735	5 mgs 5 mgs 5 mgs
Diamorphine 20 – 200 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 22/05 22/05	1920 0830 1030	20 mgs 20 mgs 20 mgs
Midazolam 20 – 80 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 22/05 22/05	1900 0800 1030	20 mgs 20 mgs 20 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Jean Stevens, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Stevens was 72 at the time of her final admission to the Gosport War Memorial Hospital although she had long standing cardiac and gastrointestinal problems and had been very seriously ill needing intensive care during 1995. She also had chronic unexplained abdominal pain and with recent negative investigations she had been referred to a chronic pain clinic for management.

4.3. However, her acute admission was with a severe and dense left sided stroke on 26th April. She had also had constant chest pain that day and when she had further chest pain on 28th April, it seems likely that she had a definite myocardial infarction simultaneously with her stroke. She then suffered from probable

aspiration pneumonia and was extremely ill for several days including having further chest pain.

4.4. Nursing and medical notes document that the family is seen and indeed the medical staff think that it is likely that she is going to die. Certainly she is restless and distressed and in my view probably clinically unstable certainly until 17th May as she still had abnormal signs in her chest, pyrexial and had a raised white count with a very low albumin. There is to be no doubt that her prognosis was extremely poor both from the likelihood of surviving or even getting significant improvement from her stroke.

4.5. During her admission to Hasler she is written up on the PRN side of the drug chart for 2.5 ms IV then 5 mgs SC PRN of Diamorphine. This would be a standard regime for people suffering myocardial infarction with recurrent cardiac pain. The drug is given on a number of occasions in Haslar sometimes for pain and sometimes for non-specific distress, judging from the nursing cardex. It would be perfectly appropriate to use this dose of Diamorphine if she was getting recurrent pain as it would not be possible to intervene in other ways because of her stroke. It seems likely that a clinical management decision (not recorded) was made on the 17th May to stop using Diamorphine and restart a regular oral analgesic, Co-dydramol, given via the NG tube. No further doses of Diamorphine are given in Haslar after 00.10 early on the morning of the 16th May.

4.6. She is seen on two occasions by Geriatricians, who both think she was unstable at that time and not yet suitable for transfer. I would strongly agree. Indeed there is then a further a discussion before it is agreed that she will go to the GWMH. In my view she was likely to be still unstable and it will have been clinically prudent to keep her for another week in Haslar. There can be no doubt that she is getting continued pain. She is written up for 6 hourly Co-dydramol which she received 4 times a day for the 2 days before her transfer to GWMH.

4.7. The drug chart appears to show poor prescribing practice at Haslar as the dose of Diamorphine is not written in words as well as figures nor is the total dose to be given written on the drug chart. There is no evidence she was given her regular medication, including oral analgesia, on the morning of her transfer and the Co-dydramol is not mentioned on the transfer letter.

4.8. There is a summary of the clinical problems functional status upon arrival at GWMH but it is not clear from the notes whether the

patient was examined, and if she was, the examination was not recorded. There is no medical assessment on whether or not she is pain, and if she is in pain why she is pain, nor of her clinical status upon arrival in particularly as she had been so ill recently. In my view this is poor clinical practice.

4.9. She is not written up for the Co-dydramol that she was on regularly at Haslar although it was not mentioned in the transfer letter. On the PRN part of the drug chart doses of Oramorphine are written up orally and a large range of Diamorphine and Midazolam is written up as required There is no documentation in the medical notes at Gosport War Memorial Hospital as to why these drugs were written up upon admission without apparently a clinical assessment of her pain or clinical status. Nor is there any explanation of why no other analgesics apart from strong opiates were prescribed. One note in the nursing cardex refers to abdominal pain which of course may have been the same pain that she had for many years prior to her admission. In general the Diamorphine she had received at Hasler had been for chest pain and further angina. There is no evidence in the medical or nursing cardex that she has any acute cardiac problems or angina in GWMH. In my view this management was poor clinical practice

4.10. She receives her first dose of Oramorphine at 1430, only 45 minutes after the nursing cardex records her arrival and then receives a further 3 doses until the morning of 21st. It is not clear whether it was a nursing or medical decision to actually give the Oramorphine.

4.11. On 21st May a decision is made that she is dying and she should be for symptom control with a syringe driver. Including the two doses given on the morning of 21st May she had received in total 40 mgs of Oramorphine in a 24 hour period. In these circumstances and assuming the patient was still distressed then it would be reasonable to start with 20 mgs of Diamorphine in a syringe driver over 24 hours. However, in my view it is unacceptable clinical practice to give the doses of Oramorphine in the first 24 hours after her arrival and start the syringe driver without making and recording a clinical assessment in the medical notes.

4.12. There are significant irregularities with the drug charts. Oramorphine has been written up on the regular side of the drug chart but not actually prescribed with no note to say why. A large range of Diamorphine is written up on the PRN part of the drug

chart before it is required and it is not written in words or figures nor is the total dose written.

4.13. Midazolam is a sedative which can be suitable for very restless patients and is usually given initially in a dose of 20 mgs in 24 hours although some people believe the dose should be much lower (5 – 20 mgs in older people, in particular the most frail). There is nothing in the notes to explain why it was thought that both Midazolam and Diamorphine were required in this patient. In my view the regular doses of Oramorphine and then the syringe driver together with the 20 mgs of Midazolam would have given a risk of over sedation for example causing respiratory depression in this lady who already had severe heart, lung and neurological disease.

5. OPINION

5.1. Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with a severe left hemiplegia, probable myocardial infarction and continued myocardial ischemia.

5.2. She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

5.3. There is some evidence of poor medical practice in Haslar. In particular:

- Use of the drug chart in Hasler with the failure to write controlled doses of drugs in word and figures as well as the total dosages to be given.
- The apparent failure to give her regular medication, including oral analgesia, on the morning of her transfer to the GWMH.
- The failure to document the regular Co-dydramol in the transfer letter.
- The early transfer of a patient who had been seriously ill and clinically unstable to the short period before transfer.

5.4. Documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- Lack of a documented medical assessment on admission.
- Lack of any recorded assessment of her clinical condition and in particular her source of pain.

- Starting regular opioid analgesia within an hour of admission and a syringe driver within 24 hours of admission ,without any medical records of justification for either regular strong opioid analgesia or a syringe driver .
- The failure to prescribe any analgesia other than the strong opiate analgesia on admission to the GWMH.
- The lack of a written justification requiring both Diamorphine and Midazolam in the syringe driver.

5.5. The use of the drug chart in the Gosport War Memorial Hospital is also significantly in deficient. In particular:

- The failure to give regularly the drugs prescribed on the regular side of the drug chart without explanation in medical or nursing notes.
- Prescription of a large range of a controlled drug in the "as required" side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

1. I understand that my overriding duty is to the court, both in preparing reports and in giving oral evidence. I have complied and will continue to comply with that duty.
2. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert are required.
3. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.
4. I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.
5. Wherever I have no personal knowledge, I have indicated the source of factual information.
6. I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.
7. Where, in my view, there is a range of reasonable opinion, I have indicated the extent of that range in the report.
8. At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I

subsequently consider that the report requires any correction or qualification.

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

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature: _____ Date: _____

Jean STEVENS
DOB: Code A
Died: 22/05/1999

SUMMARY OF CONCLUSIONS

Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with severe left hemiplegia , probable myocardial infarction and continued myocardial ischemia.

She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

There is some evidence of poor medical practice in Haslar.

Documentation and management of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital.

The use of the drug chart in the Gosport War Memorial Hospital is also significantly deficient.

1. INSTRUCTIONS

To examine the medical records, and comment upon the standard of care afforded to the patient in the days leading up to her death against the acceptable standard of the day.

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day?

2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case?

3. CHRONOLOGY/CASE ABSTRACT.

(The numbers in brackets refer to the page of evidence. For the three volumes: number / 1, number / 2 and number / 3)

3.1. Jean Stevens was a 72 year old lady at the time of her death in the Gosport War Memorial Hospital on 22 May 1999. She had a long past medical history including diverticular disease diagnosed in 1982 (24/1), appendisectomy in 1967, various arthritic pains, atrial fibrilation from 1994 (854/2), asthma needing inhalers and a gastric ulcer in 1994 (753/2).

3.2. However as a result of abdominal pain she undergoes a Sigmoid colectomy in 1995. This is complicated by what is eventually found to be an colo-vaginal fistula and she undergoes a further laparotomy (135-36/1) after which she is very ill and needs a period of time in the intensive care unit. However, she does eventually return home although continues to get chronic abdominal pain with normal investigations (113/1) including a normal CT (121/1) and is finally referred to the pain clinic for her chronic abdominal pain although she does not receive the appointment before her final admission to Hasler.

3.3. 26th April 1999 she is admitted acutely to Hasler Hospital through the A&E department for both the onset of a left hemiplegia together with constant chest pain (114-117/1). The medical notes document her stormy admission (174-205/1). On 28th April she has chest pain with both EGC and cardiac enzyme abnormalities (179/1) suggesting an acute myocardial infarction and is admitted to the coronary care unit. Subsequently she has probable aspiration pneumonia on 30th April (183/1) and possibly a further MI, certainly with more chest pain on 5th May (192/1).

3.4. Nursing notes confirm her serious condition. On 5th and 6th May she is agitated and distressed needing doses of Diamorphine. On 6th May she is seen by Dr Lord (194/1) who finds her extremely unwell and certainly not fit for rehabilitation or transfer to the Gosport War Memorial Hospital. She has more chest pain on 10th May (197/1) and the family are seen on 12th May and the poor prognosis is explained (200/1). On 12th May she is reviewed by Dr Tandy (67/1) who notes she has a dense flaccid hemiplegia and very dysarthric speech although she can obey simple commands. She is tolerating naso-gastric feeding but because of her recent chest pain was certainly not stable for transfer yet.

3.5. The nursing notes said that she was stressed and agitated on 15th May (95/1) and required subcutaneous Diamorphine, however, on 16th May (98/1) she slept well without it. On 17th May she is very demanding and continually disturbing other patients with calling out. On 18th May she has general aches and pains despite regular Co-codamol, although on 19th May (91/1) she is settled and slept all night. Her blood tests confirm her poor health with a very low albumin of 23 and a raised white cell count of 16 (201/1) on 13th May. She remains pyrexial on 17th May with crepitations at her left base and an albumin of 22 and a white cell count of 14 (203/1).

3.6. She is transferred after discussion with the Gosport War Memorial Hospital (GWMH). But the transfer letter written on the 19th (69/1)

fails to mention that she is receiving regular Co-dydramol, although it does state she is on Diamorphine 5 mgs subcutaneous PRN for pain.

3.7. The drug chart from Haslar appears on pages (71-72/1) and (550-560/2). She is written up for Diamorphine 2.5mg IV 4hourly PRN on the 1st May, changed to 5mg SC PRN from the 13th May and receives 12 doses in total between the 5th of May and the 16th May. She is also written up for Co-codamol 2 tablets QDS on the 26th April and receives regular doses until the 29th April. Co-dydramol is started on the 17th May and continues until the 19th. According to the drug chart no drugs of any sort are given on the morning of the 20th May, the day she is transferred.

3.8. The medical receiving notes on 20th May (20/3) comprise a brief summary starting with "transfer to Daedalus Ward 555K". It documents that she had a left dense hemiplegia, her past medical history and her current Barthel. Her examination is recorded. So there is no other medical note and the next note is a nursing note on 22nd May verifying death by a nurse. I do not understand the 555K note.

3.9. The nursing cardex records her transfer at 1340 on 20th May. It records her NG feeding and slurred speech but Mrs Stevens appeared quite alert and aware of her surroundings (26/3). A Barthel is recorded at 1 (32/3), a Waterlow of 25 (30/3) and an abbreviated mental test score of 4 out of 10 (33/3). The nursing contact sheet starts on 21st May (34/3) at 1130. It is possible that the contacts sheet for the 20th May is missing. This sheet records that "now on regular (4 hourly Oramorphine 10 mgs in 5 mls)". At 1800 she has been "uncomfortable despite 4 hourly Diamorphine. Husband seen and care discussed, very upset, agreed to commence syringe driver at an equivalent dose to Oramorphine with Midazolam, aware of poor outlook but anxious that medication given should not shorten her life. At 1945 commenced syringe driver". On 22nd May condition deteriorating, very bubbly, on Hyoscine 800 mgs added to 20 mgs of Diamorphine and 20 mgs Midazolam. With Hyoscine increased to 1600 is very bubbly at 1020 (35/3).

3.10. The handling profile (42/3) under the client risk factor 'pain' states "abdominal pain". The nursing care plan of 20th May (58/3) documents problems with the nasal gastric tube and the night care plan (60/3) states that on 20th May, Oramorphine 2.5 mls given as per cardex, complaining of pain in stomach and arm.

3.11. The drug chart has Oramorphine in 10 mgs in 5 mls, oral 5 mgs 4 hourly enough to start on 21st May, however, only two doses are given at 1000 and 1400 and the other doses are omitted. It also has

Oramorphine 10 mgs in 5 mls for 10 mls nocte to start on 21st May also written as a regular prescription but again this is never given. Oramorphine 10 mgs in 5 mls orally 2.5 – 5 mls 4 hourly as required is written up on 20th May, 5 mgs are given on 4 doses as documented in Table 1. Diamorphine 20 – 200 mgs S/C in 24 hours is written up on 20th May on the as required part of the drug chart and started at 1920 on 21st May, 0830 on 22nd May and restarted again with the increase of dose of Hyoscine at 1030 on 22nd May. Midazolam 20 – 80 mgs subcut in 24 hours in written up on 20th May as required and 20 mgs is started at 1920 on 21st May at 0800 on 22nd May and again restarted at 20 mgs at 1030 on 22nd May.

TABLE 1

Drug	Prescribed as	Prescriber	Given Doses
Diamorphine 2.5 mg IV PRN 01/05 changed to: 5mg SC PRN 13/05	As required	?	05/05 x1 06/05 x2 08/05 x2 09/05 x1 10/05 x1 12/05 x1 13/05 x1 15/05 x2 16/05 x1
Oramorphine 10 mgs in 5 mls For 10mls nocte to start 21/05	Regular	BARTON	Never given
Oramorphine 10 mgs in 5 mls Oral 5 mls 4 hourly to start 21/05	Regular	BARTON	21/05 1000 10mgs 21/5 1400 10mgs (other doses not given)
Oramorphine	As required	BARTON	20/05 1430 5 mgs

10 mgs in 5 mls Oral 2.5 – 5 mls 20/05 4 hourly	(PRN)		20/05 20/05 21/05	1830 2245 0735	5 mgs 5 mgs 5 mgs
Diamorphine 20 – 200 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 22/05 22/05	1920 0830 1030	20 mgs 20 mgs 20 mgs
Midazolam 20 – 80 mgs S/C in 24 hours 20/05	As required (PRN)	BARTON	21/05 22/05 22/05	1900 0800 1030	20 mgs 20 mgs 20 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

4.1. This section will consider if there were any actions or omissions by the medical team, nursing staff or attendant GP's that contributed to the demise of Jean Stevens, in particular, whether beyond reasonable doubt, the actions or omissions more than minimally, negligibly or trivially contributed to death.

4.2. Mrs Stevens was 72 at the time of her final admission to the Gosport War Memorial Hospital although she had long standing cardiac and gastrointestinal problems and had been very seriously ill needing intensive care during 1995. She also had chronic unexplained abdominal pain and with recent negative investigations she had been referred to a chronic pain clinic for management.

4.3. However, her acute admission was with a severe and dense left sided stroke on 26th April. She had also had constant chest pain that day and when she had further chest pain on 28th April, it seems likely that she had a definite myocardial infarction simultaneously with her stroke. She then suffered from probable

aspiration pneumonia and was extremely ill for several days including having further chest pain.

4.4. Nursing and medical notes document that the family is seen and indeed the medical staff think that it is likely that she is going to die. Certainly she is restless and distressed and in my view probably clinically unstable certainly until 17th May as she still had abnormal signs in her chest, pyrexial and had a raised white count with a very low albumin. There is to be no doubt that her prognosis was extremely poor both from the likelihood of surviving or even getting significant improvement from her stroke.

4.5. During her admission to Hasler she is written up on the PRN side of the drug chart for 2.5 ms IV then 5 mgs SC PRN of Diamorphine. This would be a standard regime for people suffering myocardial infarction with recurrent cardiac pain. The drug is given on a number of occasions in Haslar sometimes for pain and sometimes for non-specific distress, judging from the nursing cardex. It would be perfectly appropriate to use this dose of Diamorphine if she was getting recurrent pain as it would not be possible to intervene in other ways because of her stroke. It seems likely that a clinical management decision (not recorded) was made on the 17th May to stop using Diamorphine and restart a regular oral analgesic, Co-dydramol, given via the NG tube. No further doses of Diamorphine are given in Haslar after 00.10 early on the morning of the 16th May.

4.6. She is seen on two occasions by Geriatricians, who both think she was unstable at that time and not yet suitable for transfer. I would strongly agree. Indeed there is then a further a discussion before it is agreed that she will go to the GWMH. In my view she was likely to be still unstable and it will have been clinically prudent to keep her for another week in Haslar. There can be no doubt that she is getting continued pain. She is written up for 6 hourly Co-dydramol which she received 4 times a day for the 2 days before her transfer to GWMH.

4.7. The drug chart appears to show poor prescribing practice at Haslar as the dose of Diamorphine is not written in words as well as figures nor is the total dose to be given written on the drug chart. There is no evidence she was given her regular medication, including oral analgesia, on the morning of her transfer and the Co-dydramol is not mentioned on the transfer letter.

4.8. There is a summary of the clinical problems functional status upon arrival at GWMH but it is not clear from the notes whether the

patient was examined, and if she was, the examination was not recorded. There is no medical assessment on whether or not she is pain, and if she is in pain why she is pain, nor of her clinical status upon arrival in particularly as she had been so ill recently. In my view this is poor clinical practice.

4.9. She is not written up for the Co-dydramol that she was on regularly at Haslar although it was not mentioned in the transfer letter. On the PRN part of the drug chart doses of Oramorphine are written up orally and a large range of Diamorphine and Midazolam is written up as required There is no documentation in the medical notes at Gosport War Memorial Hospital as to why these drugs were written up upon admission without apparently a clinical assessment of her pain or clinical status. Nor is there any explanation of why no other analgesics apart from strong opiates were prescribed. One note in the nursing cardex refers to abdominal pain which of course may have been the same pain that she had for many years prior to her admission. In general the Diamorphine she had received at Hasler had been for chest pain and further angina. There is no evidence in the medical or nursing cardex that she has any acute cardiac problems or angina in GWMH. In my view this management was poor clinical practice

4.10. She receives her first dose of Oramorphine at 1430, only 45 minutes after the nursing cardex records her arrival and then receives a further 3 doses until the morning of 21st. It is not clear whether it was a nursing or medical decision to actually give the Oramorphine.

4.11. On 21st May a decision is made that she is dying and she should be for symptom control with a syringe driver. Including the two doses given on the morning of 21st May she had received in total 40 mgs of Oramorphine in a 24 hour period. In these circumstances and assuming the patient was still distressed then it would be reasonable to start with 20 mgs of Diamorphine in a syringe driver over 24 hours. However, in my view it is unacceptable clinical practice to give the doses of Oramorphine in the first 24 hours after her arrival and start the syringe driver without making and recording a clinical assessment in the medical notes.

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chart before it is required and it is not written in words or figures nor is the total dose written.

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5. OPINION

5.1. Mrs Stevens was a 72 year old lady with known bowel disease, cardiac disease and chronic abdominal pain who was admitted with a severe left hemiplegia, probable myocardial infarction and continued myocardial ischemia.

5.2. She has a difficult and complex admission to the Haslar and was lucky to survive immediate admission.

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- The apparent failure to give her regular medication, including oral analgesia, on the morning of her transfer to the GWMH.
- The failure to document the regular Co-dydramol in the transfer letter.
- The early transfer of a patient who had been seriously ill and clinically unstable to the short period before transfer.

5.4. Documentation of her medical care was inadequate and in my view unacceptable medical practice in the Gosport War Memorial Hospital. In particular:

- Lack of a documented medical assessment on admission.
- Lack of any recorded assessment of her clinical condition and in particular her source of pain.

- Starting regular opioid analgesia within an hour of admission and a syringe driver within 24 hours of admission ,without any medical records of justification for either regular strong opioid analgesia or a syringe driver .
- The failure to prescribe any analgesia other than the strong opiate analgesia on admission to the GWMH.
- The lack of a written justification requiring both Diamorphine and Midazolam in the syringe driver.

5.5. The use of the drug chart in the Gosport War Memorial Hospital is also significantly in deficient. In particular:

- The failure to give regularly the drugs prescribed on the regular side of the drug chart without explanation in medical or nursing notes.
- Prescription of a large range of a controlled drug in the "as required" side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as the total dosages to be given.

6. EXPERTS' DECLARATION

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subsequently consider that the report requires any correction or qualification.

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

10. I have attached to this report a statement setting out the substance of all facts and instructions given to me which are material to the opinions expressed in this report or upon which those opinions are based.

7. STATEMENT OF TRUTH

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

Signature: _____ Date: _____

'rom: Code A
ent: 21 Apr 2008 12:22
'o: Valerie Barr Code A
ubject: FW: Meeting
'al,

'ou have already booked a room and refreshments for this meeting on 16 May but you will note that two dditional people from the NMWC are now attending, in light of this please see whether you can obtain a igger room and increase the catering.

'lease also update the visitors list.

ttendees:

le
arah Ellson (FFW)
amsin Hall (FFW)

laire Strickland (Nursing and Midwifery and Council)
lrs Jo MacDoanld (Nursing and Midwifery and Council)

lark Mallinson (Nursing and Midwifery and Council)

'eter Swain may also attend.

'lease let me know the outcome.

'hanks
Code A

---

rom: Mark Mallinson Code A
ent: 21 Apr 2008 10:37
'o: Code A
ubject: RE: Meeting

Code A

'hanks for arranging this. Please note that I and Mrs Jo McDonald will also be attending with Clare. everal recent enquiries concerning the nurses have meant that Jo , who is head of case management, hould attend any discussions.

lark

---

rom: Code A
ent: 14 April 2008 12:52
o: Code A
c:
ubject: RE: Meeting
nportance: High

ear Mark,

s Sarah and Tamsin will be travelling from Manchester for this meeting, I would be grateful if you would cknowledge receipt of the email below.

/ith thanks
Code A

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rom: Code A
ent: 3 Apr 2008 15:28
o: Code A
c:
ubject: Meeting

ear Mark,

urther to our telephone conversation today thank you for confirming that Claire is able to attend the neeting to discuss the Gosport War Memorial Case on the 16th.

he details of the meeting are:

ate: 16 May 2008
ime; 9.30 to 11.30
enue: GMC, Room 2.18, Second Floor, 350 Euston Road, Regents Place, London NW1 3JN

lease ask Claire to report to our ground floor reception when she arrives.

will be attending the meeting as well as our Solicitors, Sarah Ellson and Tasmin Hall.

would be grateful if you would let me know if anyone else from the NMC will accompany Claire.

lease acknowledge receipt of this email.

/ith kind regards
Code A

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ieneral Medical Council

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'he Tun, 4 Jacksons Entry, Holyrood Road, Edinburgh. EH8 8AE

:egus House, Falcon Drive, Cardiff Bay. CF10 4RU

0 Adelaide Street, Belfast. BT2 8GD

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'ax: 0845 357 9001

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itsupport@nmc-uk.org

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'1B 1PZ and registered charity number 1091434.

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/w.nmc-uk.org

****

'rom: Code A
ent: 21 Apr 2008 12:37
'o: 'Mark Mallinson'
:c: Code A
ubject: RE: Meeting
lark,

hank you for confirming who is attending.

Ve look forward to meeting to you all.

Code A

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rom: Mark Mallinson Code A
ent: 21 Apr 2008 10:37
'o: Code A
ubject: RE: Meeting

Code A

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lark

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rom: Code A
ent: 14 April 2008 12:52
'o:
:c: Code A
ubject: RE: Meeting
mportance: High

)ear Mark,

.s Sarah and Tamsin will be travelling from Manchester for this meeting, I would be grateful if you would cknowledge receipt of the email below.

Vith thanks
Code A

---

om: Code A
ent: 03 Apr 2008 15:28
o:
c: Code A
ubject: Meeting

ear Mark,

urther to our telephone conversation today thank you for confirming that Claire is able to attend the eeting to discuss the Gosport War Memorial Case on the 16th.

ne details of the meeting are:

ate: 16 May 2008
me; 9.30 to 11.30
enue: GMC, Room 2.18, Second Floor, 350 Euston Road, Regents Place, London NW1 3JN

lease ask Claire to report to our ground floor reception when she arrives.

will be attending the meeting as well as our Solicitors, Sarah Ellson and Tasmin Hall.

would be grateful if you would let me know if anyone else from the NMC will accompany Claire.

lease acknowledge receipt of this email.

/ith kind regards
Code A

0 Adelaide Street, Belfast. BT2 8GD

'el: 0845 357 8001
'ax: 0845 357 9001

****

****

rom: Hall, Tamsin [Code A]
ent: 21 Apr 2008 15:54
o: [Code A]
ubject: Ltr to Ian Barker MDU 21.04.08.DOC

ttachments: DOCS_7343749_1.DOC

s promised, here is my draft letter to the defence.

particularly wanted to check you are happy with the section I have left in italics regarding ean Stevens.

lso, please note that we do have a lot of witnesses to get through. We are hoping that the efence will agree much of the evidence and some of the witnesses will not take too long on ie stand. However, we do have some concerns about the 8 week listing potentially which I anted to flag up now.

/e don't think that we need to alter the listing at this stage but will need to keep an eye on iis. As we have 'booked' Counsel and the expert it would perhaps be preferable to take the sk of going part-heard so as not to lose the September start. I would be grateful for your ioughts.

lso, I need to discuss with you notifying the families of the patients as to whether their ases will be proceeding. I wondered if you would like the letters to go out from Field Fisher /aterhouse or from the GMC? (Either way I am, of course, happy to draft the letters)

hanks for looking at this letter, I would like to send it over to the defence this evening.

amsin

amsin Hall | Solicitor
or Field Fisher Waterhouse LLP
[Code A]

lobile [Code A]

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
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/eb www.ffw.com **CDE**823

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/e use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with quivalent standing and qualifications.

From: Thomas Wood Code A
Sent: 21 Apr 2008 15:03
To: Code A

Attachments: Scan001.PDF

Code A

This letter came by fax today, I've put a copy on Siebel.

Tom

Thomas Wood
Investigation Officer
Fitness to Practise Directorate
Direct Dial: Code A
Fax No:
Email: Code A

-----Original Message-----
From: SCANNER@GMC-UK.ORG [mailto:SCANNER@GMC-UK.ORG]
Sent: 21 April 2008 17:21
To: Thomas Wood Code A
Subject: Scan from a Xerox WorkCentre Pro

Please open the attached document. It was scanned and sent to you using a Xerox WorkCentre Pro.

Number of Images: 2
Attachment File Type: PDF

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From: Rebecca Faulkner Code A
Sent: 22 Apr 2008 10:44
To: Code A
Cc:
Subject: Dr Barton Further Stage 5 (22 April 08)

Attachments: Barton Further Stage 5 22 April 08.doc; GMC Case Protocol stage 5 form.doc; Annex F - BT Meet Me Guide.doc

Hello,

Please find attached the minutes of this morning's conference

Barton Further Stage 5 22 Apri...

As noted, we will speak again on 5 June 08 at 10:00. Blank agenda and dial in details attached for your reference.

GMC Case Protocol stage 5 form...

Annex F - BT Meet Me Guide.doc...

Kind regards,

Rebecca

Rebecca Faulkner
Adjudication Co-ordinator
General Medical Council
Manchester DDI : Code A

rom: Code A
ent: 23 Apr 2008 16:12
o: Code A
c:
ubject: Dr Barton
ello,

vrite further to your previous two emails which I have now discussed with Peter:

dna Purnell

/e agree with Counsel's and your advice that this case should not be added to Dr Barton's charges.

owever, as criticisms have been made possibly against Dr Lord and Dr Reid who are our possible itnesses, please ask Counsel to advise whether there is sufficient evidence to establish impairment due misconduct or performance in respect of any of them.

ean Stevens

/e agree that this case should be added to the existing charges.

alsar Hospital

/e note that Professor Black has made some criticism of Mrs Stevens care at the Halsar Hospital.

eter is of the view that we should continue with Dr Barton's case and then consider any other lines of nquiry when the hearing has finished as any other allegations against other doctors would have to be onsidered under the new rules.

harges

/e note that the charges maybe further amended and we will check them when they are re-submitted.

ule 11(2)

t some point please provided reasoning in respect of all the cases that have been added in terms of rule 1(2)

rovided that, where the Committee refer any case relating to conduct to the Professional Conduct ommittee and **the Solicitor (or the complainant) later adduces grounds for further allegations of erious professional misconduct of a similar kind,** such further allegations may be included in the harge or charges in the case, or the evidence of such grounds for further allegations may be introduced at ne inquiry in support of that charge or those charges, notwithstanding that such allegations have not been eferred to the Committee or formed part of the subject of a determination by the Committee.'

isk of Case going part heard

eter is of the view that you think we need more time we should ask Adjudication if it is possible to extend ne current listing now, but we should not move the current listing date.

etter to the patient's families

lease draft the letters to the patient's families advising them of whether of whether of not the allegations oncerning their relatives will be heard at the hearing and I will sign them.

Code A

rom: Peter Swain Code A
ent: 30 Apr 2008 15:05
o: Code A
ubject: RE: GMC v Dr Barton
Code A

n not at all convinced that the finding of the inquests would be relevant to our hearing, since as I nderstand it we are not alleging that Dr Barton caused the deaths of the patients. However, I cknowledge the risk that the inquests could arrive at conclusions that are inconsistent with the outcome the FtPP if we hold our hearing first. Even so, these cases have been so thoroughly looked already, it is fficult to see new factors or evidence emerging at the inquests.

et's discuss tomorrow. We may well need a con at least with FFW and possibly with counsel.

eter

---

rom: Code A
ent: 30 April 2008 14:59
o: Peter Swain Code A
ubject: FW: GMC v Dr Barton

eter,

ou will note from the attached that the Coroner is due to open Inquests into 10 cases, eight of which are ue to be considered by the FTPP.

/e will need to discuss whether we can continue with the September FTP hearing as the finding of the nquest will be relevant to our own investigation and may have an impact on the cases we have decided to roceed and not proceed with.

Code A

---

rom: Code A **On Behalf Of** Hall, Tamsin
ent: 30 Apr 2008 14:46
o: Code A
c: Ellson, Sarah
ubject: GMC v Dr Barton

)ear Code A

'lease find attached letter from the Coroner which arrived at these offices yesterday. ;arah Ellson and Tamsin Hall are presently out of the office but wanted you to have ıis information which they will discuss with yourself and Peter later in the week.

;ind regards

Code A **Secretary to Sarah Ellson, Tamsin Hall, Laura Kelly and Kelly McMahon**
)r Field Fisher Waterhouse LLP
Code A

:onsider the environment, think before you print!

ield Fisher Waterhouse LLP Portland Tower Portland Street Manchester M1 3LF
el+44 (0)161 238 4900 **Fax**+44 (0)161 237 5357 **E-mail** info@ffw.com
/eb www.ffw.com **CDE**823

rom: Code A
ent: 30 Apr 2008 14:46
o: Code A
c: Ellson, Sarah
ubject: GMC v Dr Barton

ttachments: DOCS_7397092_1.PDF

ear Code A

lease find attached letter from the Coroner which arrived at these offices yesterday. arah Ellson and Tamsin Hall are presently out of the office but wanted you to have iis information which they will discuss with yourself and Peter later in the week.

ind regards

Code A **Secretary to Sarah Ellson, Tamsin Hall, Laura Kelly and Kelly lcMahon**
)r Field Fisher Waterhouse LLP
d: Code A

onsider the environment, think before you print!

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'eb www.ffw.com **CDE**823

Field Fisher Waterhouse

Case Report
January 2008

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Hall / Sarah Ellson
Date of Rule 8 letter:	Old rules
Date considered by Case Examiner:	14/02/02
Date FFW Instructed:	11 May 2007
Class of Case (1-5)	Class 5
Target date for completion of investigation:	End of January 2008
Interim Order Expires:	IOPs held 21 June 2001, 21 March 2002, 19 September 2002 – No orders made

Summary: Dr Barton is a GP. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis at the Gosport War Memorial Hospital. Dr Barton retired from this post in 2000. A number of complaints were made by relatives of elderly patients who had died at GWMH in 1998. The common complaint was that patients admitted to the GWMH for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. Hampshire Police carried out three extensive investigations between 1998 and 2006 and the deaths of 92 patients were examined. Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation. 10 cases were referred to the CPS. The Crown Prosecution Service reviewed the evidence and concluded that the prosecution test was not satisfied and there was insufficient evidence for criminal proceedings.

The 10 cases were ED, EL, SG, RW, ES, RL, LP, HS, GP and AC [RW and AC together with EP, AW and GR were included in the GMC rule 6 referral letter sent in 2002 after the first police referral]. There are 2 further cases where the patient's relatives have expressed an interest in the investigation.

Investigations: Counsel has prepared advice regarding Doctors Lord, Tandy and Reid and which patients to proceed with. We are due to interview healthcare professionals and are in the process of completing production statements for all witnesses.

Recommendation: Professor Black to finalise expert reports, production statements from witnesses for their police statements and visits to witnesses as necessary, liaise with Coroner, police and PCT, .

Listing time estimate: 8 weeks.

Counsel: Tom Kark

Listed: 8 September – 31 October 2008

Prospects of Success: Medium

Field Fisher Waterhouse

Case Report
February 2008

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Hall / Sarah Ellson
Date of Rule 8 letter:	Old rules
Date considered by Case Examiner:	14/02/02
Date FFW Instructed:	11 May 2007
Class of Case (1-5)	Class 5
Target date for completion of investigation:	End of January 2008
Interim Order Expires:	IOPs held 21 June 2001, 21 March 2002, 19 September 2002 – No orders made

Summary: Dr Barton is a GP. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis at the Gosport War Memorial Hospital. Dr Barton retired from this post in 2000. A number of complaints were made that patients admitted to the GWMH for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. Hampshire Police carried out three extensive investigations between 1998 and 2006 and the deaths of 92 patients were examined. Of these 92, 10 cases were referred to the CPS who reviewed the evidence and concluded that the prosecution test was not satisfied and there was insufficient evidence for criminal proceedings. The 10 cases were ED, EL, SG, RW, ES, RL, LP, HS, GP and AC [RW and AC together with EP, AW and GR were included in the GMC rule 6 referral letter sent in 2002 after the first police referral].

We have served the DNOH and included charges on LP, EL, EP, AW, GR, RL, AC, RW, ES, GP, ED (11 patients in total). Counsel has advised that there is not enough evidence to proceed regarding SG and HS.

Professor Black is preparing reports on EP and JS in order to ascertain if they could also be included.

Investigations: We have interviewed most witnesses and are finalising their statements. We have inspected the CHI files.

Recommendation: Professor Black to finalise outstanding expert reports, production statements from witnesses for their police statements and visits to witnesses as necessary, liaise with Coroner, police and PCT.

Listing time estimate: 8 weeks.

Counsel: Tom Kark

Listed: 8 September – 31 October 2008

Prospects of Success: Medium

Field Fisher Waterhouse

Case Report
April 2008

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Hall / Sarah Ellson
Date of Rule 8 letter:	Old rules
Date considered by Case Examiner:	14/02/02
Date FFW Instructed:	11 May 2007
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Investigations: Professor Black has now done all his "new" reports including a generic report. Charges for JS (Patient L) have been served on the defence – they are objecting to the late additional of another patient. The defence have not applied to change the hearing date but are raising it in light of additional charge, delay in getting evidence to them (consequence of complex case) and possibility of inadequate time. Counsel has drawn up list of witnesses and we are continuing to finalise witness statements. The Coroner has indicated intention to have inquests in "the autumn".

Recommendation: Chase remaining outstanding witness statements and disclose. Obtain and disclose expert reports in new format for old cases (ie modify police reports). Advice defence if we are calling Reid, Lord and/or Tandy. Decide with GMC how and whether Inquest may affect listing. Meeting with NMC on 16 May to discuss their related cases. Sort possible pharmacist/pharmacology expert to discuss drugs charts and medication used.

Listing time estimate: 8 weeks. **Counsel:** Tom Kark and Ben Fitzgerald

Listed: 8 September – 31 October 2008 **Prospects of Success:** Medium

Confidential
Addendum (I)
BARTON

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee
13 October 2004

Information: Further information:

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday 21 March 2002

PROFESSOR NORMAN MACKAY in the Chair

Case of
BARTON, Jane Ann

DR BARTON was present and was represented by MR A JENKINS of counsel, instructed by the Medical Defence Union.

MR J LLOYD of counsel, instructed by Field Fisher Waterhouse, the Council's Solicitors, appeared in order to present the facts to the Committee.

[*The Chairman introduced those present to Dr Barton and her legal representatives.*]

MR LLOYD: Dr Barton was previously before this Committee in June of last year, when she was subject to police investigation into the death of an elderly lady by the name of Gladys Richards at Gosport War Memorial Hospital in 1998. The only evidence before the Committee in June of last year were statements taken by police from her two daughters, the medical notes of Mrs Richards and exculpatory statements by Dr Barton herself, and by Dr Lord, the consultant geriatrician of the ward to which Mrs Richards was admitted. Those documents appear at pages 7 to 278 of the Committee's bundle. There was at that time no independent medical expert opinion indicating any fault on the part of Dr Barton and, in those circumstances, the Committee found no grounds on which to make an order concerning her registration. The transcript of the proceedings is at pages 280 to 289 of the bundle.

As I say, at the time of that hearing the police investigation was still continuing, not only into the death of Mrs Richards but into the deaths of four other patients as well. The police subsequently received three experts' reports on these five cases: the report of Professor Livesley, which is at pages 294 to 327 of the bundle, into the case of Mrs Richards only; the report of Dr Mundy, which is at pages 328 to 334 of the bundle, which relates to the other four patients; and the report of Professor Ford, at pages 335 to 373 of the bundle, which deals with all five cases.

Having received advice from counsel, the police decided not to prefer criminal charges against the doctor, but the reports were forwarded to the Fitness to Practise Directorate in the light of very serious concerns raised about the standard of care given by Dr Barton and, in the light of those matters, it has been referred back to this Committee.

At the relevant time Dr Barton was working as a clinical assistant in elderly medicine at Gosport War Memorial Hospital. Can I deal with the reports, first of all insofar as they relate to Gladys Richards? Mrs Richards was a 91-year-old patient who was operated on for a fractured femur on 28 July 1998 and transferred to Daedalus ward at the hospital on 11 August 1998. She was further operated on on 14 August 1998 and returned to the ward on 17 August.

Professor Livesley's opinion is at pages 307 to 311 of the Committee's bundle. Perhaps I can summarise the opinions which I appear in those pages, I hope accurately. It says first of all that, despite recording that Mrs Richards was not in pain on 11 August 1998, she was prescribed wide dosage ranges of opiate and sedative drugs to which Mrs Richards was known to be sensitive. Secondly, when she returned to the ward on 17 August 1998 in pain, but not suffering any life-threatening condition, she was not given oral pain relief but continuous subcutaneous administration of diamorphine, haloperidol and midazolam from 19 August until her death on the 21st. During that time at no time did Dr Barton appropriately review Mrs Richards' condition. Also, thirdly, during this period there is no record of Mrs Richards being given fluids as food in an appropriate manner.

So far as Dr Ford's report is concerned, he deals with this case at pages 341 to 347 of the Committee's bundle. I would ask the Committee to refer to the paragraphs at 345-6, "Evaluation of drugs prescribed and the administration regimens". I shall not read out passages from those paragraphs but I shall, if I may, refer to the summary conclusions at page 347, in which the doctor says,

> "During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Barton. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death".

Perhaps I can move on to the second patient, Arthur Cunningham. He was aged 79 when he was admitted to the hospital on 21 September 1998, to attempt to heal and control pain from a sacral ulcer. His case is dealt with by Doctors Mundy and Ford. Dr Mundy's comments are at pages 330 to 331 of the bundle. Perhaps I can summarise his criticisms. He said, "Morphine was started without any attempts to control the pain with less potent drugs"; the use of a syringe driver was started without clear reason, and the dose of diamorphine increased without clear indication.

So far as Dr Ford is concerned, his report into the case of Mr Cunningham is at pages 348 to 354 of the bundle. Again, may I refer the Committee, without reading it, to the passage which is headed "Evaluation of drugs prescribed" at pages 350, and the summary at page 354, which I will read if I may.

> "The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression."

Moving on to the case of Alice Wilkie, she was an 81-year-old lady who was admitted to Gosport on 6 August 1998 with urinary tract infection, complaining of pain, and she was prescribed diamorphine. Dr Mundy deals with this patient at page 331 of the Committee's bundle and his comments are these:

> "There was no clear indication for an opioid analgesic to be prescribed and no simple analgesics were given, and there was no documented attempt to establish the nature of her pain. In my view the dose of diamorphine that was prescribed...initially was excessive and there is no evidence that the dose was reviewed prior to her death".

Dr Ford deals with this at pages 355 to 358. His conclusion at 358 is this:

51

> "In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death".

The case of Robert Wilson, aged 75. He was admitted to Gosport on 14 October 1998, having suffered a fractured arm. He was also known to suffer with alcohol abuse, gastritis, hyperthyroidism and heart failure.

Dr Mundy deals with that at pages 331 to 332. He has no significant criticism of Dr Barton.

Dr Ford is more critical at pages 359 to 363. Again I would refer the Committee to the "Evaluation of drugs prescribed and the administration regimens", and perhaps I can read some extracts from those paragraphs.

> "The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate."

At paragraph 5.12,

> "The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate".

Paragraph 5.13,

> "The increase in diamorphine dose...is not appropriate...and potentially very hazardous. Similarly the addition of midazolam...was...highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive".

Finally, the case of Eva Page. She was an 87-year-old lady who was admitted to Gosport on 27 February 1998 for palliative care, having been diagnosed with possible lung cancer. Dr Mundy deals with her case at pages 332 to 333 of the bundle. He says that, in the absence of any symptoms relevant to the cancer and of any pain, she was inappropriately started on opioid analgesia.

Dr Ford deals with the matter at pages 364 to 368 of the Committee's bundle. Again, I ask the Committee to refer to his evaluation and to the summary at page 368. He says,

> "In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton on 3 March. In my view this was an inappropriate, potentially hazardous prescription".

That deals with the reports of those three experts.

51

The most recent developments in relation to the doctor's practice insofar as they relate to her hospital practice are revealed in letters from the NHS Trust, which are at pages 378 to 380 of the bundle. I would ask the Committee to have regard to those. They are both dated 13 February 2002.

It is clear that Dr Barton has entered an arrangement with the Trust, and we can see at page 380 that it has been agreed that she "would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital" and that she "would voluntarily stop prescribing opiates and benzodiazepines with immediate effect". It would appear from page 378 that the arrangements that have been come to with her would be reviewed subsequent to this hearing.

So far as any conditions upon this doctor's registration are concerned, clearly the Committee will have regard to the issues of protection of the public and public confidence in the profession. It is our submission that it would not be appropriate that this doctor's registration should remain unrestricted, and that the voluntary arrangement into which she has entered should be formalised by conditions, perhaps along the lines of those imposed by the NHS Trust.

I know not whether the doctor has any private practice outside of her NHS practice, but it may be that the Committee would wish to consider imposing a condition which restricts her to NHS practice, for the purpose of her ongoing supervision. Those are my submissions on behalf of the Council.

THE CHAIRMAN: There may be questions from members of the panel.

MR WARDELL: Is your last point that you certainly are not seeking for the Committee to consider suspending this doctor? I wanted to clarify that.

MR LLOYD: It is a matter of course for the Committee, but I have taken instructions on it this morning to clarify the position. The position is as I have set it out.

MR WARDELL: There is another matter, and it may be that Mr Jenkins wants to develop this. I have no idea what is in his mind, but I wanted to seek clarification as to whether the Committee is entitled to know what is Dr Lord's role in this matter, as is set out in the Hampshire Constabulary letter which is in front of us at page 292. There is implicit criticism there of the consultant in charge. Are we entitled to know whether that particular consultant has been referred to the Council, or whether the police are continuing their investigations into him, or whatever? It may be that could be relevant to the part that this doctor has played relative to the consultant.

MR LLOYD: I can certainly say that, so far as any police investigations are concerned, they are concluded, and there are no police investigations ongoing into Dr Lord. I wonder if I may take instructions on the other matter? [*Having taken instructions*] I have no instructions on any other action taken against Dr Lord.

S14

THE CHAIRMAN: The working relationship between Dr Lord and Dr Barton might be explored through Mr Jenkins.

In the absence of further questions, Mr Jenkins, would you like to begin?

MR JENKINS: Sir, what I propose to do is ask Dr Barton to give evidence before you.

JANE ANN BARTON, Sworn
Examined by MR JENKINS

Q Dr Barton, I want briefly to go through your *curriculum vitae*. The Committee will see from the front page of their blue papers that you qualified with the degree MB BCh 1970 in Oxford and that your home address is in Gosport. If we turn to page 266 of the bundle, we can see a statement produced by you to the police at a stage some months ago. I want to go through it with you, if we may.

You say in the second paragraph there that you joined your present GP practice, initially as an assistant, then as a partner and, in 1988, you took up the additional post of clinical assistant in elderly medicine on a part-time session basis. You say the post originally covered three sites but, in due course, was centred at Gosport War Memorial Hospital. You retired from that position this year. I think you retired in the spring 2000, is that right?
A Yes, that is right.

Q How many sessions were you doing at the War Memorial Hospital? I think we have the answer at paragraph 4, but I will just ask you about it. Tell us how many sessions you were doing.
A The health care trust allocated me five clinical assistant sessions, of which one and a half were given to my partners in the practice to cover the out-of-hours aspect of the job; so that I remained with three and a half clinical assistant sessions in order to look after 48 long-stay geriatric beds. I would visit each of the wards at 7.30 each morning, getting to my surgery at nine. Towards the end of the time doing the job, I was back very nearly every lunchtime to admit patients or to write up charts or to see relatives. Quite often, especially if I was duty doctor and finished my surgery at about seven in the evening, I would go back to the hospital in order particularly to see relatives who were not available during the day because they were working. That became a very important time commitment in the job.

Dryad ward had no consultant cover for the 10 months that you are considering these cases. Dr Lord was trying to cover both wards as well as her commitments on the acute side and the other hospital in the group, and found it very difficult to be there very often.

Q I will break it up and take it in stages, if I may. You would be there from 7.30 to nine o'clock each weekday morning, is that right?
A Yes.

Q You have mentioned two wards. One was Daedalus; the other was Dryad ward.
A Yes.

Q Were you in charge of both of the wards?
A Yes.

Q How many beds were there?
A Forty-eight in total.

Q Over the period with which this Committee is concerned, what was the level of occupancy typically of those 48 beds?
A We were running at about 80 per cent occupancy, but of course that was not enough for the health care trust towards the end of my time there. They attempted to increase it up to 90 per cent, which is running a unit very hot, when you have one part-time jobbing general practitioner and no increase in resources of nursing staff, support staff, OT and physio, and no support from social services.
Q How many other doctors would be there throughout the day to treat these 48 patients if all the beds were full?
A None.

Q So yours was the medical input?
A Mine was the medical input.

Q Between half-past seven in the morning and nine o'clock each weekday morning.
A Time to see each patient, to actually look at each patient, but not time to write anything very substantial about very many of them.

Q If you wanted to see relatives, were you able to see relatives at those early hours in the morning?
A No, except for that one particular case where they spent the night in her single room with her, with their notebooks. Generally, relatives preferred to see me either at lunchtime or in the evening. I would see them in the morning if it was that urgent, but it was generally not appropriate.

Q When you first started this job in 1988, what was the level of dependency typically of patients who were under your care?
A This was continuing care. This was people who – now, because their Bartell or dependency score is less than four, are a problem – went to long-stay beds and stayed there for the rest of their natural lives. So I had people that I looked after for five years, for 10 years, in these beds. The sort of people that I was given to look after in these beds generally were low dependency; they did not have major medical needs, but were just nearing the end of their lives. The analogy now, I suppose, would be a nursing home.

Q Did that position change as time went on?
A That position changed.
Q Tell us how.

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A Continuing care as a concept disappeared. The National Health Service was no longer going to look after people who were as dependent as that. It was going to go into the private sector. I cannot give you an exact year, but it happened in the 1990s. At the same time, social services found that, with their budget constraints, they had difficulty placing people with a Bartell of less than four. So there was constant conflict between what we were supposed to be looking after and doing with the patients and what the private sector was going to take from us.

Q Just explain to us, what does a Bartell of less than four mean? What is the range of the Bartell scores?
A You or I have hopefully a Bartell of 20. That means we are able to take care of ourselves; do all the activities of daily living; cut up your food and eat it; go to the loo; change your clothes; walk about. Most of these people in the places mentioned have a Bartell of zero; I think one chap had one of four. So these were very dependent people.

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

Q What you have told us is that, over time, the level of dependence of the patients increased.
A It escalated enormously: to the point where I began to be saying to my employers, "I can't manage this level of care for this number of patients on the commitment I have". But there was not anybody else to do it. During 1998, when the consultant on Dryad went on maternity leave, they made the decision not to employ a regular locum, so that I did not even have full consultant cover on that ward and so that Althea was left to attempt to help me with both, although she was not officially in charge.

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

Q Did she have other clinical commitments outside the two wards with which we are concerned?
A She had her acute wards up on the Queen Alexandra site; she had a day hospital and outpatients to run down at the St Mary's site in Portsmouth – so she was a very busy lady.

Q How often was she able to undertake a ward round on the two wards with which you were concerned?
A She did not ward rounds on Dryad ward. She came to Daedalus on the Monday to do a continuing care round. Towards the end of my job she designated six of her beds as slow stream stroke rehab' beds, and she did a Thursday ward round – which I could not always make because it was my antenatal day. She was in the hospital and doing outpatients on Thursday as well, so she was in my hospital twice a week – but available on the end of a phone if I had a problem.

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

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

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

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

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

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

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

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

Q Is <u>that</u> it?

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A Which you carry in your coat pocket. *[indicates document]*

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

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

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

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

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

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

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

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A Between 40 and 42 patients, yes.

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

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

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

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

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

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

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

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Q Perhaps I can ask this. Was it apparent that the Trust were seeking to raise the level of experience and qualification of the nursing staff in the War Memorial Hospital? And the answer should go on the transcript.
A Does it?

Q Was it apparent?
A It was not apparent that they were making any great attempts to improve the cover, the experience and the training of some of the nurses.

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

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

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

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

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

Q Did you feel that your relationship with the nursing staff was such that such informal communication could take place?
A I trusted them implicitly. I had to.
Q What we see again and again in the comments of Professor Ford and others is that the expert can see no justification for raising the level of prescribing. The expert in each case will have looked at the notes. Was there always

recorded a justification for increasing the level of prescribing or the level of administration?
A Not always in my notes. I would hope that the nursing notes would be copious enough. In particular, interestingly, the night staff tend to make more of a full record of what the patient has been like through the night. It was quite often their feeling, night sister's feeling, that the patient was less comfortable or was beginning to bubble, or something like that, that would suggest to me that we needed to move up a step or in a step with the drugs we were using.

Q I will ask you to turn to page 370, which is the final couple of paragraphs of Professor Ford's report. Paragraph 7.5, two-thirds of the way down that paragraph, he says,

> "It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward".

What do you say about levels of nursing staff on the ward during the period with which we are concerned?
A He is absolutely right. These experienced, caring nurses had the choice between tending to patients, keeping them clean, feeding them and attending to their medical needs, or writing copious notes. They were in the same bind that I was in, only even more so. As you can see from the medical records you have had, the health care trust produces enormous numbers of forms, protocols and guidelines, and sister could spend her whole morning filling those out for each patient or she could nurse a patient.

Q He goes on,

> "Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards".

Do you have a comment on that?
A I agree entirely. There was inadequate senior medical input.

Q During 10 months of 1998 was there any senior medical staff input?
A No.

Q It is not apparent that Professor Ford was aware that you were doing three and a half sessions—
A In a cottage hospital.

Q ...in the cottage hospital.
A No.
Q It may be that Professor Ford believed that you were permanent staff.
A Failed junior staff! His last comment in paragraph 7.5 – his review of Dr Lord's medical notes – is absolutely correct. She was caring and thoughtful and considerate, and with a considerable workload – probably more than she

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should have been carrying. Therefore it is difficult to criticise. She did what she could, within the constraints that she had available to her.

Q I am not going to go through the individual cases. This is not a trial; this Committee is not here to find facts proved or not proved. But I think it fair to you to invite you to comment on Professor Ford's next paragraph. He says,

> "...the level of skills of nursing and non-consultant medical staff" – it was only you – "and particularly Dr Barton",

– the word "particularly" suggests he may have believed there were other medical staff –

> "were not adequate at the time these patients were admitted".

How do you respond to that?
A I find it very upsetting. I was only a clinical assistant. The definition of a clinical assistant is in fact that it is a training post, and the only training that I received was that I went to get for myself as a part of my postgraduate learning, and I did my best at that time. In my opinion they were probably adequate.

Q Can we turn to the last page of the bundle, page 380? This is a letter dated 13 February 2002 and sets out matters that were agreed between you and the acting chief executive, Dr Old. Yes?
A Yes.

Q Attention has already been drawn to this document, but is it right that you agreed to cease to provide medical care, both in and out of hours for adult patients at the Gosport War Memorial Hospital?
A Yes.

Q And you agreed voluntarily to stop prescribing opiates and benzodiazepines.
A I did.

Q Had you not agreed those, were you threatened with any action?
A Dr Old told me that, under the change in Government legislation on 14 December last year, he was entitled to suspend me from general practice; but he did not wish to do that and, provided we came to this voluntary agreement, he would wait to see what the GMC had to say on the matter.

Q This is the same health authority who had been putting through a significantly higher volume of patients to your cottage hospital and with much higher levels of dependency?
A This is the employers of the health care trust who had been putting through significant.... The health authority in fact purchase work from the health care trust and, theoretically, employ general practitioners. So this was my employer telling me that he could suspend me from the day job as well. So I agreed to the voluntary restrictions on my practice. At that time I had four patients in general practice on opiates and approximately 15 on any form of

benzodiazepine. I handed the four patients over to my partners and said I felt no longer able to treat them. I no longer sign any prescriptions for sleeping tablets in general practice; the other partners do that for me.

Q You have given us the figures. Do you describe yourself as a high prescriber of benzodiazepines?
A I was quite surprised at how few of my patients got benzodiazepines from me.

Q And of those prescribed opiates—
A One was for terminal care. She went into hospital a couple of days after I was suspended and died there. The other three are maintained by the partners for longstanding chronic pain.

Q Just to remind the Committee, in your statement at page 266 you say in paragraph 3,

> "As a general practitioner, I have a full-time position; I have approximately 1,500 patients on my list".

A Yes.

Q *The Committee can see, of the 1,500 patients, precisely how many are* prescribed benzodiazepines and/or opiates.
A Yes.

Q [*To the Committee*] Sir, we have a small bundle of correspondence. I am sorry that you have not been given it in advance.

THE CHAIRMAN: We will refer to it as D1. [*Same handed*]

MR JENKINS: Sir, we are giving you a number of letters. I am happy if they are collected in D1, or we can number them sequentially.

THE CHAIRMAN: I assume they have been circulated. Shall we put them in chronological order?

MR JENKINS: I would be happy with that. The first letter you should have is one dated 16 February. It is from the consultant physician, Dr Jarrett. He talks of a "bed crisis at Queen Alexandra Hospital continues unabated". "It has fallen on us", he says,

> "to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some under-utilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post-acute patients. A policy offering guidance is enclosed".

You should see a document, enclosure 2, "Emergency use of community hospital beds". You will see it reads,

"Due to current crisis with the acute medical beds at Queen Alexandra Hospital and the detrimental effect on surgical waiting lists, the Department of Medicine for Elderly People is making some urgent changes to the management of beds in the small hospitals".

Can I break off and remind the Committee, this relates to the year 2000. The situation with which you are concerned for the five patients whose records you have were treated in 1998. So this is after, but we hand these documents to you to give you the continuing picture. You will see,

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

1. Waiting for placement...
2. Medically stable with no need for regular medical monitoring...",

and the other matters that you see listed.

The next document is a letter from Dr Barton dated 22 February to Dr Jarrett. The letter reads,

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

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

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

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

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

I would also question the term 'under-utilisation' in a unit which is handling approximately 40 per cent of the continuing care done by Elderly Services at this time".

The next document in time is a letter from Dr Jarrett dated 7 March, by way of response. I do not need to read it to you, but you have heard Dr Barton suggest

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that there was a request, effectively, for three quarters of a million pounds from the primary care group to go towards the local hospital. You may find a hint of that in the last paragraph of this letter.

The next document is the one with the fax strips down the centre of it. It is a letter from Dr Barton dated 28 April 2000, tendering her resignation. It is addressed to Peter King, personnel director, and it reads as follows:

> "Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport War Memorial Hospital. I have highlighted these worries on two occasions previously in the enclosed letters.
>
> I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example, on one of the wards I will only be having locum consultant cover until September. In addition, an increasing number of higher risk 'step down' patients continue to be transferred to the wards, where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.
>
> The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation".

You will see a reference to the original contract of employment in 1993.

The last letter, dated 19 May from Fiona Cameron, is one responding to the letter we have just read. The second paragraph reads as follows:

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

Sir, that is the evidence I seek to place before you. I have called Dr Barton and, if there are questions for her, the Committee or Mr Lloyd may wish to ask those questions now before I go on to sum up, if I can put it that way.

THE CHAIRMAN: Mr Lloyd, do you wish to ask questions?

THE LEGAL ASSESSOR: I have no questions, sir.

<u>Questioned by the COMMITTEE</u>

DR RANSON: Did you have consultant cover during 1998?
A I had a lady called Dr Jane Tandy, who became pregnant, who commenced her annual leave on 27 April 1998 and followed on with maternity leave from 1 June until 8 February 1999. So basically she was very pregnant, and then she was gone for the rest of the year.

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Q And no replacement or locum cover?
A No.

Q So you were in fact on your own in a training grade post?
A Yes.

MR WARDELL: I would like to ask some questions in order to have a feel for the 48 beds you were looking after with regard to patients. You mentioned the Bartell Score, that I am not familiar with at all but I am pleased that I am at 20.
A On a good day!

Q Absolutely! You said that the bed occupancy rate was about 80 per cent when you were there. Perhaps you were looking after about 38, up to 40 patients?
A Yes.

Q With regard to your looking after those patients, could you give us a feel of what you did? You said you were there for an hour and a half in the morning. Can you run through fairly quickly the typical kind of week you would have at the hospital?
A I would arrive as they opened the front door of the hospital at 7.30 and I would go straight to Dryad ward first. I would walk round the ward with the nurse who had just taken the night report, so it was the most senior nurse on. We did not, fortunately, have these named nurses at that point. I would stop by every bed and I would ask, "Are they in pain? Have they had their bowels open? Do I need to see the family? Is there anything I should know?". So I got a report at the foot of each bed. That was Dryad.

Daedalus liked to do it slightly differently, in that I did the report with the person who had taken the hand-over in the office, and then was invited to look at any patients they had concerns about. They preferred to do it in front of their paperwork. But the concept was the same: you went through all the patients in your care each morning, and that took until just before nine.

Q How many days a week did you do that?
A That was five. That was each weekday morning.

Q Was that your total involvement with the hospital?
A That is when it started. Generally, with the rate at which we were running admissions in 1998, I think an average week would contain five admissions. I had to try to get them to bring them down to my hospital before four o'clock in the afternoon. Lunchtime was better, because (a) they get very cold and stressed if you carry them round the countryside and bring them in after dark and (b) it gave me time to clerk them and to check whether any further investigations, bloods or anything needed doing, and to get them settled into the ward. So I would go back most lunch times, unless I had a PCG or purchasing meeting or something like that. In those days I was only on duty once a fortnight, but I would quite often go back in the evening if I felt there was somebody I was particularly worried about – to talk tot he relative or to support the nursing staff.

Q Mr Jenkins put in front of us a number of documents, including the second one, which is "Emergency use of community hospital beds". In point 7 there, the second sentence reads, "...this placement does not entitle patient to NHS continuing care".
A There was no such thing in 2000. If your condition became medically stable and you could persuade social services to either fund you or agree to have you at all, then you would be moved on – even though your dependency score might be very low.

Q In that period, say 1998 to 2000, were you experiencing dilemmas whereby – and I use the word "conspiracy" advisedly, because I have the evidence from a report that I chaired during that period when I was in another post in the House of Commons – in evidence we had it said that there was a conspiracy between social services, doctors and management with regard to trying to push people who were entitled to have NHS care out of hospitals into nursing homes, where they would have to pay out of their own resources? Were you in that horrible dilemma?
A If you knew anything about Gosport, you would realise that (a) there is not much potential for private practice and (b) there were not vast numbers of patients who were self-funding. Self-funders were not the problem then. If they were stable and social services would agree that they could go to a nursing home at all, that was not the problem. I would never conspire with anyone in social services.

Q I was not levelling that at you. I was just thinking about the dilemma, that if you had patients in beds, such as the patients you were dealing with, then they would be covered in terms of the NHS system—
A They were not.

Q They were not?
A They were not. They were not entitled to stay in any of those beds. In order to keep them in those beds, you had to write in the notes, "Requires ongoing medical care". Despite a Bartell of zero, if they required no further medical input and their medical condition was stable, you then had to find them a nursing home. But the sort of people we are talking about here were not going to become stable.

MR WINTER: You refer to raising concerns in 1998 verbally with lower levels of management about your working situation. Would you be prepared to say a little more about what you actually did and whether you considered putting your concerns in writing at that point?
A I should have put my concerns in writing, because I was sitting on these strategic bodies. We were talking about how the health community was going to move forward, how we were going to improve step-down care, and how we were going to make available more beds for acute surgery so that the Trust achieved its waiting list targets and therefore its money from region. But I did not put anything in writing. I became increasingly concerned. I spoke to lower management, who probably did not even relay those concerns further up. I spoke to my clinical colleagues.

Dr Lord tried at that time to get more funding and was unsuccessful. The first time we got any extra funding was in 2000 when I resigned and we got an extra three-quarters of a million for St Christopher's and Gosport War Memorial to do more post-acute rehabilitation work. So they knew we were in trouble, but I did not go to print at that stage.

Q Could you say approximately how many times you raised these matters with people in lower management?
A Once every couple of months.

THE CHAIRMAN: I wonder if I might be allowed to ask a few questions, just so that I understand the situation? Am I correct in assuming that Gosport War Memorial Hospital is a stand-alone community hospital?
A It has no theatre facilities; it now has no A&E or minor injuries facility; it has a little X-ray department with basic, standard equipment in a Portacabin. It has a little outpatient department to which consultants come down from the centre to do peripheral clinics, and it has approximately 100 beds.

Q These are including the 48 long-term care beds?
A We have long-stay elderly medical patients; we have babies; we have a maternity unit and we have a small GP ward.

Q Can you tell me roughly what the average length of stay was in, say, 1989, about 10 years ago, and then in the later part of the 1990s? How had the average length of stay changed?
A I had patients I had had for five years. I had some very ill patients transferred from the Royal Hospital, Haslar, after orthopaedic surgery or transferred from the main unit because they lived in Gosport and their relatives lived in Gosport. But those were the minority. The majority of patients were long stay.

Q Was there a calculation of the average length of stay in the early 1990s?
A It would be difficult to do, because we also did shared care and respite care in those days. I was looking at the figures the other day. You would find it very difficult to get a feel for the average length of stay, but it was generally reckoned to be a good long time. Then in the late 1990s – I could not find any research on this subject, but there are two major risk times for these elderly transferred from a nursing home to an acute unit and then down to a long-stay unit. They may well die in the first two, three days – something to do with the shock of being moved really makes them quite poorly. If they survive that—

Q While you do not have a specific figure for average length of stay, you are quite convinced that the dependency level increased over the decade?
A Massively, yes.

Q We are aware of how the Gladys Richards case came to the surface. It is not clear to me from the papers how the other cases were identified. Can you help me with that? [*Dr Barton conferred with counsel*]

MR JENKINS: Sir, you will recall from what I said to an earlier constitution of this Committee that the relatives of Gladys Richards complained. What I said to an earlier Committee was that they complained about everybody, including the police officers who conducted the inquiry. They generated some publicity locally about their concerns, as a result of which relatives of other patients – and I think the four with which you are concerned – expressed concerns. I think that is how the police became involved in those other cases.

DR BARTON: The health care trust also decided to invoke CHI, the Commission for Health Improvement, and CHI produced a lot of local publicity saying, "If you have any concerns about your hospital, this is the phone number, these are the people to get in touch with". And of course I have no input as to how much and where they got their information from; but they must have received an enormous amount of positive and negative feedback from the people of Gosport.

THE CHAIRMAN: Technically, as a clinical assistant you did not carry ultimate responsibility for the clinical care of patients?
A No. You will see in a couple of the reports that we were using the Fentanyl skin patch for opiate pain relief. I was not allowed to sign for that. That had to be countersigned by a consultant. I was working for a consultant.

Q And the consultants under whom you worked reviewed the prescribing practices that you indulged in, did they?
A I do not know. Not with me.

Q So you did not do the ward rounds with the consultant?
A Yes.

Q You did?
A Yes, but no comments were made at any time at this point about reckless prescribing or inappropriate prescribing.

Q They did not raise any questions about the prescribing that was being done for these patients?
A They did not raise any concerns, no.

Q Were there any audit meetings in the hospital?
A I did not go. I was not invited to go to audit meetings.
Q Turning to page 380, I would also like some clarification. It implies in the first bullet point there that there is still some relationship to the Gosport War Memorial Hospital. What was the continuing relationship you had?
A In Gosport there is something called the Gosport Medical Committee, which is made up of all the practising doctors on the peninsula, which I think at the moment is about 36. We are employed by the health care trust to look after 20 GP beds upstairs from my erstwhile geriatric beds. We have admitting rights to those beds and we are allowed to look after our own patients. We are also invited to look after step-down patients from the acute unit. Although, as a GP you can be much more hard-nosed about refusing to accept somebody who you feel is beyond the capability of the hospital to look after than I could as a clinical assistant downstairs in the wards. That is why you will see something about, "a

retrospective audit of your prescribing on the Sultan ward". That is, what I was doing – whether I was prescribing inappropriate opiates upstairs on the GP ward.

Q That has been helpful clarification. Was I correct in assuming – this is the second bullet point – that you told us this was in relation to your primary care duties?
A The voluntary stopping prescribing opiates?

Q Yes.
A Yes, I am not prescribing any opiates or benzodiazepines at the moment.

THE CHAIRMAN: I think these are the points I wanted to raise. Are there any further points from members of the panel? In the absence of further points, Mr Jenkins?

MR JENKINS: There is one, sir, and it was raised by Mr Lloyd. Do you have any private patients?
A No.

MR JENKINS: Sir, may I sum up very briefly? You may think that this is plainly an excellent and dedicated doctor. It may appear to you, and I would encourage this view on your behalf, that it may have been problems with the allocation of resources at the Gosport War Memorial Hospital which has led to a situation where best practice was not followed.

You will have to consider the reports of the various experts placed before you. You will have to consider as well whether they are considering Dr Barton's position as it was. I may have missed it, but it is not apparent from my reading of the reports that there is shown to be an understanding by Professor Ford and the other doctors that they were well aware that Dr Barton was working three and a half sessions; that she was effectively, during the period with which we are concerned, the only medical input into the care of these patients; that she had a significant number of patients to see and to evaluate and to continue to care for, in a very restricted period of time.

You have to consider whether it is necessary for the protection of members of the public to impose conditions. I do not deal with the question of suspension because I say that it is plainly not appropriate in this case.

Is it necessary for the protection of members of the public to impose conditions? Dr Barton is no longer undertaking the job that she started in 1988. You know the reasons why. I say she poses absolutely no threat to members of the public, either in her general practice or in any form of hospital medicine. She does not undertake any of the latter.

Is it necessary in her own interests to impose conditions? I say not. The last issue is whether it is otherwise in the public interest. You will know that there has been a police investigation, in fact two, arising out of the complaints in this case. You will know the results of the police investigation: that a decision has been taken not to charge.

I repeat what I have said. It is slightly troubling that it is not apparent that the experts instructed by the police have been presented with the full picture of Dr Barton's clinical involvement with these patients before being invited to express a view. But I say that it is not in the public interest either for this body to impose conditions upon this doctor in the circumstances in which you know she practises. She does not pose a risk to patients. It is not necessary in her interests, and it is not otherwise in the public interest.

If, however, you feel that because of police investigation, because of the possibility of press coverage, that it is necessary to demonstrate that this body is able to make decisions, I would invite you to do no more than reimpose what Dr Barton has voluntarily agreed with the health authority.

Those are the submissions that I make.

THE CHAIRMAN: I now turn to the legal assessor.

THE LEGAL ASSESSOR: The advice I give the Committee is as follows. They may make an order restricting this doctor's registration only if they are satisfied it is necessary to do so for the protection of members of the public, otherwise in the public interest, or in the interests of the doctor. In addition they must be satisfied that the consequences of any restriction that they might impose of her registration will not be disproportionate to the risks posed by the doctor remaining in unrestricted practice.

Mr Jenkins, Mr Lloyd, unless there is anything else on which you would like me to advise the Committee, that is the advice I give.

MR JENKINS: Sir, I have mentioned the little green book with which Dr Barton has helped: I leave it with you.

THE CHAIRMAN: Thank you.

The parties withdrew by direction from the Chair and the Committee deliberated in camera.

The parties having been readmitted:

THE CHAIRMAN: Dr Barton, the Committee has carefully considered all the evidence before it, including the submissions made on your behalf.

The Committee has determined, on the basis of the information available to it today, that it is not satisfied that it is necessary for the protection of members of the public, in the public interest or in your own interests that an interim order

under Section 41A of the Medical Act 1983 as amended should be made in relation to your registration.

CATHERINE LEE

Catherine Lee

Date of Birth: Code A Age: **92**
Date of admission to GWMH: **14th April 1998**
Date and time of Death: **14.45 hours on 27th May 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **44 days**

Mrs Lee's past medical history:-

1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

Mrs Lee lived at Addenbrookes Residential Home. She had a daughter and grand-daughter. It was noted that she had poor mobility and was confused at times. Mrs Lee sustained a fractured neck of femur at Addenbrookes on 2nd April 1998 and was admitted to Haslar Hospital for surgery to correct the fracture. She was then admitted to Gosport War Memorial Hospital on 14th April 1998 for continuing care.

On admission a Waterlow score of 30 was recorded with another score of 29 recorded on 8th May 1998
A nutritional assessment plan was completed on 15th April 1998 with a score of 4.
Barthel ADL index was recorded on 14th April 1998 scoring 0, another on 25th April 1998 scoring 1 and another one on 9th May 1998 scoring 4
A handling profile was completed on 16th April 1998 noting that Mrs Lee needed the assistance of 2 and a hoist for transfers.
A mouth assessment was completed on 15th April 1998.
Care plans commenced on 14th April 1998 for MRSA screening, 15th April 1998 for sleep, 16th April 1998 for hygiene, nutrition, constipation and on 26th April 1998 for small laceration right elbow.

HAMPSHIRE CONSTABULARY

14th April 1998

Clinical notes – transferred to Dryad Ward from Haslar for continuing care. Barthel 0. Make comfortable, happy for nursing staff to confirm death. It was noted that Mrs Lee has sustained a right fracture neck of femur and had undergone surgery of canulating screws on 3rd April 1998. It noted that Mrs Lee had poor mobiltiy needed the assistance of 2 nurses, was confused at times, needed full assistance with eating and drinkng due to poor eye sight and that she had a poor appetite. She needed all care for hygiene and dressing and her pressure area were intact and that she needed nursing on a pressure relieving mattress.

Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

Summary – restless, confused. Oramorph 5mg 4 hourly.

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

Clinical notes – MRSA negative. Bottom slightly sore. Start gentle mobilisation will not be suitable for Addenbrookes. Seen by Dr Banks has severe dementia.

24th April 1998

Summary – fell while attempting to get up from commode. Sustained skin flat to right elbow. Accident form completed. Daughter informed.

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge.

Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

Summary – seen by Dr Barton re pain oramorph increased to 10mgs 4 hourly (20 mgs nocte).

18th May 1998

Clinical notes – increasingly uncomfortable when I called much better on oramorph.

20th May 1998

Summary – visited by daughter. For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**

Summary – restless, agitated. Seen by Dr Barton. Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

22nd May 1998

Summary – grimacing when turned. Syringe driver renewed at 09.30 diamorphine 20mgs and midazolam 40mgs. Continues to mark, position changed every couple of hours.

23rd May 1998

Summary – syringe driver recharged at 7.35. 20mgs diamorphine 40mgs midazolam. Position changed every 2 hours.

25th May 1998

Summary – further deterioration. Syringe driver renewed at 07.00 in some distress when being turned. Syringe driver renewed at 14.55 diamorphine 40mgs.

26th May 1998

Clinical notes – died peacefully at 14.45.

Death verified by SR Hamblin and SN Barrett.

In reply please quote PCH/2000/2047
Please address your reply to the Committee Section FPD
Fax: Code A

COPY

By Special Delivery and First Class Mail

24 September 2004

Dr Jane Ann Barton

Code A

Dear Dr Barton

I am writing to notify you that the President has considered information received by the GMC about your conduct.

The President, exercising his powers under rule 4 of the General Medical Council (Interim Orders Committee)(Procedure) Rules 2000, considers that the circumstances are such that you should be invited to appear before the Interim Orders Committee (IOC) in order that it may consider whether it is necessary for the protection of members of the public, or is otherwise in the public interest, or in your own interests, that an interim order should be made suspending your registration, or imposing conditions upon your registration, for a period not exceeding eighteen months, in exercise of their powers under section 41A of the Medical Act 1983 as amended.

The President has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved. The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

You are invited to appear before the IOC at **09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you so wish, to address the Committee on whether such an order should be made in your case.

You may, if you wish, be represented by Counsel, or a solicitor, or by a member of your family, or by a representative of any professional organisation of which you may

be a member. You may also be accompanied by not more than one medical adviser. The IOC is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for the attention of **Adam Elliott, Committee Section** Code A Code A

You are invited to state in writing whether you propose to attend the meeting, whether you will be represented or accompanied as indicated above, and if so, by whom.

The IOC normally meets in private but you may if you wish, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public. If you wish for the meeting to be held in public could you please notify Adam Elliott, Committee Section (fax number as above), as soon as possible.

The GMC is under a statutory duty to publish the outcome of IOC hearings. It is our usual practice to do so by placing the outcomes of hearings on our website. If you do not attend the hearing could you please supply Adam Elliott (fax number as above) with a telephone or fax number where you can be contacted on the day of the hearing so we can let you know of the decision before placing the information on our website. If you do not provide such a contact number, or we are unable to contact you, the outcome of the hearing will still be published.

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

In accordance with Section 35A(2) of the Medical Act 1983 (as amended), you are required to inform us, within 7 days of receipt of this letter, of the name and address of the following: -

- all of your current employers,
- the Health Authority with which you have a service agreement,
- locum agency/agencies with whom you are registered, and
- the hospital/surgery at which you are currently working.
- If you engage in any non-NHS work, you are also required to notify us, within the same period of time, of the name of the organisation/hospital by which you are employed, or have any working arrangements. Please forward this information directly to me. Upon receipt of these details, your employers will be notified of the Committee's consideration of the matter.
- If you are approved under Section 12 of the Mental Health Act, or Section 20 (b) of the Mental Health (Scotland) Act 1984, you must also notify us of this fact.

I enclose copies of the relevant provisions of the Medical Act, the IOC Procedure Rules, a paper about our fitness to practise procedures and a paper about the procedures of the IOC.

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

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

Yours sincerely

COPY

Paul Hylton
Assistant Registrar

Cc: Mr Ian Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ
ISPB/TOC/0005940/Legal

FAO Paul Hylton
Committee Section FPD
General Medical Council
178, Great Portland Street
London W1W5JE

Dr Jane Barton

Code A

Your Reference PCH/2000/2047

27th September 2004

Dear Mr Hylton

re Interim Order Committee hearing on 7th October 2004

I am a Principal in General Practice contracted to Fareham and Gosport Primary Care Trust.

I am on the Bed Fund for Gosport War Memorial Hospital, Bury Road Gosport, administered by the same Primary Care Trust.

I am a partner in the practice of Dr PA Beasley and partners,

Forton Medical Centre,
White's Place
Forton Road,
Gosport PO123JP.

I have no other employment or contract either NHS or non NHS and I am not approved under Section 12 of the Mental Health Act.

I propose to attend the hearing on 7th October 2004. I will be represented by my solicitor Ian Barker of the MDU .

Yours Sincerely

Code A

Dr Jane Barton

5

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

THE MDU

MDU Services Limite
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Londo
SE1 8P

DX No. 3650
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Email: mdu@the-mdu.com
Website www.the-mdu.com

Mr Adam Elliott
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: 0207-915-7406

Dear Mr Elliott

Dr Jane Barton – Interim Orders Committee – 7th October 2004

Further to the letter from Mr Hylton to Dr Barton of the 24th September, and indeed our telephone conversation today, can I confirm that I continue to act for Dr Barton.

As you know, Dr Barton has previously appeared before the Interim Orders Committee on three occasions. On each occasion the matters raised have been essentially of the same origin and nature.

On each occasion Dr Barton has been represented by Mr Alan Jenkins of Counsel. The matter is necessarily a little complex and continuity of representation, somewhat unusually for the purposes of such hearings, in this instance is of clear importance. Indeed I would respectfully submit that it would only be reasonable and fair for Dr Barton to have that continuity of representation.

I very much regret to advise you that Mr Jenkins is unavailable on 7th October. I have made enquiries to see if it might be possible for his existing commitment to be dealt with on another occasion, but understand this is simply not possible.

In these circumstances I would be most grateful if consideration could be given to the provision of an alternative date for the hearing of this matter. I appreciate that the General Medical Council would not seek to delay the matter for any significant period of time, but it may be relevant to observe that at none of the previous three hearings, in June 2001, March 2002 and September 2002 was considered necessary by the Committee to make an Order affecting Dr Barton's registration.

Can. I also take the opportunity to point out that the letter to Dr Barton of 24th September, advising her of the forthcoming hearing does not appear to comply with Rule 5 (1) of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000. The letter does not contain a brief statement of the matters which appear to raise the relevant question set out sub sub rule (b).

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

Further, Dr Barton has not yet been provided with any documentation. Curiously, it seems to be suggested that the issue of what documentation will be disclosed has still to be determined. Specifically, in paragraph 3 of the letter from Mr Hylton it is said that the GMC is in the process of clarifying with the Police the level of disclosure that can take place. As you will appreciate, Rule 5 (3) of the procedure rules requires that the Registrar shall send a Practitioner copies of any documents received in connection with a case. It is therefore not open to the GMC to be selective – any document received should be disclosed.

I make the points in relation to compliance with Rule 5 (1) and Rule 5 (3) as clearly there are issues to resolve before the matter can reasonably proceed and in those circumstances too brief adjournment might be sensible for all concerned.

I would be most grateful if this application could be given urgent consideration and if I can assist with the provision of any further information, including further details of Mr Jenkins' availability, I will be pleased to do so immediately.

It may assist if I mention now that Mr Jenkins would be available both on the 13th and 15th October, when I understand the IOC will be sitting to consider cases generally.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

Code A Code A

E:\Committee\ioc\PHC\2004\Barton\Barker(MDU)290904

Your reference **ISPB/TOC/0005940/Legal**
In reply please quote **ACE/JJC/PCH/2000/2047**

By post and fax – Code A

Please address your reply to the Committee Section FPD
Fax Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

30 September 2004

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

Dear Mr Barker

Dr Jane Barton – Interim Orders Committee (IOC) 7 October 2004

Thank you for your letter of 27 September 2004 in which you request that the Chairman of the IOC consider postponing the scheduled hearing of Dr Barton's case in accordance with Rule 7(1) of the Committee's Rules.

I can confirm that the Chairman of the Committee considered your request and that he did not accede to it.

The Chairman in considering this request considered the nature and purpose of the IOC, which is namely, to determine whether interim action is required to be taken against the registration of a doctor who may pose a risk to the public, the public interest or their own interests and in fulfilling this function it is considered that the Committee should meet as soon as practicable whilst bearing in mind the need to balance the consequences for the practitioner of the imposition of an interim order and to ensure that the doctor is afforded the opportunity to attend any hearing and be represented, although not necessarily by the Counsel of their choice.

The Chairman took account of the Council's letter notifying Dr Barton of the forthcoming hearing and the timetable contained therein and in reaching his decision considered that the date of 7 October 2004.

In reaching his decision the Chairman determined that whilst unfortunate that Dr Barton's chosen Counsel is not available, there was still sufficient time to instruct fresh Counsel to attend and make representations. It is the Council's intention to dispatch a copy of all the papers in the case on 30 September 2004, providing Dr Barton with 7 days in which to prepare a defence. It was the opinion of the Chairman that this was sufficient time in which to fully instruct new Counsel to prepare such a defence. The Chairman further considered that the Council's letter of 24 September 2004 put Dr Barton on notice that the hearing would be taking place on 7October

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

5C

In all the circumstances, the Chairman having taken into account your letter of 27 September 2004 and balanced the information contained within against the reasons for Dr Barton's referral considered that, it was important in the public interest that Dr Barton's case be heard as soon as possible.

The hearing scheduled to take place on 7 October 2004 will take place as listed and Dr Barton is invited to appear before the IOC at **09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. You are further invited to state in writing whether you propose to attend the meeting, whether Dr Barton will attend and whether she will be represented by Counsel, and if so, by whom.

The IOC normally meets in private but Dr Barton may if she wishes, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Secretariat having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

With regard to your point regarding Rule 5(1)b it is the opinion of the Council that the letter dated 24 September gave the following brief statement of the matters which appear to raise the relevant question set out in Rule 5(1)b:

> *The President has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved.*

Further, the Council submits that its letter of 24 September also gives a full explanation as to when Dr Barton can expect to have disclosure of the information to be considered by the Committee, and what information she can expect to be disclosed. The Council is mindful of the provisions of Rule 5(3) but it is not of the view that it's letter contravened those provisions. The letter states that:

The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

The clarification with the Police is in respect of what information the CPS determines can be disclosed to the GMC. The Police are fully aware that any information disclosed to the GMC and subsequently disclosed to any of its Committees must also be disclosed to Dr Barton. The Council will disclose to Dr Barton all information that is to be put before the IOC.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Adam Elliott
Interim Orders Committee Secretariat

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

Mr Adam Elliott
Committee Section
General Medical Council
178 Great Portland Street
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Also by fax: 0207-915-7406

THE MDU

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

Dear Mr Elliott

Dr Jane Barton – Interim Orders Committee – 7th October 2004

Thank you for your letter of 30th September, and I am grateful for the provision of written reasons of the decision not to grant adjournment in this matter.

I am grateful too for the observations concerning Rule 5 (1). It remains my contention, however, that the brief statement required by that Rule has not been provided. The information that you quote within the letter is hardly sufficient. There is no basic summary or indication of what the information provided by Hampshire Constabulary might be. Indeed, as I understood the position yesterday no written statement or evidence had been supplied by Hampshire Constabulary to the GMC at that time.

In any event, I am concerned to make further request for adjournment of Dr Barton's case with the benefit of additional information, and indeed having had the opportunity to consider the written reasons for the Chairman's previous decision.

As you will know, Dr Barton has thus far received no documentation at all in this matter. The statement from the Hampshire Constabulary which it is understood you were to receive yesterday has yet to materialise. Further, I am advised that a significant volume of patient records had been made available to the GMC, which it is felt is not necessary to trouble the Interim Orders Committee but which is nonetheless available. It must be right that Dr Barton has the opportunity to consider those records, which I understand to be some 3 feet deep. It may of course be that there is no information which is necessary to place before the Interim Orders Committee in that regard, on behalf of Dr Barton, but unless and until Dr Barton has had the appropriate opportunity to consider the materials, that cannot properly be determined.

Unfortunately, Dr Barton is not immediately able to consider any such documentation even if it were to be made available forthwith. Sadly, her mother and mother-in-law have both been profoundly ill recently. Indeed, her mother-in-law has only recently been moved from an Intensive Treatment Unit. She will visit them tomorrow and at the weekend. Her first realistic opportunity to look at any amount of documentation would be on Monday of next week.

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

In addition to Dr Barton's ability or lack of it to consider such a significant quantity of material at this stage, sadly Counsel previously instructed for Dr Barton, Mr Alan Jenkins, remains unavailable for the hearing on 7th October. I appreciate at once that the Interim Orders Committee would not ordinarily be concerned to take Counsel's availability into account. However, this matter has previously been considered on three separate occasions by the Interim Orders Committee – and substantively on each occasion, rather than being merely by way of review. There is therefore a long and significant history from which I would submit that it is desirable that there should be continuity of representation, both for Dr Barton herself, and indeed to assist the Committee.

With reference to the limited information given within the letter of the 24th September to Dr Barton about the matter, which you have kindly quoted in your letter to me of 30th September, it is clear that the matter concern the Gosport War Memorial Hospital. Dr Barton ceased to have any involvement with that hospital some long time ago. It must therefore be the case that any matters raised by the Hampshire Constabulary are historical. As best I am aware of it, there has been no expression whatsoever of concern in relation to Dr Barton's recent practice.

I would respectfully submit that this point is highly relevant in terms of the consideration of the public interest in ensuring that a hearing take place very rapidly. It is also relevant in that regard that on each of the three occasions when Interim Orders Committee has met to consider Dr Barton – on each occasion with reference to the Gosport War Memorial Hospital – the Committee concluded that it was not necessary to make an order affecting Dr Barton's registration.

Accordingly, there is as best I am aware of it no indication that Dr Barton's present behaviour gives any obvious cause for concern, and to the extent that her previous activities as a Practitioner have been considered in relation to this very hospital, no action has been taken by the IOC. It must surely be the case in those circumstances that the public interest could not reasonably be adversely affected by an adjournment of a mere week to facilitate both the proper consideration of paperwork and representation by established Counsel.

I would be grateful if my further application for adjournment could be given urgent consideration.

Yours sincerely

Code A
Ian S.P. Barker
Solicitor

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
5 October 2004

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Telephone: 020 7202 1500
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Email: mdu@the-mdu.com
Website www.the-mdu.com

Mr Paul Hylton
Assistant Registrar
General Medical Council
350 Regent's Place
London
NW1 3JN
BY HAND

Dear Mr Hylton

Dr Jane Barton - Interim Orders Committee

I write with reference to your letter to Dr Barton of 30th September 2004. As you will be aware from our various conversations, I represent Dr Barton.

In your letter of 30th September you indicated that you had voluminous patient records available to you and that if Dr Barton required a copy of those records you would arrange for her to receive a copy expeditiously.

You will recall that you and I spoke on the 30th September, and I indicated that Dr Barton would indeed wish to have sight of the records. I understood that you would endeavour to make those records available the same day, if not the following day.

We spoke again on the 1st October and you indicated that it had not been possible to copy the notes in view of the lack of facilities brought about the GMC move of offices, which I do very much understand. As I understood it, the records were then to be made available yesterday afternoon, but as you will appreciate, these records have still to arrive.

My expectation is that the medical records concern the patients in relation to whom information is given by the Hampshire Constabulary in purported summaries and expert observations. I remain concerned on behalf of Dr Barton to have access to the medical records, but have to point out that Dr Barton cannot realistically assist the Committee now in relation to any points involving specific patients in circumstances in which she will not have had the anticipated and hoped for opportunity to consider medical material.

I look forward to your response.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

Code A

RECEIVED
- 5 OCT 2004

In reply please quote PCH/2000/2047

Your ref. ISPB/TOC/0005940/Legal

By Fax and first class post

5 October 2004

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Mr Ian Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Dear Ian

Dr Jane Barton – Interim Orders Committee

Thank you for your letter of 5 October 2004, a copy of which I will pass on to Adam Elliott in our Committee Section.

I note your comments regarding the medical records and I should inform you that unfortunately, due to the problems experienced by our Reprographics section in the course of our move to our new premises, it is likely that a copy of the records will not be available until tomorrow at the earliest.

I have considered whether it would be prudent to use a commercial reprographics company. However, given the nature of the information, I decided against that course of action.

I will forward a copy of the records to both you and Dr Barton as soon as they are available.

Yours sincerely

Code A

Paul Hylton
Assistant Registrar

2nd Floor Regents Place 350 Euston Road London NW1 3JN Telephone 0845 357 8001 Fax 020 7189 5001
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

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Your reference **ISPB/TOC/0005940/Legal**
In reply please quote **ACE/JJC/PCH/2000/2047**

By courier and fax – Code A

Please address your reply to the Committee Section FPD
Fax Code A

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

6 October 2004

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

Dear Mr Barker

Dr Jane Barton – Interim Orders Committee (IOC) 7 October 2004

Further to your letter of 30 September 2004 and our subsequent telephone and e-mail conversations. I can confirm that the Chairman of the Committee did on 1 October 2004 consider your further request to postpone Dr Barton's hearing.

The Chairman considered that whilst the submissions you made may have force in relation to whether or not the Committee should impose an interim order on Dr Barton's registration it was not for the Chairman alone to consider such matters and that in all the circumstances, it was necessary for the reasons given previously and in the public interest that the hearing of Dr Barton's case be expedited notwithstanding that her chosen Counsel is not available.

The hearing scheduled to take place on 7 October 2004 will take place as listed and Dr Barton is invited to appear before the IOC at 09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. I am grateful for your confirmation that Dr Barton will be attending the hearing and that she will be represented by Mr Foster, Counsel.

The IOC normally meets in private but Dr Barton may if she wishes, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an

adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Secretariat having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Adam Elliott
Interim Orders Committee Secretariat

Confidential
Addendum (II)
BARTON

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee
13 October 2004

Information: *Further information:*

1.	Transcript – IOC Hearing – 21 June 2001	**553 – 562**
2.	Expert Review – Catherine Lee	**563**

A

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

B

Thursday, 21 June, 2001

C

Chairman: Professor MacKay

D

Case of:

BARTON, Jane Ann

E

Dr. J.A. Barton was present and was represented by MR A. JENKINS of Counsel, instructed by Solicitors to the Medical Defence Union.

F

MISS L. GRIFFIN, of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council.

G

H

MISS GRIFFIN: Sir, this case comes before you under the Conduct procedures. The nature of the case is set out at the beginning of your bundle as, in summary, one of unlawful killing. A police investigation is continuing and has not come to a determination as yet, in relation to whether or not any charges will be brought against Dr Barton.

The papers before you relate to a patient by the name of Gladys Richards, who was treated at the Gosport War Memorial Hospital in August 1998, where she died. Mrs Richards was born on 13 April 1907. There is a short summary of her medical condition at page 57 from the Royal Hospital Haslar, Gosport, Hants, dated 10 August 1998, written by Sergeant Staff Nurse Curran.

The Committee can see that Mrs Richards had sustained a right fractured neck of her femur on 30 July 1998 whilst in the Glenheathers Nursing Home. She was admitted to the ward and had a right cemented hemi-artheroplasty, and was now fully weight-bearing, walking with the aid of two nurses and a Zimmerframe.

Her past medical history is set out in summary. She was deaf in both ears. She had had cataract operations to both eyes. She had a recent history of falls and was suffering from Alzheimer's, which condition had deteriorated over the previous six months. She had had a hysterectomy in 1955. Her allergies were set out and the drugs that she was currently taking.

The Committee can then see certain details set out as to her day-to-day living.

Straddling that document is a letter from Dr Reid at pages 56 and 58, dated 5 August 1998. Again, in summary it gives the Committee some information as to Mrs Richards' standard of health shortly before her death in 1998.

Sir, the complaint about Dr Barton is brought on the basis of the two statements at the beginning of your bundle. The first is from Mrs Leslie Lack, and the second is from Mrs Gillian MacKenzie, the daughters of the late Mrs Richards. I ask the Committee to pay attention to those careful, considered and detailed statements in coming to their conclusions today. Those ladies were extremely concerned about the standard of care and attention that was being paid to their mother while she was under the care of the hospital, and in particular Dr Barton. They speak about concerns as to the standards of the care assistants and their attitude towards their mother, and also the standard of care afforded tot heir mother by the nurses at the hospital and their level of communication. They also complained of the level of nourishment and hydration provided to their mother, particularly in the last days of her life.

It was the wish in particular of Mrs Lack that her mother be transferred back to the Haslar Hospital, from where she had been transferred to the Gosport War Memorial Hospital. It transpires that that hospital was willing to accept her, but that Dr Barton was reluctant to send her back. What was explained to the ladies shortly before their mother's death was that she had developed a haematoma after the successful manipulation of her hip after it had become dislocated. The suggestion was made at that stage that as she was in so much pain and had been receiving significant pain relief, that she should have some Diamorphine. The reaction of her relative was to

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

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

B

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

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

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

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

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

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

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

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

A

Sir, in relation to pain relief there is a note on page 243 that on 18 August 1998 the patient was reviewed by Dr Barton for pain control by a syringe driver, and her treatment was discussed with both daughters. "They agreed to use of syringe driver to control pain and allow nursing care to be given."

B

Dr Barton's notes are copied at pages 222-223. The Committee may find some of them difficult to read. We have the benefit of a police statement by Dr Barton, however, in which she sets out the substance of some of those notes in typewritten form. The Committee will note in particular the note in the form of a rhetorical question: "Is this lady well enough for another surgical procedure?" That was made on 14 August 1998. Turning the page, the Committee will see on 18 August the first note, "still in great pain" continuing, "I will see daughters today; please make comfortable". On 21 August: "Much more peaceful" or "restful" and there is a reference to a drug being given for her chest. The pronouncement of death is recorded again at the bottom of that page.

C

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

D

Sir, it may be suggested that there has been significant delay in this matter coming before you. The statements of Mrs Flack and Mrs MacKenzie that were provided to us by the police were not forthcoming until 6 June 2001, as can be seen from page 6. This matter comes before the Committee at the first possible opportunity subsequent to the information being provided to the General Medical Council.

E

It is my submission that in this case it would not be appropriate to consider conditions on the doctor's registration; that in essence the facts in the papers raise such a significant concern about this doctor that this Committee ought to consider suspending her registration on an interim basis.

THE LEGAL ASSESSOR: The events took place in August 1998. Do we have any information about when the inquiry commenced?

F

MISS GRIFFIN: I understand that there was an initial investigation by the police which was concluded, and no action was taken at that time, on the advice of the Crown Prosecution Service. I know not the basis for that advice. Subsequently a complaint was made about the conduct of that investigation by Mrs Richards' daughters, and the matter has subsequently been re-investigated.

G

THE LEGAL ASSESSOR: Is it the second investigation that is being referred to in the letters at pages 4 and 5?

MISS GRIFFIN: Yes.

H

THE LEGAL ASSESSOR: The statements were taken in January and March 2000 by the police. The letter of 27 July on page 4 indicates that the investigation is ongoing and no charge is preferred. The letter at page 5, dated 20 September, says

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

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

B

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

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

C

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

D

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

E

F

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

G

H

A I do not mean to criticise the daughters at all. Plainly, they were extremely fond of their mother and they were anxious to do everything that could possibly be done for her. It may well be the case – as I know Dr Barton would say – that they were unable to accept that their mother was terminally ill, and they did not accept it. They believed that their mother would remain alive and continue to live. It would seem that they blamed those around their mother for failing to maintain her and keep her alive.

B It is clear from the medical records that this lady was in poor shape and was deteriorating. There has been no conspiracy by medical staff or the nursing staff, the charge nurse, or those others who were responsible. There is no conceivable basis for saying here that there is a *prima facie* case and that those responsible on a day-to-day basis caused this lady's death, or brought it about.

C This case may have been brought here prematurely. We suggest that it should not have been brought here at all. There may be, at some stage in the future, if there is an opinion of an expert in palliative care or terminal care, an argument that there were failures in Dr Barton's care of this patient, but on the evidence you have seen there is no basis for such a proposition at all.

D Page 266 is Dr Barton's statement, which was provided by her when she was spoken to by the police. She was one of quite a number of people who were spoken to by the police and she was in no different position from the other people responsible for this lady's care. You will see Dr Barton's position, qualifications and experience. She qualified in 1972. She became a partner in her present practice in 1980. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis. She was working at the Gosport War Memorial Hospital. She retired from that position last year. Obviously, this statement dates from 2000.

E Her present situation is stated in paragraph 3. She is also the present Chair of the Gosport Primary Care Group.

F She was carrying out five clinical assistant sessions at the Gosport Hospital. As you will see from paragraph 4, she would attend the hospital every weekday morning at an early hour and engage in two formal ward rounds with the consultant geriatrician. She would do that before she went to treat her patients in her general practice. She did not have constant attendance at hospital. She was not in a position to review at short notice this lady's condition. It is a misunderstanding on the part of the sisters to the extent that they suggest that Dr Barton was there and able to assist and deal with matters as and when they arose.

G As far as the doctor's present position is concerned regarding opiates, she does not continue to work as a clinical assistant at this hospital. She has not prescribed Diamorphine for over a year. The last time she prescribed an opiate of any kind in palliative care was Fentanyl, and that was for a patient who was being nursed intensively. She does prescribe morphine sulphate tablets for her own patients, but obviously only when it is appropriate.

H There is no basis here for saying that the prescription of an opiate for this lady was excessive or inappropriate.

A

Page 21 is the statement of the sister who was herself a Registered General Nurse.

> "I have had sight of a report prepared by Dr Lord and dated 22 December 1998, which has attached to it a Hampshire Constabulary exhibit label "

B

She goes on to say a few things about the report and, if I can use this phrase, she tries to pooh-pooh it. She says that the report appears to have been prepared by reference some time after the event to information, notes and documents supplied by colleagues with whom she worked on a regular basis. Can I show you this report, because this was the consultant under whose care this lady was admitted? It provides a commentary on two aspects of the case with which you may be concerned: (1) the use of a syringe driver and the prescription of Diamorphine; (2) the provision of

C

fluids for this lady. (Same handed to members of the Committee)

Sir, you and your colleagues will have seen the suggestion that one of the sisters believed the use of Diamorphine was merely to accelerate the death, that Diamorphine was to be used for euthanasia. They raised that proposition, it would seem.

D

> "My sister asked the ward manager: 'Are we talking about euthanasia? It is illegal in this country, you know.' The ward manager replied: 'Goodness, no, of course not.'"

Diamorphine has a perfectly proper use and is used very commonly in terminal care.

The second proposition raised by the daughters is that the use of a syringe driver for

E

Diamorphine was foisted on them and they were unhappy with it. There were discussions. One would hope that there will be discussions between the nursing and medical staff and the relatives, so that agreement can be obtained as to a proper and therapeutic approach. It is clear from the documentation to which you have been referred that there were such discussions. It is regrettable that the daughters were later to say that they did not really agree, but you have been given the references at

F

page 243.

The true situation is that, clearly, there were discussions with the daughters and they were perfectly proper discussions. There is no basis for saying that this drug should not have been given or given at that level.

In relation to fluids, you have the opinion of the consultant. You have Dr Barton's position stated at some length in the statement at the end of the bundle, which I know

G

you will have read. The decision that was taken in this case, I suggest, was an entirely proper one. There is no basis here for suggesting that it was gravely improper or that it departed from proper medical practice. It is perhaps unfortunate that the sisters did not understand, or were later to say that they did not understand or agree with the decision, but it is clear from the records that there were regular discussions between those nursing this lady and the medical staff as to how she should be treated.

H

A As to the decision not to transfer this elderly and demented lady back for a third transfer to the Haslar Hospital in a very few days, there is no basis for saying that that was a wrong decision or one that did not have her best interests at heart – it plainly did. The report of the consultant clearly bears out the approach that Dr Barton took.

B There is no conceivable basis for alleging that any actions by Dr Barton in prescribing or causing to be administered the Diamorphine, caused the death. There is no basis for saying that anything she did reduced the quality of life of this lady or shortened her life. There is no basis for saying in this case that there should be a suspension. I do not deal with the question of conditions. Clearly, conditions have not been asked for. In any event, Dr Barton no longer works in this unit, and I have given you her present situation as far as opiates are concerned.

C DR BHANUMATHI: I notice that Diamorphine was given in the dosage of 40 mg and the patient was on 45 mg of Morphine prior to that. I know that pain control was not too good, but the day the 40 mg of Diamorphine was started it was equivalent to 120 mg of Morphine, which was three times the dosage. What was the dosage that she was on, on the 21st?

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

DR BHANUMATHI: There is no mention of dosages anywhere, as to whether it was increased or decreased from 14 August.

MR JENKINS: It was not decreased. There is a record here. There is a prescription sheet, but I do not have a page number. That shows the administration.

E DR SAYEED: Who had the ultimate legal responsibility in Gosport Memorial Hospital? Is there a consultant involved?

MR JENKINS: They are consultant beds.

DR SAYEED: How often does the consultant do a round?

F MR JENKINS: I think the position may have changed since 1998, but Dr Barton's statement says that there were two consultant ward rounds a week.

DR SAYEED: We are talking about 1998. Who carried the ultimate clinical responsibility of those beds?

G DR BARTON: Dr Lord, whose statement you have just read, had responsibility for the patient. She was on study leave for the last three days of Gladys Richards' life but she carried out weekly war rounds prior to that.

DR SAYEED: The clinical assistance sheet shows that it is two sessions weekly.

MR JENKINS: It is page 266. It was five clinical assistant sessions.

H DR SAYEED: Was any junior doctor involved?

Dr Barton: There are no junior doctors. It is just me.

DR BHANUMATHI: Going back to what I was saying, now that I have had a chance to read it properly, the Diamorphine was 40 to 200 mg (page 254), which is a very big jump of medication. Who authorised it and how was that done?

DR BARTON: The dosage was reviewed every morning, and if an increase was necessary, it would be put up – obviously not straight from 40 to 200 mg but in 20 mg steps until the patient was comfortable. As it turned out, it was not necessary. Gladys needed no increase from the 40 mg initially put.

DR BHANUMATHI: The nurses were not left to increase the dosage; it was by au of the doctor.

DR BARTON: Yes.

THE LEGAL ASSESSOR: Sir, the Committee can only act if they are satisfied either that it is necessary for protection of the members of the public, or otherwise in the public interest, or in the interests of the practitioner that an order be made under section 41(A)(i) of the Medical Act 1983. Before you, the Committee, can be so satisfied in any case, it is necessary to find that the evidence before you amounts to a *prima facie* case supporting interim action on one or more of the grounds that I have just referred to. In this particular case, I simply draw to your attention the absence of any independent specialist medical expert opinion indicating fault of any kind on the part of Dr Barton, which is obviously something you will have to take into account in considering the question of whether or not there is a *prima facie* case here suggesting fault. If you find that you are so satisfied in respect of any one or more of those grounds, then you must decide whether to make an order attaching conditions to the registration or suspending that registration in either case for a period not exceeding 18 months.

MR JENKINS: Might I add one point, which I should have raised? Those instructing me did make inquiries of the GMC about this case. I know that the screener, when he or she looked at the papers in this case, did not have Dr Barton's statement to look at. It was provided by the police at a date after the screener had looked at these papers, so all the screener saw was the statements of the two sisters and the medical records.

MISS GRIFFIN: My understanding is that the police statement at page 266 came in with the fax header sheet that was received dated 12 June this year (page 265) and that is the date after which the screener screened the matter. My understanding and my instructions are that the screener did have the statement of Dr Barton.

THE CHAIRMAN: We are dealing with all the documents before us, which include Dr Barton's statement. We will give due weight to all the documentation we have.

MR JENKINS: We have received a letter from the Fitness to Practise Directorate dated 19 June. Of course, I will check with my learned friend, but we have raised in correspondence the question of whether the screener saw Dr Barton's statement, and

we were told that the screener, in reaching his decision, considered the documentation that was supplied to us by the police on 6 June 2001 and which was served on Dr Barton. Dr Barton's statement was received at a later time than that.

THE LEGAL ASSESSOR: In any event, as the Chairman has made clear, this Committee considers all the material matters before it and is not in any way bound by the fact that the screener has decided to refer the case to the Committee.

MR JENKINS: I raise it for the sake of completeness, for no other reason.

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

DECISION

THE CHAIRMAN: Dr Barton, the Committee have carefully considered all the evidence before it today.

The Committee have determined that they are not satisfied it is necessary for the protection of members of the public, in the public interest or in your own interests that an order under section 41(A) of the Medical Act 1983 should be made in relation to your registration.

Expert Review

Catherine Lee

No. BJC/31

Date of Birth: Code A

Date of Death: 27 May 1998

Catherine Lee was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Haslar Hospital where she had been admitted for surgery to repair a fractured neck of femur.

On admission, it was noted that Mrs Lee had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing.

On admission she was settled on the ward and given oral Morphine.

This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May.

She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam.

The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.

Code A

Code A

Code A

Code A

Vanessa Carroll

The Guardian
14 September 2002
Page 2

Inquiry launched into 'suspicious deaths' at hospital

John Carvel
Social affairs editor

The government yesterday launched a special inquiry into the suspicious deaths of elderly people at a cottage hospital in Gosport, near Portsmouth, after relatives complained that there may have been at least nine unlawful killings.

Sir Liam Donaldson, the chief medical officer, has called in Richard Baker, a professor at Leicester University, to conduct a clinical audit of services for older people at the Gosport War Memorial hospital.

Prof Baker was the expert appointed by the Department of Health to investigate the practice of Dr Howard Shipman after his conviction as a serial killer. His finding that Shipman might have been responsible for 330 deaths persuaded ministers to expand a public inquiry into his crimes.

Officials were last night unaware of the government launching any similar clinical audit before a prosecution and conviction.

Police investigated the hospital between 1998 and 2001 after concern among relatives about the death of an elderly woman who was prescribed diamorphine. This led to allegations about the deaths of eight other patients.

Hampshire police sent papers to the crown prosecution service, which decided there was not sufficient evidence on which to base a prosecution, according to a Department of Health spokeswoman.

The commission for health improvement (CHI), the government's hospital inspectorate, said: "The police were sufficiently concerned about the care of older people at the hospital to share their concerns with us."

The CHI found there was systematic failure to provide good quality care, including insufficient guidelines on prescribing painkillers and sedatives, inadequate review of prescribing for older people and lack of supervision.

In a report in July it said: "CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998."

The inspectors were "unable to determine whether these levels of prescribing contributed to the deaths of any patients". But it was clear that this level of prescribing would have been questioned if adequate checking mechanisms had been in place.

"Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001."

However, the inspectors said they had no serious concerns about current standards.

Sir Liam's decision to mount an investigation was based on uneasiness that neither the police nor the inspection team "was in a position to establish whether trends and patterns of death were out of line with what would be expected". Inquiries of this kind are extremely unusual, officials said.

The original investigation was sparked when Gillian Mackenzie of Eastbourne, East Sussex, contacted police about the death of her 91-year-old mother in 1998.

She said at the time: "I am a realistic woman. I knew there was a chance of my mother dying when she was admitted to hospital. It is the manner she died that shocked me.

"I will never know what would have happened if she had not been prescribed diamorphine, but we must ensure that all the circumstances of these deaths are fully explained."

The Daily Telegraph
14 September 2002
Page 8

CPS to look at hospital deaths

A third inquiry into the deaths of elderly patients at a cottage hospital was announced yesterday as police said they were sending new evidence on four of them to the Crown Prosecution Service.

Nine elderly people died at Gosport War Memorial Hospital, Hampshire, amid allegations of unlawful killing and over-use of pain-killing drugs. Police are in touch with the General Medical Council and the Commission for Health Improvement.

Police first investigated the case of a 91-year-old woman. Officers were then contacted by eight other families.

The Sunday Times
15 September 2002
Page 5

Police probe 13 hospital deaths

Lois Rogers
Medical Correspondent

POLICE are investigating the deaths of 13 elderly hospital patients who relatives believe were killed with overdoses of powerful drugs, including the painkiller diamorphine.

On Friday Liam Donaldson, the chief medical officer, ordered an audit of the hospital's death rates, which will be carried out by the same expert who analysed mortality among patients of the GP Harold Shipman.

Shipman, who was sentenced to life two years ago, is believed to have killed more than 250 elderly people by giving them overdoses of diamorphine, the pure form of heroin that is used as a painkiller but is lethal in overdose.

All 13 of the Hampshire patients were admitted to Gosport War Memorial hospital between 1997 and 2000 to recover from various operations and treatments. None of their families was told at the time of admission that their relatives were expected to die.

Jane Barton, a GP who was in day-to-day charge of medical care at the hospital until July 2000, was referred to the General Medical Council's professional conduct committee last week. A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

However, there is no suggestion that Barton, who has refused to comment, or any of the others who worked on the wards deliberately caused harm to any patient.

Among the cases being probed are the deaths of:

- Elsie Devine, 88, who was admitted to the hospital to recover from a kidney infection. Her relatives were urged to leave the hospital shortly before she died. They were stunned to discover she had been given large doses of diamorphine.
- Leonard Graham, 75, who was recovering from pneumonia. His wife was "told" to ring her daughter while a drug dose was administered. He died shortly afterwards.
- Betty Rogers, 67, who was recovering from a chest infection. Her daughter was urged to go home having been told her mother was not near death. Fifteen minutes later she received a call saying she had died.

Other deaths under investigation include Stanley Carby, 65, Eva Page, 88, and Dulcie Middleton, 85.

Among those who are helping the police with their inquiries is Jim Ripley, a 76-year-old gout sufferer who was admitted to Gosport War Memorial hospital in April 2000. He narrowly escaped death after falling into a painkiller-induced coma on one of the three wards now under investigation. It took five hours for an emergency doctor to arrive after he lost consciousness at hospital. He was transferred to the nearby Haslar hospital where staff soon established he had not had a stroke, as was first suspected, but was in an "analgesic coma".

A number of families were advised to take holidays during their relatives' last hours. "Why did they tell me to go on holiday? Surely they knew he was going to die," said Dorie Graham, whose husband Leonard died in 2000. She complained to the police more than a year ago.

Edna Purnell, 91, entered the hospital for rehabilitation after a hip replacement. She was put in a darkened room and heavily sedated, according to Mike Wilson, her son. Wilson consulted a solicitor and tried to get her moved to a private hospital. He was then himself rushed into hospital after a heart attack and while he was there she died.

The medical notes of Alice Wilkie, 88, record her as having died twice on the same day. Her granddaughter Emily Yeats believes this is because her files were mixed with those of Gladys Richards, 91, who died hours later. Both received cocktails of painkillers that investigations by the Commission for Health Improvement (CHI) revealed should not have been used together.

A CHI report into the hospital's practice, published in July, criticised the use of diamorphine combined with a strong anaesthetic, and another drug usually used to treat schizophrenia. This combination, the report said, "could carry a risk of excessive sedation and respiratory depression in older patients, leading to death".

The CHI was originally asked to investigate the hospital by the police, who had begun a criminal investigation into the 1998 death of Richards, after her family alleged she had been unlawfully killed.

Although the CHI report said it could not look at any particular death, it found doses of up to 200 milligrams a day of morphine were being administered through pumps into patients' bloodstreams. Prescriptions for morphine and other potent drugs were regularly written in advance, so that nurses could administer them unsupervised.

Ian Piper, the chief executive of the Gosport and Fareham primary care trust, which now administers the hospital, said he could not comment on individual cases. The trust has just sent its first draft of proposals to meet the 22 recommendations for change in the CHI report. Standards of care at the hospital had improved, said Piper.

Families of 10 of the dead patients attended a meeting called by Ian Readhead, deputy chief constable of Hampshire, last week. Police said a file on the affair will be sent to the Crown Prosecution Service this month. The Nursing and Midwifery Council said it was investigating disciplinary proceedings against several nurses.

Donaldson has commissioned Richard Baker, professor of clinical governance at Leicester University, to repeat the statistical analysis he conducted into Shipman's practice.

Donaldson said previous inquiries into patient concerns at Gosport had not established whether patterns of death were "out of line with what would be expected". Baker will seek to answer the question fully.

News of the World
15 September 2002

New old folks death probe?

THE professor who investigated serial killer Dr Harold Shipman is to head a probe into hospital deaths.

Richard Barker will lead the third inquiry into the deaths of at least eight elderly patients at Gosport War Memorial Hospital, Hants.

Venessa Carroll

Daily Mail (Late)
16 September 2002
Page 19

Shipman case expert heads hospital probe

AN expert who worked on the case of mass murderer Harold Shipman is to head an inquiry into the deaths of 13 patients at a hospital.

There are fears that some who died at Gosport Royal Memorial Hospital in Hampshire between 1997 and 2000 may have been killed by a drug overdose.

Files on several of the cases are being sent to the Crown Prosecution Service although there is no suggestion that any of the patients was harmed deliberately.

The investigation began after families raised concerns that their relatives may have been given overdoses of drugs including diamorphine.

Professor Richard Baker of Leicester University has been commissioned to study the deaths. He analysed death rates at GP Harold Shipman's practice in Hyde, Greater Manchester.

Shipman is serving life for murdering 15 patients but has been blamed for killing 200 more.

Jackie Smith

The Times
7 November 2002
Page 3

Shipman-style inquiry into 50 deaths at hospital

By Michael Horsnell and Russell Jenkins

AN EXPERT in the use of diamorphine, the heroin-based painkiller, is to be appointed by police conducting an investigation into the suspicious deaths of more than 50 elderly patients at a community hospital.

Relatives allege that the drug, used by Harold Shipman to kill many of his patients, was over-prescribed at the Gosport War Memorial Hospital in Hampshire. Detectives are preparing to interview relatives of those who died at the 180-bed hospital amid claims of unlawful killing.

Many patients died while receiving recuperative care under a regime in which prescriptions for morphine and other potent drugs were regularly written in advance so that nurses could administer them unsupervised.

Ann Alexander, a solicitor who represented more than 300 families in the Shipman inquiry, had a two-hour meeting with Detective Chief Superintendent Steve Watts of Hampshire police and his deputy Nigel Neven yesterday.

She said: "It was a very productive meeting. They have completely reassured me about their intentions to do whatever they can to get to the bottom of whatever has been going on at this hospital."

After complaints by some relatives that police had failed to respond fully to initial concerns, it was disclosed that officers will examine how Greater Manchester Police put together the Shipman inquiry, notably its use of expert witnesses. Ms Alexander said: "Police want to see every single family that wishes to see them. They are hoping that anyone who has not been in touch and who has concerns should come forward."

The meeting, at her office in Altrincham, Greater Manchester, came after worried families contacted a helpline established by health managers. A total of 57 people attended a public meeting held by Alexander Harris, solicitors, on Sunday to hear concerns about treatment at the hospital dating back to the early 1990s.

The law firm represents relatives of 27 elderly patients who died at the hospital and one who survived, but there are believed to be at least as many again whom detectives want to contact.

Among the cases under investigation are those of Leonard Graham, 75, who was recovering from pneumonia. Another, Betty Rogers, 67, was recovering from a chest infection. Her daughter was urged to go home, having been told her mother was not near death. Fifteen minutes later she received a call saying her mother had died.

Other deaths under investigation include those of Stanley Carby, 65, Eva Page, 88, and Dulcie Middleton, 85.

The hospital has already been the subject of an investigation by the Commission for Health Improvement, which criticised its prescribing practices. Althought a commission report said that it could not look at any particular death, it found doses of up to 200 milligrams a day of morphine were being administered by pumps.

In September the government's chief medical officer commissioned a clinical audit. Professor Richard Baker, who worked on the Shipman inquiry, was appointed to examine death rates at the hospital.

In the same month the chief executives responsible for managing the hospital at the time of the deaths were suspended. Ian Piper, of Fareham and Gosport Primary Care Trust, and Tony Horne, of East Hampshire Primary Care Trust, were redeployed to other duties. The suspensions were prompted after internal documents from 1991 — prior to the deaths — were uncovered which highlighted concerns about prescribing practices at the hospital. The hospital has moved to reassure current patients by appointing an experienced senior nurse from another area to oversee and review patient care.

Jane Barton, who was in charge of the day-to-day treatment of some elderly patients at the hospital until July 2000, was referred to the General Medical Council in September. A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

There is no suggestion that Dr Barton, who has refused to comment, or any of the others who worked at the hospital, deliberately caused harm.

The Hampshire and Isle of Wight Health Authority said: "It is important to note that whilst the CHI investigation had some serious concerns about services in the past, it concluded that policies and procedures are now in place to ensure safe standards of care at the hospital."

Hampshire police said: "Detective Chief Superintendent Steve Watts today had a meeting with Alexander Harris in Altrincham who are representing the families of people who died at the Gosport War Memorial Hospital. Senior members of his investigating team were at the meeting. The investigation is ongoing."

The Times
7 November 2002
Page 3

Relatives tell of their anguish

Case History 1:

ANNE REEVES would have looked after her mother at her home in Fareham, Hants after the elderly widow completed successful treatment for a kidney infection at Queen Alexandra Hospital, Portsmouth.

But her own husband was also in hospital, having a bone marrow transplant for leukaemia. So it seemed a sensible idea for Elsie Devine, 88, to recuperate at the War Memorial Hospital in Gosport. She died on November 21, 1999.

Mrs Reeves said: "She had been doing very well. Then on November 19 my brother Harry visited and was met by Jane Barton who said mother was in kidney failure and had 36 hours to live.

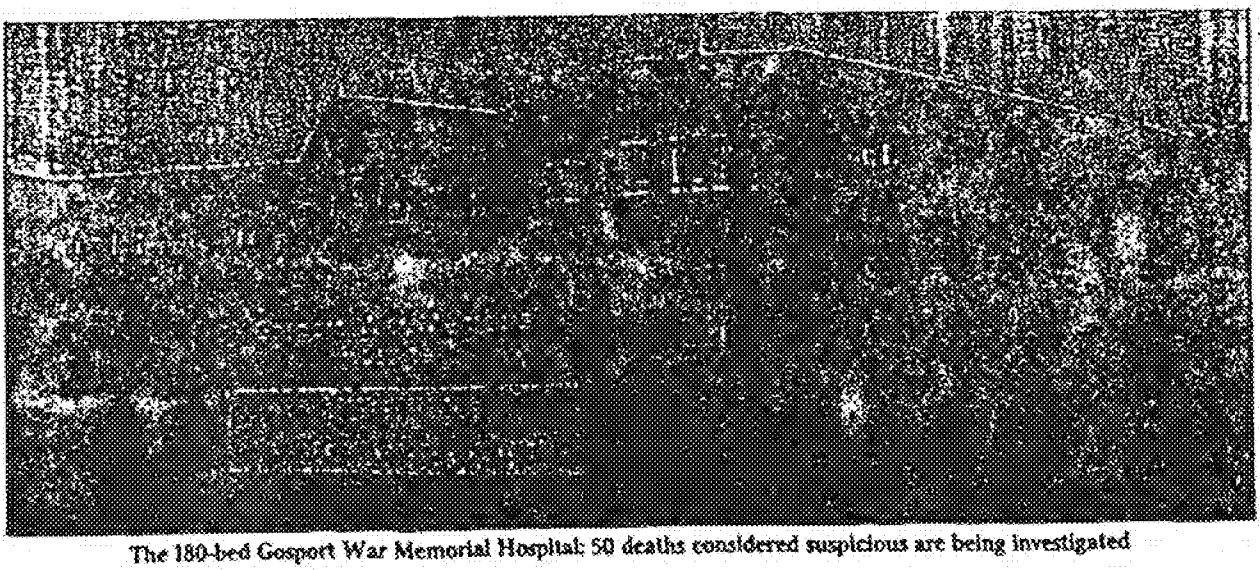
"She couldn't speak and couldn't open her eyes. She was just lying there."

Mrs Reeves, who has obtained her mother's drug charts, added: "She had been put on a cocktail of sedatives and, in the end, it killed her. I don't know why, because she wasn't in any pain."

Case History 2:

FORMER dockyard worker Jim Ripley, 78, went into the hospital for recuperation from arthritis and bursitis in April 2000 but after a couple of days he started hallucinating.

On the morning of April 8 he became unconscious and despite calls by his wife Paule at 8.30am for a doctor to see him, he was not seen until after 3pm that day. The doctor originally suspected he had suffered a stroke but, after he was transferred to another hospital, he was diagnosed as having suffered an analgesic coma caused by overprescription of morphine, according to Mrs Ripley. She said: "I am extremely angry but very lucky that my husband is alive and so very, very sorry for everyone else that lost their family. My husband had turned from being a strong elderly man to a frightened old man and it was pitiful to see."



The 180-bed Gosport War Memorial Hospital: 50 deaths considered suspicious are being investigated

BJC/22 & JR/1	HARRY HADLEY	COPIES OF TWO SETS OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/26	ALAN HOBDAY	COPY OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/35	EVA PAGE	COPY OF PAPER RECORDS
BJC/36	GWENDOLINE PARR	COPY OF PAPER RECORDS
BJC/37	EDNA PURNELL	COPIES OF TWO SETS OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/38	MARGARET QUEREE	COPY OF PAPER RECORDS AND COPIES OF TWO MICROFILM PAPERS
BJC/40	VIOLET REEVE	COPY OF PAPER RECORDS AND A COPY OF MICROFILM PAPERS
BJC/42	JAMES RIPLEY	COPIES OF TWO SETS OF PAPER RECORDS
BJC/47	DAPHNE TAYLOR	COPY OF MCROFILM PAPERS

CONTENTS OF BOXES TO G.M.C. 10 09 2004

REF.	NAME	FILE CONTENT
BJC/1A	VICTOR ABBATT	COPY OF MICROFILM PAPERS
BJC/2	DENNIS AMEY	COPY OF MICROFILM PAPERS
BJC/6A	CHARLES BATTY	COPIES OF TWO SETS OF MICROFILM PAPERS
BJC/6B	DENNIS BRICKWOOD	COPY OF PAPER RECORDS
BJC/9	SYDNEY CHIVERS	COPIES OF TWO SETS OF PAPER RECORDS
BJC/17	CYRIL DICKS	COPIES OF TWO SETS OF PAPER RECORDS AND COPY OF MICROFILM PAPERS
BJC/23	CHARLES HALL	COPY OF PAPER RECORDS AND COPIES OF TWO SETS OF MICROFILM RECORDS
BJC/31	CATHERINE LEE	COPIES OF TWO SETS OF PAPER RECORDS
BJC/7	STANLEY CARBY	COPIES OF TWO SETS OF PAPER RECORDS
BLC/12	WALTER CLISSOLD	COPY OF PAPER RECORDS

FORMAT OF FILE CONTENTS

1. DOCUMENT LISTING THE CONTENTS OF THREE BOXES DELIVERED TO G.M.C 10 09 2004

2 REVIEW OF EXPERTS

A. IRENE WATERS
B. ROBIN FERNER
C. PETER LAWSON
D. ANNE NAYSMITH

3. POLICE OFFICER'S REPORT

4. CASE REVIEWS BY MATTHEW LOHN

RECEIVED FROM HAMPSHIRE CONSTABULARY

THREE BOXES CONTAINING FILES AS LISTED

TWO FILES CONTAINING PAPERS/REVIEWS OF THE EXPERTS

IRENE WATERS, ROBIN FERNER PETER LAWSON, ANNE NAYSMITH AND MATTHEW LOHN

POLICE OFFICERS REPORTS AS ENCLOSED WITHIN THE TWO FILES

SIGNED

TIMES ONLINE PRINT THIS ARTICLE

November 07, 2002

Shipman-style inquiry into 50 deaths at hospital

BY MICHAEL HORSNELL AND RUSSELL JENKINS

AN EXPERT in the use of the heroin-based painkiller diamorphine is to be appointed by police conducting an investigation into the deaths of more than 50 elderly patients at a community hospital.

Relations allege that the drug, used by Harold Shipman to kill many of his patients, was overprescribed at the Gosport War Memorial Hospital near Portsmouth.

Detectives are preparing to interview relations of those who died at the 180-bed hospital amid claims of unlawful killing. Many patients died while receiving recuperative care under a regime in which prescriptions for morphine and other potent drugs, it is claimed, were regularly written in advance so that nurses could administer them unsupervised.

Ann Alexander, a solicitor who represented more than 300 families in the Shipman inquiry, had a two-hour meeting with Detective Chief Superintendent Steve Watts, of Hampshire police, and his deputy, Nigel Neven, yesterday.

She said: "It was a very productive meeting. They have completely reassured me about their intentions to do whatever they can to get to the bottom of whatever has been going on at this hospital."

After complaints by relations that police had failed to respond fully to initial concerns, it was disclosed that officers will look at how Greater Manchester Police organised the Shipman inquiry, notably its use of expert witnesses. Ms Alexander said: "The police want to see every single family that wishes to see them. They are hoping that anyone who has not been in touch and who has concerns should come forward."

The meeting, at her office in Altrincham, near Manchester, came after worried families contacted a helpline set up by health managers. A total of 57 people attended a public meeting held by Alexander Harris, a firm of solicitors, on Sunday to hear concems about treatment at the hospital dating back to the early 1990s.

The firm represents relations of 27 elderly patients who died at the hospital and one who survived, but there are believed to be at least as many again whom detectives want to contact. Among the cases under investigation are those of Leonard Graham, 75, who was recovering from pneumonia. Another, Betty Rogers, 67, was recovering from a chest infection. The patient's daughter was urged to go home, having been told that she was not near death. Fifteen minutes later she received a call to say that her mother had died.

Other deaths under investigation include those of Stanley Carby, 65,

Eva Page, 88, and Dulcie Middleton, 85.

The hospital has already been the subject of an investigation by the Commission for Health Improvement, which criticised its prescribing practices. Althought a commission report said that it could not look at any particular death, it found that doses of up to 200 milligrams a day of morphine were being administered by pumps.

In September, the Government's Chief Medical Officer commissioned a clinical audit. Professor Richard Baker, who worked on the Shipman inquiry, was appointed to examine death rates at the hospital.

In the same month, the chief executives responsible for managing the hospital at the time of the deaths were suspended. Ian Piper, of Fareham and Gosport Primary Care Trust, and Tony Horne, of East Hampshire Primary Care Trust, were moved to other duties. The suspensions were prompted after internal documents from 1991, before the deaths, were found which highlighted concerns about the hospital's prescribing practices.

It has sought to reassure its present patients by appointing a senior nurse from another area to review patient care.

Jane Barton, who was in charge of the day-to-day treatment of some elderly patients at the hospital until July 2000, was referred to the General Medical Council in September.

A consultant geriatrician and seven nurses are also the subject of complaints about the dead patients' treatment.

There is no suggestion that Dr Barton, who has refused to comment, or any of the other people who worked at the hospital, deliberately caused harm.

The Hampshire and Isle of Wight Health Authority said: "It is important to note that, while the (Commission for Health Improvement) investigation had some serious concerns about services in the past, it concluded that policies and procedures are now in place to ensure safe standards of care at the hospital."

Hampshire police acknowledged that a meeting between Mr Watts and Alexander Harris, representing the families of people who died at the Gosport hospital, had taken place.

HAMPSHIRE CONSTABULARY

VICTOR ABBATT

VICTOR ABBATT

Victor Abbatt

Date of Birth: Code A Age: **77**
Date of Admission to GWMH: **29th May 1990**
Date and time of Death: **00.05hours on 30th May 1990**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **1 day**

Mr Abbatt was married and had a son and daughter. He had had recent bouts of chest infections, confusion and poor mobility. It was noted that he was a heavy smoker.
Mr Abbatt was admitted to the Gosport War Memorial Hospital on 29th May 1990 as an emergency, requested by Dr Barton. His wife could no longer cope with him at home.
On admission Mr Abbatt was assessed and his medication was boarded.
The foot of his bed was elevated because his ankle and foot were oedematous.
During the night Mr Abbatt became very confused and incontinent of urine.
He was given Temazepam 10 mgms at 22.15 hours.
Mr Abbatt died at 00.05 hours on 30th May 1990, his son and daughter were informed and his death certified by Dr A? and S/N Bro?.

Code A

BJC/01A
VICTOR ABBATT
77
Admitted with bronchopneumonia
Was cyanosed at time of admission
Given temazepam 10mg at 2215
Died at 0005

Bad medicine to prescribe and give temazepam to someone with breathing difficulties
But already very unwell
PL grading A2

Exhibit No	Patient Identification	Assessment Note	Assessment score
BJC/01A	Abbott, Victor	Very brief admission – admitted one day and died at 0500 hours the next. Admission diagnosis was chest infection and mild heart failure. Noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission – and they then administered the Temazepam 10mg apparently written up for him. NO DRUG CHART WITH THE NOTES RECORDED. So unable to comment on whether any drug written up or administered might have contributed to the apparently sudden development of cyanosis and/or subsequent death.	82

DOCUMENT RECORD PRINT

Officer's Report

Number: R7E

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: TEL/EXT:

SUBJECT: OPERATION ROCHESTER DATE: 13/11/2002
VICTOR JOHN ABBOTT B.

On 10th November 2002 (10/11/2002) I visited Pauline GILMORE (nee ABBOTT) and John Richard ABBOTT Code A at Paulines home address of Code A Code A

They had contacted the Health Authority in relation to the death of their father, Victor (Vic) ABBOTT who had died GWMH on 30/05/1990, after seeing media reports on the hospital.

Victor ABBOTT lived at Code A with his wife Doris Rose ABBOTT .

He worked as a stevedore for the MOD and is described as being very fit.

He suffered from arthritis and the ..... but was not taking any medication for them. He was a life long smoker and had a chesty cough.

Around April 1990, Victor ABBOTT had a chest infection for which he was prescribed antibiotics. He was visited by his wife's GP, Dr PETERS , as he was not on a doctors list. The infection left him very weak and unwell but he was not admitted to hospital, he did attend GWMH for an x-ray which confirmed the diagnosis of chest infection.

At this point he was sleeping a great deal and was suffering from hallucinations due to the lack of oxygen getting to his brain. This was directly attributable to the infection and stopped as he began to recover. They are described as 'brief' and 'temporary'.

Dr PETERS oversaw his treatment which did not include any pain killers, just the antibiotics.

Throughout this period, Mr ABBOTT remained alert and able minded, he was however left very weak and required help to reach the bathroom. Because of this his wife became very tired and worn down and it was suggested that Mr ABBOTT be admitted to the GWMH mainly for him to regain his strength and as a respite for Mrs ABBOTT.

Mr ABBOTT didn't wish to be admitted but recognised that his wife needed a rest. He was admitted to a mens surgical ward on the ground floor of the GWMH and 1930 hrs on 30/05/1990 and settled into a chair, the family left him as he was about to taken to the day room to have a cigarette. The staff

informed them that he would 'be made comfortable' and that they could 'come and see him in the morning'.

Around midnight the hospital contacted the family to inform them that John ABBOTT had died.

The family are concerned that their father was given medication that was too strong and as a result he died.

Mr ABBOTT was cremated.

Kathryn ROBINSON

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AX

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 01/12/2003

I attended the home address of Mrs GILMORE at 1000 hrs on Thursday 27th November 2003 (23/11/2003) in relation to her father, Victor ABBOTT , as per the policy log. Also present were her husband and brother.

I discussed the nature of the family's initial concerns as per officers report 7E.

They felt that all of the relevant points had been covered and were given a copy of their father's medical records.

The family is happy to be notified by letter in 'layman's terms' but would like to have the opportunity for a follow up visit if they feel they have questions.

Expert Review

Victor Abbatt

No. BJC/01A

Date of Birth: Code A

Date of Death: 30 May 1990

Mr Abbatt was admitted to the Gosport War Memorial Hospital on 29 May 1990 as an emergency. Dr Barton requested this as his wife could no longer cope with him at home.

On admission he was diagnosed as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission. He was then administered 10mgs Temazepam apparently which had been written up for him.[VA1]

The experts criticised the use of a small dose of Temazepam in a patient who is cyanosed. They note, though, that Mr Abbatt was already very unwell.

HAMPSHIRE CONSTABULARY

DENNIS AMEY

DENNIS AMEY

Dennis Amey

Date of Birth: Code A Age: **62**
Date of Admission to GWMH: **14th November 1990**
Date and time of Death: ***16.30 hours on 20th December 1990***
Cause of Death:
Post Mortem:
Length of Stay: **38 days**

Mr Amey past medical history shows that he suffered from:-
Parkinson's disease

Prior to his admission to the Gosport War Memorial Hospital Mr Amey lived at home with his wife. He was admitted on 7th November 1990 for terminal care, he suffered from Parkinson's disease.
Mrs Amey requested that her husband was admitted.
Mr Amey had problems with his catheter, he was incontinent and was having spasms and was in pain.
He needed help with feeding and had difficulty with swallowing. He was noted to be irritable by the duty doctor.
He was nursed on a Pegasus mattress and had red sores.
It was noted in the clinical notes that he had pus discharging from his penis and had gangrenous areas around his scrotum and that he needed pain relief.

On 19th December 1990 Mr Amey was written up for **Diamorphine to be administered using a syringe driver**. The dosage was 120mgs over a 24 hours period.
On 20th December 1990 Mr Amey died at 16.30 hours.

Code A

BJC/02
DENIS AMEY
62
There are no drug cards or relevant nursing notes
Severe PD
Developed gangrenous – decided on conservative treatment

Started on morphine elixir on 11/12/90
On 120mg diamorphine sc per 24 hours by 19/12/90

This is a huge dose but might have been appropriate
There is not enough detail in the notes to be sure of what the opiate requirements were
- probably some medication cards and casenotes missing

He was clearly very unwell and in pain
However the dose of opiate might have contributed to his death
PL grading B but difficult to give a number

BJC/02	Arney, Denis	Admitted for terminal care (long term) because wife no longer able to cope. Very severe Parkinson's. Had long term catheter. Treated with Septrin for presumed UTI but then developed pyuria and oliguria, succeeded by scrotal gangrene. Surgical opinion requested but in view of very severe Parkinson's surgery not offered (not clear whether thought unsafe or just inappropriate). Managed with opioid pain relief, apparently by diamorphine via syringe driver. At one point from notes was on 120mg diamorphine/day. NO DRUG CHART IN NOTES RECORDED. It is therefore unclear, and cannot be determined from the evidence available to me at this time, whether the doses of diamorphine administered were escalated only in response to uncontrolled pain and indeed what those doses were.	82

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BD

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 06/12/2003

I attended the home address of Lesley LOWE , the daughter of Denis George AMEY Code A at 1000 hrs on Thursday 27th November 2003 (27/11/2003). Also present was her sister, Susan MAY , Code A Code A The visit was as per the policy log, a set of their father's medical records were provided.

I outlined their concerns as per officers report 8C and they felt that they had nothing further to add in relation to their father, however they wished to bring to our attention concerns they have in relation to their mother, Freda AMEY , Code A who currently lives in a warden controlled complex.

Mrs AMEY has been a diabetic since her late 50's, early 60's. She suffered from Osteoporosis and her diabetes is now insulin driven.

Mrs AMEY was being treated by her GP, Dr BARTON and was being prescribed pain killers.

On one occasion Mrs AMEY had to see Dr KNAPMAN , a partner in Dr BARTON's surgery. Dr KNAPMAN said to Mrs AMEY "Why are you on morphine, you'll end up at ..." and said the name of a local undertakers. He took her off the morphine.

Some years later, around 1999, Mrs AMEY was suffering from back pain. Dr BARTON visited and gave her an injection. She was admitted to the GWMH t o be assessed for her diet and diabetes.

After a couple of days after being admitted Mrs AMEY is described as being "out of her head", incoherent and slurring her words. Her tongue appeared swollen.

The family removed Mrs AMEY from hospital and after a couple of days she appeared to be her normal self.

Dr BARTON felt that Mrs AMEY should then have gone into a nursing home and she took Mrs AMEY off her patient list. Mrs AMEY now attends the Bridgemary Surgery and is under Dr EVSKIN .

They also mentioned their granddaughter, Emma BLOOD, who at the age of 21 yrs had a fall at her flat. She was admitted to the QA where she developed shingles. She was then transferred to the GWMH to recuperate from her illness. She had no injuries from her fall.

Whilst at the GWMH she had a box which went somewhere into her neck, she died shortly afterwards. Whilst at the hospital she suffered from hallucinations, believing that she was in the workhouse.

The family are happy to be notified by letter.

Expert Review

Dennis Amey

No. BJC/02

Date of Birth: Code A

Date of Death: 20 December 1990

Mr Amey was admitted to Gosport War Memorial Hospital on 14 November 1990 following a request from Mrs Amey. Mr Amey at that time had problems with his catheter, he was incontinent and was having spasms. Mr Amey had very severe Parkinson's disease. He was admitted for terminal care.[DA1]

Mr Amey was started on Morphine elixir on 11 December 1990 and by the time of his death on 19 December 1990 he was on 120mgs of Diamorphine subcutaneously per twenty-four hours. Dr Lawson notes that Mr Amey was very unwell and in pain.

The experts have determined that this dose of Morphine was high and possibly sub optimal but without additional documentary evidence cannot be clear as to whether the doses of Diamorphine was escalated only in response to uncontrolled pain.

CHARLES BATTY

CHARLES BATTY

Charles Batty

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **September 1990**
Date and time of Death: **10.55 hrs on 2nd January 1994**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **3 years 3 months**

Mr Batty's past medical history states that she suffered from:-

1969 – Menieres
1973 – Partial gastrectscomy
1975 - Gastrectomy
1976 – Cervical spondylosis
1981 – Epilepsy
1984 – Prostatectomy benign
1989 – Colostomy – CA descending colon
Parkinson's Disease
History of depression.

Mr Batty lived at home with his wife. They had a daughter. Mrs Batty had CVS disease and felt that she was unable to cope. Mr Batty was admitted to the Gosport War Memorial Hospital in September 1990 for Geriatric long stay and for physio and investigation for his Parkinson's disease. It was noted that as his Parkinson's worsened he was unsteady on his feet and needed a stick and the help of a nurse.

Care Plans for sleep, colostomy, catheter, noting urinary tract infection and retention and mobility noting problem right foot, personal hygiene, epilespy and agitated were completed dated 14th November 1993.
A care plan for commenced on 27th September 1993 for red sacrum.

20th December 1993

Seen by Dr Lord – no change.

28th December 1993

Complaining of generalised pain. Seen by Dr Barton. **Oramorph 10mg 6 hourly.**

30th December 1993

Nightmare end of last week disturbed and agitated. Quick and complete recovery.
Appears in pain **Oramorph increased** 10mg 4 hourly and 20mg nocte. ? whether pain is being controlled, difficulty taking oral medication. Discussed with Carol/Rhonda happy to put syringe driver.
11.30 hours syringe driver commenced **Diamorphine 40mgs.**

CHARLES BATTY

31st December 1993

General condition deteriorates. Nursed on side left buttock very red. Red/blackened area noticed. Syringe driver satisfactory. Assisted when patient turned. Twitching at times.

1st January 1994

Unchanged. Nursed on side. Skin marking also on right heel.

2nd January 1994

Mr Batty died at 10.55 hours. Next of kin informed. For cremation.

Code A

BJC/06A
CHARLES BATTY
80

History of Parkinson's Disease, epilepsy and Meniere's
Lengthy stay in hospital, condition appeared stable with agitation and difficult behaviour. This was initially treated with lorazepam and thioridazine.
Pain mentioned in nursing notes on 28/12/93 not mentioned in available medical notes. Cause of pain not clear. Went from little analgesia to oramorph 60mg in 24 hours. Within 8 hours converted to syringe driver with an increase in dose. Dose kept stable for next 3 days up to his death.

Cause of pain unclear. Large opiate dose without other forms of pain relief and rapid change to driver. Cause of death is unclear.

PL grading B2

	BJC/06A	Batty, Charles	On coproxamol regularly for a period of years for generalised pain, not clear where, though recurrent fungal infections of the groins and scrotum appeared to be part of it and also, latterly, had pressure area problems. As soon as he began to complain of generalised pain he was started on Oramorph and the dose escalated, then when he had difficulty swallowing changed to syringe driver with a further dose escalation. Clearly difficult to assess his pain because of his dementia. But it did not appear that his	C2

Expert Review

Charles Batty

No. BJC/06A

Date of Birth: Code A

Date of Death: 2 January 1994

Mr Batty was admitted to Gosport War Memorial Hospital in September 1990 for long stay care. He had a previous history of Parkinson's disease, epilepsy and Ménières.

He was treated with Coproxamol regularly for a period of years for pain although its origin was not clear.

In December 1993 he was complaining of generalised pain and started on Oramorph. Dr Lawson notes that Mr Batty went from little analgesia to Oramorph 60mgs in twenty-four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment.

The experts review has determined that the treatment was sub optimal due to the high doses, especially Midazolam. Cause of death was felt to be unclear by the expert team.

HAMPSHIRE CONSTABULARY

DENNIS BRICKWOOD

DENNIS BRICKWOOD

Dennis Brickwood

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **3rd February 1998**
Date and time of Death: **21.15 hrs on 12th June 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **19 weeks**

Mr Brickwood's past medical history:-

Masangio-proliferative glomerulonephritis due to chronic renal failure
Fracture neck of femur
CA prostate
Myeloma diagnosed on bone marrow
Spinal osteoporosis
Artrial fibrillation

Prior to his admission to hospital in February 1998, Mr Brickwood lived at home with his wife. He fell and sustained a fractured neck of femur. Mr Brickwood had been his wife's main carer as she had also had hip replacements and was not mobile. It was hoped that he would be discharged home with a complete care package or go into residential care. He had deteriorating vision and had cataracts in both eyes. Mr and Mrs Brickwood had a son.

It was noted in Mr Brickwood's notes that he was allergic to morphine and was on warfarin.

Prior to his admission Mr Brickwood had a history of falls. He was a very alert man but slow at times.

He was admitted to Gosport War Memorial Hospital from Queen Alexander for rehabilitation following an operation where a dynamic hip screw was inserted.

A Waterlow score of 25 was recorded on 22nd April 1998 going down to 17.

A Barthel ADL index was completed noting 11 on 18th April 1998 going up to 17 later. The aim was to rehabilitate Mr Brickwood with a view to him going home with a complete care package.

A nutritional assessment of 3 was recorded on admission.

15th January 1998

Admitted to Hospital after fall where he sustained a fracture to the neck of femur on the right side.

20th January 1998

Operation dynamic hip screw.

3rd February 1998

Transfer to Gosport War Memorial Hospital for rehabilitation. He was nursed in a side room because he tested positive for MRSA. He was nursed on a Pegasus biwave mattress and needed the help of two nurses for transfers.

March 1998

OT assessment.

5th March 1998

Clinical notes state GP contact by nursing staff. Gets **drowsy with small amount of morphine.** Need to be cautious previously been on MST.

6th April 1998

Unsuccessful home visit.

14th May 1998

Sore heels noted. Skin intact.

24th May 1998

Complained of excessive chest pain. Impression musculoskeletal pain.

4th June 1998

No improvement. Chesty very rattly. **For morphine.** Family happy with care and **syringe driver discussed.**

5th June 1998

Higher dose of oramorph given.

9th June 1998

Changed oramorph to MST. Complaining of chest pain.

10th June 1998

Taking MST/oramorph. For syringe driver is pain not adequately controlled.

11th June 1998

Painful back- swallow and appetite poor. Seen by Dr Knapman syringe driver commenced. Family informed.

12th June 1998

Deteriorating pronounced dead by S/N Giffin at 21.15 hours. Relatives present.

15th June 1998

Death certified. For cremation

Code A

BJC/06B
DENNIS BRICKWOOD
80

Hip fracture, carcinoma of prostate, osteoporosis with vertebral fractures, myeloma. Aiming for home but had an unsuccessful home visit.
Developed musculoskeletal chest pain and chest infection. Chest xray suggested anterior rib fracture. Codydramol ineffective. Converted to oramorph then dose increase to MST then large dose increase to syringe driver. Died 24 hours after starting driver. No other analgesics tried ?would have responded to NSAID or heat packs.

Cause of death unclear and use of analgesia was not ideal

PL grading B2

Exhibit No	Patient Identification	Assessment Note	Assessment score
		condition was deteriorating prior to starting opioids.	
BJC/06B	Brickwood, Dennis	Patient was being actively prepared for discharge against his and his family's will (because they did not wish to pay for residential care) when he developed a chest infection which did not respond to antibiotics, despite a change of antibiotic. Opioids not started until he was failing on the second antibiotic. Clear complaints of pain from the patient. Excellent reasons for pain (vertebral fractures and cracked rib). My quibble is with the speed at which the dose of morphine/diamorphine was escalated and the large amount of hyoscine and midazolam added to the syringe driver. But I suspect death was accelerated little if at all – the doses were just a little unnecessary	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R13D

TO:
STN/DEPT:

REF:

FROM: DC2312 RUSHWORTH
STN/DEPT: FCU FLEET

REF:
TEL/EXT:

SUBJECT:

DATE: 14/02/2003

On Wednesday 29th January 2003 (29/01/2003) I went to the home of Mr Anthony BRICKWOOD concerning the death of his father Dennis John BRICKWOOD , Code A

Prior to his death, his father lived with his wife in Gosport. Sometime before his death his father was diagnosed with Prostate Cancer. It was caught fairly early and was not deemed to be terminal. He went into Haslar Hospital for chemotherapy treatment in tablet form. This treatment was successful and he was transferred to the Gosport War Memorial Hospital for rehabilitation.

A few weeks before his fathers death Mr Anthony BRICKWOOD was approached by staff. They requested that he look for a nursing home for his father as he could not stay there indefinitely. Mr BRICKWOOD states that his father was very alert and vocal. He had made a friend called Terry . Mr BRICKWOOD recalls that the two of them used to complain about the nurses who did not appear to be looking after the older and more frail patients properly.

Dennis BRICKWOOD would often tell his son that the nurses would just place food in front of patients who were clearly unable to feed themselves then an hour or so later would just take it away again without attempting to help them eat.

Mr Anthony BRICKWOOD recalls a senior nurse named Phillip who appeared to be running the ward. He seemed to have a lot of authority and was making decisions that would normally be associated with a doctor.

The evening before his fathers death Anthony had gone to visit his father after work. He found his father in good spirits, talking about the football results. Anthony's brother was also there with his son Thomas. Dennis BRICKWOOD was asking about Thomas' homework and asked him to come back tomorrow to tell him about it. At about 7.00pm (1900) the family left. About an hour later Anthony received a call from the hospital saying his father had taken a turn for the worse. He immediately went to the hospital to find his father unconscious, he noticed that he had been fitted with a syringe driver and was receiving Diamorphine. His father never regained consciousness and died the next day. As far as Mr Anthony BRICKWOOD was concerned there was no doctor on duty over that period.

The two main questions that the family are seeking answers to are:

What sort of emergency occurred shortly after they left that evening?
Who attended his father and who authorised that he should be put on such large doses of Diamorphine?

Dennis BRICKWOOD was cremated. The family is represented by Ann ALEXANDER .

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BA

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 06/12/2003

I visited Mr Antony BRICKWOOD at 2000 hrs on Tuesday 25th November 2003 (25/11/2003) at his home address, Mr Dennis BRICKWOOD was also present (brother).

The meeting was in relation to their father Dennis BRICKWOOD Code A and as per the policy log.

I outlined the concerns as noted in officers report 13D and noted the further comments of Antony BRICKWOOD as;

At the time of his fathers deterioration the family had been searching for a suitable rest home for him to move to.

His father was in the hospital for rehabilitation after a hip replacement. He had come through six weeks of isolation for a super bug.

Mr BRICKWOOD wishes to know:

1. Why the family were not consulted prior to the treatment being commenced?
2. Who took the decision and why?
3. Who administered the drug?
4. In what quantity?
5. And what was actually given to their father?

The BRICKWOOD family is happy to be informed by way of a letter, they have been given a copy of the medical records.

Antony BRICKWOOD was agitated during the meeting but he suffered the loss of his wife three weeks ago from cancer.

Expert Review

Dennis Brickwood

No. BJC/06B

Date of Birth: Code A

Date of Death: 12 June 1998

Mr Brickwood was admitted to hospital on 15 January 1998 after a fall where he sustained a fracture to his neck of femur.

On 3 February 1998 he was transferred to Gosport War Memorial Hospital for rehabilitation. His medical history included carcinoma of the prostate, osteoporosis and myoma.

He was assessed in March 1998 with a view to being discharged home but, following a trial visit on 6 April 1998, this was not considered a possibility.

In May 1998 he developed musculoskeletal chest pain together with a chest infection.

The infection did not respond to antibiotics despite a change in treatment.[DB1]

Opioids were started when Mr Brickwood's condition was failing on the second antibiotic tried.

The experts note that the Morphine/Diamorphine was escalated and a large amount of Hyoscine and Midazolam added to the syringe driver although it was not felt death was accelerated as a result of this treatment.

HAMPSHIRE CONSTABULARY

SYDNEY CHIVERS

SIDNEY CHIVERS

Sidney Chivers

Date of Birth: Code A Age: **79**
Date of admission to GWMH: **11th May 1999**
Date and time of Death: ***19.10 hrs on 20th June 1999***
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **40 days**

Mr Chivers past medical history:-

CCF
Confusion
Hypertension
Register partial sighted
IHD
Varicose veins
Hallucinations

Mr Chivers was widowed in 1995 and lived alone. He had lived in the same council house for twenty years and had just applied for a flat nearby. He had a daughter who helped with shopping and cleaning but managed without help apart from meals on wheels. Mr Chivers also had two sons in Gosport and two other sons in Southampton and Havant. Prior to his admission he had started to neglect himself.
Mr Chivers had numerous admissions to hospital. In May 1999 he was admitted to the Gosport War Memorial Hospital from the Queen Alexander Hospital for rehabilitation after suffering another CVA, CCF, CXR right plural effision and chest infection.

On admission an assessment and patient profile was completed. A handling evaluation was also completed noting that Mr Chivers needed the help of 1 or 2 nurses.
A nursing assessment was completed and several care plans were commenced including hygiene, constipation, transferring and help to settle at night.
A Barthel ADL index was completed ranging from 10-15. A nutritional score of 17 was recorded.
A Waterlow score of 15 and 17 was also recorded.

11th May 1999

Admitted to Gosport War Memorial Hospital from Queen Alexander Hospital where he had been admitted as an emergency by his GP with right CVA, CCF, CXR right pleural effision, possible chest infection. He was admitted onto Dryad Ward for continuing care.

14th May 1999

Complaining of increased pain – feeling unwell.

17th May 1999

Depressed – Seen by Dr Reid – scan at Haslar to be arranged.

21st May 1999

Brain scan – CVA at Haslar.

24th May 1999

Walking unaided.

2nd June 1999

Very confused at times. ? aim for home for trial period three to four days next week. Discuss with family.

7th June 1999

Hallucinating/distressed.

15th June 1999

Catherised – complaining of feeling weak and pain. Had to be fed. Oramorph commenced 5mgs. ? Lewi body disease.
To be discharged to rest home not for home.

16th June 1999

Fentanyl commenced 25mgs plus oramorph 5mgs.

17th June 1999

Slept long periods.

18th June 1999

In a lot of pain on movement. Bowels not open for a few days. Oramorph given. Syringe driver to be considered.
Deteriorating.

19th June 1999

Seen by Dr Brooks syringe driver commenced 40mgs diamorphine.

20th June 1999

Deteriorated. Bronchopneumonia on S/C analgesia. Syringe driver (2 drivers) reprimed diamorphine 60mgs.
19.10 hours died. Death confirmed S/N F? and Nurse B?
For cremation.

Code A

BJC/09
SIDNEY CHIVERS
80

Had a stroke. Initially doing fairly well but it became clear he was not going to make it home. There was a suspicion of Lewy Body Dementia for which traditional antipsychotics should be avoided; his dose of risperidone was increased (risperidone is a new antipsychotic which should have been OK). He deteriorated soon after the dose increase with pain in his hands and also abdominal pain. Treated with opioids and then large dose of midazolam.

I am not sure what his pain was caused by although stiffness and pain could have been due to risperidone and abdominal pain due to constipation. After starting with oramorph the opioid dose was escalated through fentanyl 25mcg to diamorphine driver 60mg and 80mg midazolam in 3 days.

Cause of death unclear and opioids escalated without trying other ways of stopping the pains.

PL grading B2

BJC/09	Chivers, Sydney	Patient had multiple problems, possibly all cerebrovascular, possibly complicated by Lewy body dementia. Medical notes too brief to allow of full understanding of the process of final deterioration, but it may have been precipitated by increased risperidone to treat his distressing visual hallucinations. Contemporaneously with that increase, and possibly caused by it, his mobility decreased noticeably. He then began to complain of generalised discomfort ?simply due to immobility and stiffness in an elderly man with a CVA. Notable that he was treated by 3 different doctors, according to my reading of the handwriting in the nurses' notes, in his last 2 days. So starting opioids, and initially moving to a syringe driver, were done by 2 other doctors and only the final dose increases, in his agonal hours, were determined by Dr Barton. But the starting doses – 40mg each of diamorphine and midazolam – were similar to those seen in other patients at the end of life and seem not to be determined by the preceding dose of oral opioids, which never exceeded 50mg in 24 hours (=17mg diamorphine).	B2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AZ

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 02/12/2003

I attended the home address of Martin CHIVERS at 1845 hrs on Monday 1st December 2003 (01/12/2003) as per the policy log in relation to his father, Sidney CHIVERS .

I outlined the concerns of his family as per OR71. These were agreed with the added concerns that the family are now aware that diamorphine was administered at the same time as a fentenol patch was being used and that the amount of diamorphine administered was 'not safe'.

The CHIVERS family have a pharmacist and a nurse within their family and both parties have had access to Martin CHIVERS copy of his fathers medical records. I provided him with a copy of our records.

The CHIVERS family would like a letter detailing the clinical teams findings with a 'follow up' visit to enable them to ask any questions. They suggest that provision is made for some form of counselling for those who require it at the time of notification.

DOCUMENT RECORD PRINT

Officer's Report

Number: R7I

TO: REF:
STN/DEPT:

FROM: DC 424 ROBINSON REF:
STN/DEPT: OPERATION ROCHESTER TEL/EXT:

SUBJECT: SIDNEY FRANCIS CHIVERS Code A DATE: 09/12/2002

At 1000 on 31st October 2002 (31/10/2002) I visited Martin Keith CHIVERS Code A Code A in relation to his father, Sidney .

Mr CHIVERS will say that Sidney CHIVERS had been an artillery man in the army, upon leaving he became a builder and pipe layer. It was whilst he was in the building trade that he was involved in an accident and lost the sight in one eye. He was registered disabled by virtue of his partial sightedness and issued a green card.

He then went on to work for British Rail as a porter and finally became a bus conductor up until his retirement.

He was initially married to Mary Patricia Joan CHIVERS nee SKITTLETHORPE and divorced her some years later. He subsequently married Susan MEAD who died around 1996 at Haslar Hospital.

Mr CHIVERS lived alone at Code A

He was mobile although suffered from water retention on his ankles and was in full control of his faculties. He had daily callers and used the services of meals on wheels.

Around three months prior to his death, (approximately April 1999) Mr CHIVERS was found at his home address collapsed.

He was taken to the Queen Alexandra Hospital, Cosham, where it was discovered that he was suffering from a kidney infection. He remained at the QA for a couple of weeks before being discharged to the GWMH, Dryad Ward for rehabilitation prior to being sent home.

At this point he is described as being mobile, cheerful and fully alert. He had been successfully treated at the QA and it was felt that he required a little more support at home and arrangements were made for Mr CHIVERS to visit three prospective accommodation. He was not in any pain nor was he receiving any painkillers. He is described as being quite capable of complaining if he was in any discomfort.

Two days prior to his discharge date Martin CHIVERS was informed by a member of staff that that his father was in pain, Mr CHIVERS was in bed and he informed his son that he had to stay in bed and that

he was having injections.

Martin CHIVERS spoke with staff who informed him that his father was suffering from headaches and was being given painkillers.

From this moment Sidney CHIVERS didn't get out of bed again. He was still compos mentus and looking forward to going home.

His condition deteriorated over the cause of the week and Martin CHIVERS was spoken to by a senior nurse and the duty consultant. He was informed that his father was extremely ill, his vital organs were failing and that they were not sure how long he would live. He was being administered Diamorphine.

Martin CHIVERS found that his father had been moved to a single room. He could not feed himself or take fluids. He was catheritorised. He was lying in the foetal position. His eyes were closed and he was breathing noisily through his mouth. Mr CHIVERS remained in this condition for about a week.

Martin CHIVERS states that on the day his father died, he was sick. He describes the vomit like thick black tar.

His concerns over his fathers death are that two days prior to his release his father was suffering from headaches and within two weeks he was dead.

Sidney CHIVERS died on 20th June 1999 (20/06/1999). His cause of death is given as Bronchopneumonia and the Dr who certified his death was J A BARTON BM.

Kathryn ROBINSON

Expert Review

Sydney Chivers

No. BJC/09

Date of Birth: Code A

Date of Death: 20 June 1999

Mr Chivers was admitted in May 1999 to the Gosport War Memorial Hospital from the Queen Alexander Hospital for rehabilitation after suffering a cerebrovascular accident as well as being treated for congestive cardiac failure and a chest infection.

In early June 1999, Mr Chivers' condition deteriorated and he complained of a pain in his hands and also abdominal pain. Soon after this he was commenced on Fentanyl together with Oramorph and on 19 June, having been seen by Dr Brooks, a syringe driver was commenced.

The experts felt that cause of death was probably unclear and noted the opioids were escalated without trying other ways of stopping the pain but did not feel the treatment was negligent.

1 495 005

CYRIL DICKS

CYRIL DICKS

Cyril Dicks

Date of Birth: Code A Age: **85**
Date of Admission to GWMH: **28th December 1998**
Date and time of Death: ***22.00 hrs on 22nd March 1999***
Cause of Death:
Post Mortem:
Length of stay: **85 days**

Mr Dicks' past medical history:

1955 – Cervical polyp
1980 – Loss of vision left eye, sub-retinal haemorrhage
1987 – left colles fracture
1996 – AF – digoxin
1999 - Cognitive impairment confirmed dementia.
1999 – CVA
2001 – Chest Infection
2001 – August – CVA
2001 – CVA with persistent dysphagia – insertion of PEG tube

Mr Dicks was the youngest of six brothers. He was a retired taxi driver. His wife died in 1993 they had been married for 50 years and had a daughter and son. Mr Dicks lived at Pier House Residential Home. He wore a hearing aid in his left ear and glasses. It was noted that he smoked 2/3 cigarettes a day and was reluctant to eat. He was dependent on nursing staff for all hygiene needs and could only walk a few steps at a time. Mr Dicks was admitted to the Haslar Hospital from the home with pneumonia. It was noted that while at Haslar Hospital Mr Dicks was nursed on a bed with a pressure relieving mattress and cot sides and that he had some red marks in places that were dry but unbroken. Mr Dicks was admitted to the Gosport War Memorial Hospital on 28th December 1998 with pneumonia that had been treated with IV and oral antibiotics, confusion, doubly incontinent and urinary tract infection. It was also noted that he had a catheter insitu.

On admission a Barthel ADL index was completed from 29th December 1998 scoring 2 to 14th May 1999 also scoring 2 the scores reached no higher that 4. An abbreviated mental study was completed on 29th December 1998 with a score of 3 recorded.

A Waterlow score of 14 was recorded on 29th December 1998. With a handling profile also completed on that day noting that Mr Dicks skin was intact need a pressure relieving cushion and 2 nurses and a hoist to help transfer.
Care plans for confusion, reduce mobility, retention of urine – catheterised size 12 and help to settle at night were completed starting on 29th December 1998.

Whilst at Gosport War Memorial Hospital Mr Dicks had a number of falls where he only sustained minor cuts and bruising. Treatment was administered and he was helped back to bed.

28th December 1998

Admitted from Haslar with pneumonia that had been treated with IV and oral antibiotics, confusion, he was doubly incontinent and had a urinary tract infection and had been catheterised.

4th January 1999

Remains poorly not eating or drinking well. Please make comfortable.
Happy for nursing staff to confirm death.

11th January 1999

Daedalus ward/NHS continuing care. Barthel 4/20 – reluctant to do much not eating or drinking. Prefers to be in bed. Plan:- to give up Pier House for Nursing Home if stable in early February 1999.

15th January 1999

Contact record – found on floor in lounge PM, examined small grazes on left hand – reassured and put to bed. Son informed.

17th January 1999

Contact record - found on floor in lounge- no apparent injury. Behaviour very irrational PM.

18th January 1999

Did not wake up this morning, stiff unrousable, not in pain – please make comfortable. **Happy for nursing staff to confirm death.**
Contact record – reviewed by Dr Barton. Extremely sleepy. Family wish Dad to be made more comfortable.

19th January 1999

Remains poorly – unresponsive. Family aware – no active treatment required not for any fluid replace. Use S/C analgesia if necessary.

20th January 1999

Catheterisation due to urinary retention.

22nd January 1999

Contact record – Mr Dicks got off commode and sat on floor. Accident form completed.

25th January 1999

Spent a lot of time in bed. Can transfer unaided. Barthel 3/20 – aggression short lived.

Daughter seen – aware very unwell and may not survive. Agreed not for NG feeds, not for antibiotic if pyrexial and NHS continuing care until early March 1999.

Contact record – seen by Dr Lord – daughter seen and is aware of prognosis in event of change of condition or chest infection to be kept comfortable.

8th February 1999

Small black spot on left heel.

15th February 1999

A bit better – eating more. Barthel 1-2/20.

1st March 1999

Not drinking much. Barthel 1/20 – no new medical problems. Heels vulnerable.

2nd March 1999

Contact record – found on floor by chair, cut to upper lip, contusion to left eye.

3rd March 1999

Podiatry – left 1st lat side toe red and inflammed.

5th March 1999

Podiatry – sat in chair. Right 2nd toe red medical side. Left 1st still red.

8th March 1999

Fall – left perior? Bruising + upper limb. Barthel 2/20. Review end of month.

9th March 1999

Contact record – seen by Dr Lord – no change.

10th March 1999

Podiatry – left 1st much improved virtually healed. Right 2nd also improved.

13th March 1999

Contact record – found on floor by side of bed. Checked for injuries.

15th March 1999

No great change. Barthel 2/20.

16th March 1999

Contact record – fell to floor in lounge. Abrasion right eye. Accident form completed.

18th March 1999

Contact record – bruising also noted on right side hip.

20th March 1999

Not so well – in pain when being moved in bed. Generalised twitching and distressed.

22nd March 1999

Marked deterioration over weekend. Family happy with treatment. Died at 22.00 hours found by S/N Basher. Death confirmed at 23.10 hours by SSN Farrell.

Contact record – 22.00 hours found in bed dead. Daughter informed does not want to see.

Code A

BJC/17
CYRIL DICKS
85

Dementia, incontinent, very dependent.
Deteriorating gradually then rapidly over the weekend of 20-21/3/99. One nursing record states sc analgesia and midazolam started on 20/3/99. There is no record of this on the available medication cards or in the medical notes. Elsewhere in GWMH notes the nurses write diamorphine doses given via syringe driver in the notes in red. This is not done here. I do not know if he was given diamorphine.

Cause of death is not clear anyway but if diamorphine was not given it was natural. Care reasonable but fell on the ward and they were prepared to use diamorphine where it was not clearly indicated.

PL grading A2

BJC/17	Dicks, Cyril	Appears to have been dying slowly, but in an expected manner, from longstanding dementia complicated by an acute ?cerebrovascular complication in January. He appeared to be in pain, and was certainly agitated, in the later stages and was probably treated with subcutaneous diamorphine and midazolam, according to the nursing note. But no doses are stated (unusually – in other cases the nurses have written the doses in their notes) and at present I cannot trace an administration record in the drug charts to show that the drugs were ever given, or in what dose. I am sure he would have died, no matter how well he was cared for. It is possible that his death was marginally accelerated by sedation, but I cannot at present adduce any hard evidence for that.	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7BP

TO: REF:
STN/DEPT:

FROM: DETECTIVE CONSTABLE 424 ROBINSON REF:
STN/DEPT: MCD E TEL/EXT:

SUBJECT: DATE: 21/01/2004

I visited Mrs Sandra TAYLOR at her home address at 2000 hrs, 21st November 2003 (21/11/2003). Also present was her husband and brother, Leslie DICKS and his wife. I outlined the purpose of my visit as per the policy log and gave the family a set of the medical records relating to their father, Cyril Aubrey DICKS , Code A - 22/03/1999.

I went through the family's concerns as recorded in officers report 11E.

They further wished to add that whilst their father was in Haslar Hospital he had been 'picky' with is food, this was normal. He hadn't complained of being in any pain but then he probably would not have mentioned it and that whilst he was moody, he was lucid and talking and was able to walk with the aid of a stick. He had never suffered from ill health apart from having a small hernia.

The family state that Mr DICKS was admitted to the GWMH for recuperation in order to get his strength back.

Upon admission he is described as being in good spirits with no complaints of pain. The family members between them visited him daily.

Approximately two weeks after being admitted the family were told that Mr DICKS had suffered a massive stroke, the following day they were informed that he was 'getting better', then they were told that he was 'failing'.

When the family turned up to visit Mr DICKS on his birthday he was sat up in bed awaiting his presents. They describe him as being 'perky and happy'. They describe his condition as being variable. When he was in bed with his eyes closed he appeared to be asleep on other occasions he would appear to be 'awake' and chirpy with his eyes open.

Mr DICKS was placed in his own room and during the last couple of days of his life he was placed on a syringe driver and diamorphine was administered. The family were not told why, nor did they see a doctor.

At this point Mr DICKS was bed bound.

On the day of his death Mr DICKS didn't wake up. The family stayed with him until 2200. They left to travel to their nearby homes and a few minutes after arriving were notified by the hospital that Mr DICKS had died.

The family wish to be notified by letter followed by a visit to provide more detail if required.

DOCUMENT RECORD PRINT

Officer's Report

Number: R11E

TO:
STN/DEPT:

REF:

FROM: DC 2479 YATES
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 18/12/2002

Sir

Re. Action 205.

I visited Mrs. Sandra TAYLOR of Code A on Tuesday, 17th December 2002 (17/12/2002). Mrs. TAYLOR has given her contact numbers as Code A and Code A Mrs. TAYLOR stated that she had contacted the police regarding the death of her father at the Gosport War Memorial Hospital in 1999 after hearing of the investigation in the media. She also stated that her younger brother, Leslie DICKS of Code A had attended a meeting at Whiteley, Fareham along with other concerned relatives.

Mrs. TAYLOR gave the circumstances as follows. Her father, Cyril Aubrey DICKS Code A was a retired painter and decorator living in Code A His GP was from the Lee on Solent Practice in Manor Way, Lee on Solent. Mr. DICKS was admitted to the Royal Navy Hospital Haslar around the 14th December 1998 (14/12/1998) suffering with a chest infection. Mr. DICKS was transferred to Daedelus Ward at the Gosport War Memorial Hospital about two weeks later for recuperation. At this time Mr. DICKS appeared to be making a full recovery.

Within a few days Mr. DICKS appeared to be heavily sedated and did not recognise his relatives during visits. Mrs. TAYLOR is not aware what medication if any her father had been administered but cannot remember seeing any drips until the last few days of his life. Mrs. TAYLOR did question staff at the hospital as to why her father was so sedated and was told words to the effect of, "Oh, he is just not so good today." During the first few weeks at the Gosport War Memorial Hospital relatives noticed that although heavily sedated he would often be sat in a chair, but after this he was always just lying in bed.

On the 22nd March 1999 (22/03/1999) Mr. DICKS died, the cause of death was given as Bronchial Pneumonia and the death certificate was signed by Dr. BARTON. Mr. DICKS was cremated.

Mrs. TAYLOR and the rest of the family thought the circumstances of her father's death strange but had absolute trust and confidence in the hospital. It was not until the media coverage that they doubted the hospital and came forward.

I have informed Mrs. TAYLOR that this is an on going and probably long term investigation and I gave

her a contact number for Operation Rochester at Hulse Road.

C YATES

Expert Review

Cyril Dicks

No. BJC/17

Date of Birth: Code A

Date of Birth: 22 March 1999

Mr Dicks was admitted to the Gosport War Memorial Hospital on 28 December 1998. On admission he was doubly incontinent with a urinary tract infection and had a indwelling catheter.

It is recorded in the Medical Notes that he had a number of falls where he only sustained minor cuts and bruising whilst at Gosport War Memorial Hospital.

The Notes recall on 4 January 1999 that he remained poorly and was not eating or drinking well.

The expert review notes that Mr Dicks was deteriorating gradually following admission and then rapidly over the weekend of 20/21 March 1999.

Although there is no record available in the medication cards or in the medical notes one nursing record states that subcutaneous analgesia and Midazolam was started on 20 March 1999.

The experts conclude the care on the ward was reasonable and that it was likely that Mr Dicks would have died no matter how well he was cared for.

HAMPSHIRE CONSTABULARY

CHARLES HALL

CHARLES HALL

Charles Hall

Date of Birth: Code A Age: **89**
Date of admission to GWMH: **5th July 1993**
Date and time of Death: **11.25 hours on 6th August 1993**
Cause of Death:
Post Mortem:
Length of Stay: **32 days**

Mr Hall's past medical history:-
Peripheral vascular disease
Non insulin dependent diabetic
Iron deficiency anemia

Mr Hall was married and lived with his wife in their own home. They had a daughter and received good help form their neighbours. Mrs Hall was finding it increasingly difficult to cope.
Mr Hall was admitted to the Royal Haslar Hospital where he underwent a sigmoid colectomy and colostomy following diverticullitis and a gangerous gall bladder. He was transferred from Haslar Hospital to Gosport War Memorial Hospital on 5th July 1993 for nursing care and assessment.

Care plan were commenced on 5th July 1993 for a blackened area to left heel, 7th July 1993 right elbow red and flaky, sacrum red and dry, 10th July 1993 sacrum slightly red, 14th July 1993 hygiene, poor mobility, vomiting, urinary incontinence, settle at night and colostomy.
An assessment of daily living was completed noting that Mr Hall had some shortness of breath on exertion, needed a diabetic diet, colostomy satisfactory, mobilises short distances with Zimmer frame.
A Waterlow score of 21 was recorded on 5th July 1993 and one of 22 was recorded on 29th July 1993.

5th July 1993

Admitted to Sultan ward from Haslar for nursing care and assessment.
Sigmoid colectomy and colostomy five weeks ago following diverticullitis and gangerenous gall bladder. Readmitted to Haslar one week ago wife could not cope, appetite down, colostomy working ok.
Nursing report – admitted from Haslar refer to Social Worker.

10th July 1993

Clinical notes state vomited x 3 brown fluid.
Nursing report – vomited x3 complaining of pain in abdomen. Fainted at lunchtime when stood up.
15.10 hours fall getting off commode. Accident form completed.

13th July 1993

Clinical notes state waiting physio and OT assessments. Abdomen soft.

14th July 1993

Clinical notes state Mr Hall was in renal failure.

15th July 1993

Clinical notes discussion with wife re poor prognosis.
Nursing report – seen by Dr Walters who has spoken with wife and patient re poor prognosis. Boarded for diamorphine 2.5mg-5mgs IM 4 hourly.

19th July 1993

Clinical notes state slightly better – pain at night from left foot. Morphine 5-10mg 4 hourly as required.
Nursing report – seen by Dr Walters boarded for oramorph 5-10mgs 4 hourly for neck pain.

22nd July 1993

Clinical notes state low R and diet. Continues to vomit. Sleeping better.

23rd July 1993

Nursing report – seen by physio wound treatment to heel discussed.

28th July 1993

Clinical notes state has necrotic heel – gradually improving.
Nursing report – referred to Dr Lord for long term care.

29th July 1993

Nursing report – seen by Dr Lord to be transferred to Daedulus ward.
Transferred to Daedulus Ward.
Clinical notes state seen by Dr Lord, Daedulus ward – renal failure much better. Diuretics stopped. Heel ulcer – black, sacrum red and vulnerable, confused. Suggest oral fluids and oramorph.

2nd August 1993

Clinical notes state black heel – 2" diameter, offensive, surrounding heel very red. Barthel 5. Encouraged fluids and oramorph if required.
Nursing report, seen by Dr Lord dressing to heel changed.

5th August 1993

Clinical notes state further deterioration needs analgesia and chat with wife.
Nursing report – condition deteriorating. Commenced on oramorph patient comfortable and appears pain free. Turned 2 hourly day and night.

6th August 1993

Nursing report – visited by wife at 10.30 hours fully aware of poor prognosis. Died peacefully 11.25hours certified by Sister Jones. Daughter contacted and Dr Barton informed.

Code A

BJC/23
CHARLES HALL
89

Had recently been through major abdominal surgery. Past history of peripheral vascular disease and surgery for it. He was deteriorating before he arrived on Daedalus. The main problem seemed to be the vascular disease and the deteriorating heel ulcer causing pain. In July he had 2 dose of morphine elixir. On 5/8/93 he had 10mg of oramorph at 09.15 and was then put on 40mg of diamorphine via syringe driver at 17.00. He died the following morning.
He undoubtedly had very severe underlying disease and would have died but I consider the move from one dose of oramorph to 40mg to be excessive.

PL grading B3

BJC/23	Hall, Charles	Very frail and terminally ill when transferred to Daedalus. Poor prognosis had already been discussed prior to transfer. Given a single dose of oramorph 10mg. This relieved symptoms and made him comfortable. If he were not in renal failure, the diamorphine equivalent would have been 20mg/24hrs. Since he was, he probably only needed 10mg/24hrs. In fact was given diamorphine 40mg/24hrs as starting dose, and died within 24 hours. Nothing to suggest intent, only that there was a lack of understanding of how to go from oral to SC and how to allow for the effect of his renal failure	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R7A

TO:
STN/DEPT:

REF:

FROM: DC 424 ROBINSON
STN/DEPT: MCIT, E

REF:
TEL/EXT:

SUBJECT: Charles Sydney HALL Code A

DATE: 28/10/2002

Sir,

I visited Diane HARCOURT, at her home address, Code A in response to her letter dated 16/10/2002. This concerned her late father (details above) and the time he spent at the GWMH.

Ms. HARCOURT will say that her father was a fit and active man. He had been a gunner in the Royal Artillary before leaving to become a diver's assistant and subsequently a publican.

He had undergone surgery for poor circulation in his foot around 1978, whereby he had a new vein inserted into his leg. He suffered no further problems with his leg but was diagnosed as a 'late onset diabetic'

Mr. HALL was admitted to Royal Hospital Haslar some time around May/June1993. This was due to him feeling unwell and being sick. He was diagnosed as suffering from a ruptured gall bladder, he underwent surgery for the removal of his gall bladder and the fitting of a colostomy bag.

Mr HALL made a full recovery and was discharged from Haslar some three weeks later to the care of his family.

He then returned home Code A be cared or by his wife,Violet Ethel HALL,b. Code A

At this point in time Mr.HALL was up and dressed every day, he never remain in bed and was recouperating well,however, his elderly wife had suffered as a result of all the stress and worry of his illness and his operation and it was suggested by the district nurse that Mr. HALL be admitted to the GWMH,in order for his wife to have some respite.

Mr.HALL was initially put into a ward on the first floor, Mrs. HARCOURT cannot recall the ward name.

She states that her father was up and dressed every day, he never remained in bed. He was unhappy with the fact that he had to return to hospital when there was nothing wrong with him. He was eating normally and generally moaning and being grumpy with the staff. He spent his time listening to music and studying the racing form in his daily paper. He was in full use of all his facualties.

At this time he had a small bed sore on the heel of his foot but this did not cause him any real discomfort and to her knowlage he didn't require any special treatment for it.

Mrs. HARCOURT states that had her father been in pain then he would have moaned about it and everyone would have been aware of it.

Approximatly a week later, her father was moved to Dryad Ward on the ground floor so that he could access the garden area.

Mrs. HARCOURT belived that her father was being moved so that he could receive some rehabilitation type care. She states that when he was admitted to the ward, he was dressed and fully mobile.

DOCUMENT RECORD PRINT

Mrs. HARCOURT has given the following information in relation to the last week of her fathers life.
Sunday 1st August 1993 (01/08/1993). Mrs HARCOURT visited her father, he was sat in the day room listening to music on the radio, he was fully clothed in his suit. He told her that he didn't like it in the new ward and that he'd been dreaming about rabbits.
Mrs.HARCOURT spoke to a nurse about her father because she thought that he had not been taking his diabetic medication. The nurse informed her that Mr. HALL had 'kidney problems' and this was the reason for him appearing strange.
On Mrs.HARCOURT's next visit she was called in to the nurses office and asked if they could put her father on Morphine, when she asked why she was told that it would make him more comfortable. She states that she was told that Dr BARTON had said that she wanted him on Morphine.
Mrs. HARCOURT refused to give her consent and suggested that they ask her mother, who was his legal next of kin. At the time of this visit her father was up, dressed and appeared well.
Mrs.HARCOURT states that her father never complained to her or her mother of any pain.
Thursday 5th August 1993 (05/08/1993)
Mrs.HARCOURT visited her father with her husband. Mr. HALL was in bed and was able to have a normal conversation with them. She did not notice any sort of apparatus around her father which could have been used for administering drugs.
Friday 6th August 1993 (06/08/1993)
Mr. HALL was visited around 0900/1000 hrs by his wife and a neighbour. He was described as sleeping peacefully.
Around midday, the hospital contacted Mrs. HARCOURT to inform her that her father had died.
Monday 9th August 1993 (09/08/1993)
Mrs HARCOURT took her mother to the GWMH in order to collect her fathers belongings and his death certificate.
They were concerned and distressed to see that the cause of death had been given as Bronchopneumonia and Senile Dementia. The certificate was certified by Dr.BARTON.
Mrs. HARCOURT states that her father never displayed any symptoms of dementia nor was it ever discussed with her family whilst he was in hospital.
She was also concerned that there was nothing that related to her fathers 'kidney problem'.
She states that her family didn't want to query the certificate because her mother was extremely upset and as she said 'it wouldn't bring him back'
Mr. HALL was cremated in accordance with his long held wishes, there was no post mortem.
Mr.HALL's GP was Dr. LYNCH, Stakes Rd Surgery, Gosport.

Expert Review

Charles Hall

No. BJC/23

Date of Birth: Code A

Date of Death: 6 August 1993

Mr Hall was admitted to Gosport War Memorial Hospital on 5 July 1993 after he had undergone a sigmoid colectomy and colostomy following diverticulitis and a gangrenous gall bladder.

On admission, in addition to the rehabilitation issues following his abdominal surgery, he was suffering pain in his left foot which was associated with vascular disease.

He was started in August on oral Morphine which was converted to Diamorphine via a syringe driver on 5 August 1993.

The experts note that although he undoubtedly had severe underlying disease the acceleration from one dose of Oramorph to 40mgs of Diamorphine was sub optimal treatment.

HAMPSHIRE CONSTABULARY

CATHERINE LEE

CATHERINE LEE

Catherine Lee

Date of Birth: Code A Age: **92**
Date of admission to GWMH: **14th April 1998**
Date and time of Death: **14.45 hours on 27th May 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **44 days**

Mrs Lee's past medical history:-

1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

Mrs Lee lived at Addenbrookes Residential Home. She had a daughter and grand-daughter. It was noted that she had poor mobility and was confused at times. Mrs Lee sustained a fractured neck of femur at Addenbrookes on 2nd April 1998 and was admitted to Haslar Hospital for surgery to correct the fracture. She was then admitted to Gosport War Memorial Hospital on 14th April 1998 for continuing care.

On admission a Waterlow score of 30 was recorded with another score of 29 recorded on 8th May 1998
A nutritional assessment plan was completed on 15th April 1998 with a score of 4.
Barthel ADL index was recorded on 14th April 1998 scoring 0, another on 25th April 1998 scoring 1 and another one on 9th May 1998 scoring 4
A handling profile was completed on 16th April 1998 noting that Mrs Lee needed the assistance of 2 and a hoist for transfers.
A mouth assessment was completed on 15th April 1998.
Care plans commenced on 14th April 1998 for MRSA screening, 15th April 1998 for sleep, 16th April 1998 for hygiene, nutrition, constipation and on 26th April 1998 for small laceration right elbow.

14th April 1998

Clinical notes – transferred to Dryad Ward from Haslar for continuing care. Barthel 0. Make comfortable, **happy for nursing staff to confirm death.** It was noted that Mrs Lee has sustained a right fracture neck of femur and had undergone surgery of canulating screws on 3rd April 1998. It noted that Mrs Lee had poor mobiltiy needed the assistance of 2 nurses, was confused at times, needed full assistance with eating and drinkng due to poor eye sight and that she had a poor appetite. She needed all care for hygiene and dressing and her pressure area were intact and that she needed nursing on a pressure relieving mattress.

Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

Summary – restless, confused. Oramorph 5mg 4 hourly.

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

Clinical notes – MRSA negative. Bottom slightly sore. Start gentle mobilisation will not be suitable for Addenbrookes. Seen by Dr Banks has severe dementia.

24th April 1998

Summary – fell while attempting to get up from commode. Sustained skin flat to right elbow. Accident form completed. Daughter informed.

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge.

Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

Summary – seen by Dr Barton re pain oramorph increased to 10mgs 4 hourly (20 mgs nocte).

18th May 1998

Clinical notes – increasingly uncomfortable when I called much better on oramorph.

20th May 1998

Summary – visited by daughter. For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**

Summary – restless, agitated. Seen by Dr Barton. Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

22nd May 1998

Summary – grimacing when turned. Syringe driver renewed at 09.30 diamorphine 20mgs and midazolam 40mgs. Continues to mark, position changed every couple of hours.

23rd May 1998

Summary – syringe driver recharged at 7.35. 20mgs diamorphine 40mgs midazolam. Position changed every 2 hours.

25th May 1998

Summary – further deterioration. Syringe driver renewed at 07.00 in some distress when being turned. Syringe driver renewed at 14.55 diamorphine 40mgs.

26th May 1998

Clinical notes – died peacefully at 14.45.

Death verified by SR Hamblin and SN Barrett.

Code A

BJC/31
CATHERINE LEE
92

Severe dementia and hip fracture. Required oramorph on admission to GWMH. Described as being uncomfortable but better on oramorph. The dose of opiates was converted well from oral to subcutaneous. She had medical problems with a poor outlook but the main descriptions in the notes are of restlessness and agitation rather than pain. The final cause of death is not clear although the medical problems were probably enough. Indication for the opiates is not entirely clear.

PL grading B2

BJC/31	Lee, Catherine	Severe dementia. Transferred for rehab after NOF. Had needed no analgesia in 24 hours prior to transfer. Started on oramorph 5mg 4 hourly from day of admission ?why. Increasingly sleepy, agitated and apparently distressed. Ate and drank less and less as became more sedated. Given diazepam as well for 2 days. Also given Fentanyl 25mcg/hour as well for 3 days. Oramorph progressively titrated upwards then changed to syringe driver. Change was actually at equivalent dose (oramorph 80mg/24 hours changed to diamorphine 20mg) but midazolam 40mg added!	B3

DOCUMENT RECORD PRINT

Officer's Report

Number: R11

TO:
STN/DEPT:

REF:

FROM: DC 2479 YATES
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 12/11/2002

Sir

Re Action 193. I have spoken to Marie CAINE of Code A Code A Mrs CAINE states that her elderly mother Catherine LEE, nee JONES 92 years Code A died at the Gosport War Memorial Hospital on 26th May 1998 (26/05/1998).

The circumstances are as follows:

Mrs LEE was a very lively elderly lady who was suffering from senile dementia, apart from this she was a very healthy lady who had not visited her GP for many years and enjoyed an active life, walking for miles a day. Mrs LEE was being cared for at home by her family and at the beginning of May 1998 the family were offered the chance of respite care to give them a break. Mrs LEE was placed at Addenbrook for a period of care but on the first night fell three times and broke her hip. The family were unable to ascertain whether Mrs LEE had actually got out of bed and fallen or had fallen out of bed.

Mrs LEE was transferred to the Royal Naval Haslar Hospital where key hole surgery was performed on her hip. She remained at Haslar for 5 days during which time her family describe her as being as bright as a button including the day of the operation almost immediately after she came round from the anaesthetic.

After 5 days she was transferred to Dryad Ward at the Gosport War Memorial Hospital where she was immediately always sleepy. By three days Mrs LEE was never placed in a chair and remained in bed asleep. The family queried what the staff were doing to get her walking again but were told that she was in pain and required Morphine which was administered by way of a syringe driver. Whenever Marie visited her mother she was asleep and was told just to sit by the bed and hold her hand stating that Catherine would know that she was there. On one occasion Catherine's granddaughter visited during which time Catherine was distressed and waving her hands about. This upset the granddaughter who told her mother that she would rather not visit again. This was the only time that any member of the family had seen Catherine do anything other than sleep.

On 26th May 1998 Catherine died, the death certificate was signed by Dr Jane BARTON giving the cause as Bronchial Pneumonia.

Catherine's GP was Dr KNAPMAN of the Forton Road Surgery one of the other partners was Dr BARTON.

I have explained to Marie CAINE that Operation Rochester is an ongoing enquiry into the events at the Gosport War Memorial Hospital and that there would not be any immediate answers to her query. Mrs CAINE is happy with this action and has been given a contact number for Operation Rochester.

Expert Review

Catherine Lee

No. BJC/31

Date of Birth: Code A

Date of Death: 27 May 1998

Catherine Lee was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Haslar Hospital where she had been admitted for surgery to repair a fractured neck of femur.

On admission, it was noted that Mrs Lee had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing.

On admission she was settled on the ward and given oral Morphine.

This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May.

She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam.

The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.

HAMPSHIRE CONSTABULARY

STANLEY CARBY

STANLEY CARBY

Stanley Carby

Date of Birth: Code A Age: **65**
Date of Admission to GWMH: **26th April 1999**
Date and time of Death: **13.00 hrs on 27th April 1999**
Cause of Death:
Post Mortem:
Length of Stay: **1 day**

Mr Carby's past medical history states that he suffered from:-

Left hemiplegia secondary to CVA
Angina
Obese
Hypertension
Cardiac failure
Non insulin dependent diabetic (tablet controlled)
Prostatic hypertrophy depression.

Mr Carby was married and lived at home with his wife. They had five children. Mr Carby was more or less housebound and had been for sometime. Mr Carby was transferred to Daedalus Ward after suffering a CVA. He had undergone a CT scan which showed a right parietal infarct and an old infarct. His speech was slurred and he transferred using a hoist. He was eating and drinking with assistance.

A handling evaluation was completed noting a pressure relieving mattress was in place and his skin intact. It was noted that Mr Carby needed 2 nurses and a hoist for transfers.

On 26th April 1999 a Barthel ADL index was completed and scored 1, a Waterlow score of 23 was recorded noting Mr Carby to be at very high risk of developing pressure sores. A nutritional assessment was also completed with a score of 15 recorded.

Numerous care plans were started on 26th April 1999 including personal hygiene, constipation due to mobility, swallowing, left shoulder pain, pressure sore noting Waterlow score, air mattress pressure relieving cushion and no pressure noted but unable to move to observe all areas, dysplasia, incontinent catheter insitu and assistance to sleep.

26th April 1999

Admitted to Gosport War Memorial Hospital. Daedalus ward for rehabilitation.

Clinical notes state more than happy for nursing staff to confirm death.

HAMPSHIRE CONSTABULARY

27th April 1999

Contact record states Mr Carby is very agitated when family left, unable to get to swallow. Referred to speech and language therapist.
Breath very shallow – colour poor.
Dr Barton contacted and will attend. Seen by Dr Barton and family spoken to.
Cyanosed and clammy. Wife thinks he will not survive.
Dr said **"I will make him comfortable".**
Subcutaneous analgesia commenced.

Clinical notes state further deterioration this AM. Further extension of CVA.
Wife and daughter with him and aware. I will make more comfortable.
Mr Carby died at 13.00 hours. Family present.
Death confirmed by S/N Joyce and S/N Neville.
Family distraught and distressed.

Code A

BJC/07
STANLEY CARBY
65

Admitted with a severe stroke, rapidly deteriorated and died.
When he deteriorated he was prescribed a large dose of diamorphine via driver.
However he died within 45 minutes of it being started ie too soon for it to have a *significant effect.*

Cause of death was the extension of stroke. The large dose of diamorphine makes care sub-optimal but it no effect on his death.

PL grading A2

BJC/07	Carby, Stanley	Patient experienced what was clinically felt to be extension of an already dense CVA. Blood glucose checked and OK. Although syringe driver set up with inappropriately high doses of diamorphine and midazolam (40mg of each) he died 45 minutes later. He therefore could not have received more than 1.25mg of each drug, not enough to have influenced his survival. He might well have received less, since he had a BP of 90/60 and was peripherally cyanosed, slowing the rate of absorption from the subcutaneous route. Although the notes record that Dr Lord recommended a stat of midazolam 2.5mg earlier in the morning, I cannot see evidence in the drug chart that that was actually given. Even if it were, the total midazolam dosage would not have exceeded 3.75mg and it has a short half life, so the earlier 2.5mg, if it were given, would have been metabolised before the syringe driver was set up. This appears to have been an entirely natural death.	A2

DOCUMENT RECORD PRINT

Officer's Report

Number: R8J

TO:
STN/DEPT:

REF:

FROM: DC 2403 TENISON
STN/DEPT: MCIT W

REF:
TEL/EXT:

SUBJECT:

DATE: 20/11/2002

Sir,

With regard to Actions 216, 217 & 203 I spoke with Mrs Rita CARBY and her two daughters Lucinda CARBY and Deborah McKAY in respect of the death of Stanley CARBY DOB Code A DOD 27/04/1999.

Mr CARBY joined the Royal Navy aged 13 and served for about 12 years. He left the Navy and joined the MOD as a driver. He married Rita in 1957 and had five children 2 boys and 3 girls. He was medically retired aged 58 suffering from diabetics and high blood pressure.

On about the 13/04/1999 Mr CARBY suffered a stroke and was taken to Haslar Hospital . The stroke affected the left hand side of his body and Mr CARBY required help with eating and drinking. He was however quite conversant and seemed happy and pain free. On the 26/04/1999 Mr CARBY was transferred to the GWMH he arrived at about midday.

Mr CARBY was in a small ward by his wife and Deborah during the afternoon. He seemed well and asked his daughter to place a bet on a horse. Mrs CARBY was concerned that her husbands' medical notes had not arrived and informed staff that her husband was a diabetic and needed assistance with eating and drinking. She left with her daughter at about 1645 on the 26/04/1999.

Mr CARBY was visited at about 1800 hours by his son Paul and also by his sister-in-law. He had been moved to a single room and seemed "a bit out of it." On the 27/04/1999 Mr CARBY was unable to talk and was seen by his wife and daughters. The family disagree with the medical notes they have seen, in that Dr BARTON states she informed them he might die. They also note that the drug chart shows that diamorphine commenced at 1215 hours on the 26/04/1999 whereas the start date for this particular drug was shown as the 27/04/1999.

Cause of death was shown as Cerebrovascular accident (stroke) and was certified by Dr BARTON. There was no PM and Mr CARBY was cremated.

DC 2403 Tenison

DOCUMENT RECORD PRINT

Officer's Report

Number: R7AW

TO:
STN/DEPT:

REF:

FROM: DETECTIVE CONSTABLE 424 ROBINSON
STN/DEPT: MCD E

REF:
TEL/EXT:

SUBJECT:

DATE: 26/11/2003

I visited Mrs Rita CARBY at her home address at 1245 hrs Wednesday 26th November 2003 (26/11/2003). Also present were her daughters Cindy GRANT and Debbie McKAY. The visit was in accordance with the policy log.

I gave Cindy GRANT a copy of the medical records relating to Stanley Eric CARBY Code A - 27/04/1999 and I went through the concerns as noted in officers report 8J. The family wished the following points to be noted.

That upon his admission to the GWMH, the family told the nursing staff about their fathers needs, these being, his blood pressure tablets, he required a diabetic diet, due to problems after his stroke, required a beaker to drink with, pureed food, feeding and help with his drinking. This information was given to Phillip BEAD.

Mr CARBY was then settled into bed (which had joists above) where he studied the racing form.

A family member asked for a drink for Mr CARBY which was given in a cup (not a beaker) the family got a beaker.

The family commented on S.N. JOYCE. They didn't like her manner, they formed the impression that she didn't like the size of their father who was a 'big man'.

They state that Mr CARBY's drinks were left where he couldn't reach them.

They state that their father was in good spirits, he was laughing and joking and lucid.

The family made a point of telling Phillip BEAD that they were to be informed of any change in Mr CARBY's condition. Mrs GRANT showed the note made in her father's records on pg 38.

They stated that the point in the original O/R stating that at 1800 hrs on 26/04/1999 when their brother visited, their father was still in the main ward at this time but had been moved to his own room later that evening when a family member called 'Connie' visited. At this point he is described as being tired and mumbly but still lucid and could recognise his family.

That at 1000 27/04/1999 they received a call from Phillip BEAD telling them to come straight away to the hospital.

When the family arrived Mr CARBY was totally unconscious and they were informed that he had taken 'a turn for the worse in the early hours'. The family want to know why they were not called straight away, at the time, as per request as page 38.

The family state they had to wait to see Dr BARTON who was 1½ hrs late. They state that Phillip BEAD told them that their father had suffered another stroke.

The family then sat with Mr CARBY who was lying in bed on his back, propped up and leaning to the right. The sides of the bed were up to prevent him rolling out.

His breathing sounded phlegmy so they propped him further to ease his airway. At this point they saw a tube in the area of his shoulder blades. They describe the tube as 'thin' and there were sticking plaster marks in the same area.

Mrs McKAY enquired if she should contact her brothers at this time and was told that there was plenty of time and to wait for the Dr to visit.

At this point Mr CARBY is described as being unable to open his eyes or speak. He moaned or grumbled when moved and his breathing became worse. He was able to squeeze his wife and grandson's hand.

The family notified other family members and then Dr BARTON arrived.

Cindy GRANT asked Dr BARTON if her father was going to die and was told "You've got to let nature take its course".

The family then asked Dr BARTON exactly what was happening and they asked if Mr CARBY was squeezing their hands because he was in pain. Dr BARTON then examined Mr CARBY and said that she could give him something to make him comfortable.

The family left the room whilst nurses attended to Mr CARBY. When they returned he was propped up in bed with a fan directed on him, he was cold and turning blue so the family turned the fan off and covered him up.

Approximately 10 minutes later Mr CARBY died.

The family further wish to mention the following:

When did Mr CARBY begin to deteriorate as he died so quickly between 1000.

When he had his stroke at home he was able to walk to the ambulance.

Why was he not removed back to Haslar when he suffered the second stroke.

On page 70 he was asking for a drink am 27/4 to not responding at all (entry S.N. JOYCE).

On page 68 there is no pressure sores, her father would have to have been moved in order for them to have been seen.

On page 60 Mr CARBY is sat out in chair early am, after having a blanket bath, the family were with him since 10000 how early is early?

On page 64 he was given fluids and referred to speech and language therapist, this is on the day he died.

On page 72 (27/04/1999) his urine is described as concentrated, the family described him as drinking a lot normally.

On page 48 (27/04/1999) Dr LORD has made an entry ref sub fluids. This was not in place when the family attended on 27/4 and it is not indicated or referred to in the nursing notes.

All of the above entries were made in the medical notes prior to 1000 hrs.

The family has concerns about the type of drugs and the manner in which they were administered.

The family are also concern that when Mr CARBY died Cindy became extremely upset and the nursing staff asked the family to calm her down. As this appeared to be taking some time the nurses informed her brother that they would give her an injection to clam her. They thought this inappropriate without knowing Cindy GRANT's medical history. They do not know what drug the injection would contain.

The family wish to be notified personally in a family group.

I went back through the additional concerns to clarify all points and the family confirmed the contents of my notes.

Mrs CARBY is concerned that notification may take place whilst she is out of the country visiting family.

She will probably travel in March/April time and would like to be advised if this would be around the time of notification.

Expert Review

Stanley Carby

No. BJC/07

Date of Birth: Code A

Date of Death: 27 April 1999

Mr Carby was admitted to Gosport War Memorial Hospital on 26 April 1999 for rehabilitation. He was transferred from the Royal Haslar Hospital where he had been admitted in April 1999 suffering a stroke. The stroke affected the left hand side of his body, this required Mr Carby to have assistance with eating and drinking.

On 27 April 1999 Mr Carby suddenly deteriorated becoming cyanosed dyspnoeic. This clinically appeared to be an extension of his previous stroke.

A syringe driver was set up with a high dose of Diamorphine and Midazolam. Mr Carby died forty-five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Dr Naysmith noted that he may well have received less than normal since he had low blood pressure and was peripherally cyanosed.

The cause of death was shown as cerebral vascular accident and was certified by Dr Barton. Mr Carby was cremated.

The large dose of Diamorphine makes the care sub optimal but it had no effect on Mr Carby's prognosis.

HAMPSHIRE CONSTABULARY

WALTER CLISSOLD

WALTER CLISSOLD

Walter Clissold

Date of Birth: Code A Age: **90**
Date of Admission to GWMH: **3rd August 1999**
Date of Death: **23.55 hours on 8th September 1999**
Cause of Death:
Post Mortem:
Length of Stay: **37 days**

Mr Clissold's past medical history:

1987 – CA bladder/bowel
1992 - MI
1999 - Cystoscopy
1999 - Prostatectomy
Hypertension
CCF heart
CRF Kidneys
COPD pulmonary.

Mr Clissold was living independently at home. He had a home help and his neighbour would do the shopping for him. Mr Clissold had slightly impaired hearing but managed quite well. Mr Clissold had no family and his neighbour was noted as his next of kin. He was admitted to Haslar Hospital on 21st June 1999 with shortness of breath and underwent a transurethural resection of prostate and bladder biopsy. He was transferred to the Gosport War Memorial Hospital on 3rd August 1999 for rehabilitation.

On admission a handling profile was completed noting Mr Clissold needed the help of 1 to 2 nurses and a hoist for transfers. It also noted that he was nursed on a biwave plus mattress to prevent pressure damage.
A mouth assessment was undertaken as well as care plans for constipation, long term urinary catheter, hygiene and to settle at night.
A Waterlow score of 19-23 was recorded between August and September. As well as a Barthel ADL index for the same period with a score of between 6-3.
A nutritional assessment was completed in August with a score of 18 recorded.

3rd August 1999

Admitted to Gosport War Memorial Hospital from Haslar Hospital for rehabilitation. Pressure area were noted to be intact and that Mr Clissold had CA bladder he was in renal failure and that his mobilisation was not good.

16th August 1999

Not in pain. Reluctant to do much.

27th August 1999

Abdominal pain noted.

1st September 1999

Small sacral sore. 2 nurses and a hoist to transfer.

6th September 1999

Small split sacrum. Going downhill. Abdominal pain. Fentanyl given more comfortable.

8th September 1999

Anxious – will have to have syringe driver. Syringe driver satisfactory 20mgs diamorphine.

17.30 hours – very rigid, very bubbly, deteriorated. **Syringe driver recharged with 50 mgs diamorphine.**

23.55 hours – died. Verified S/N Collins.

Code A

BJC/12
WALTER CLISSOLD
91

Unwell with advanced transitional cell carcinoma of the bladder. But originally aiming for home with support. Low in spirits and abilities declined.
Not required any prn analgesia from 3/8/99 up to his death according to the available medication card. Said to be on fentanyl on 6/9/99 but this was not on medication card and not recorded by nurses.
Deteriorating 6/9/99, comfortable night 7/9/99, big dose of diamorphine on 8/9/99 although I cannot find the medication card for this. But the case records do not appear to justify such a high starting dose.

Cause of death probably bronchopneumonia but the diamorphine dose could have contributed.

PL grading B2

BJC/12	Clissold, Walter	This man was clearly terminally ill when he was transferred from Haslar to GWM, although nobody at Haslar seems to have been explicit about that, and he himself seems to have been unaware of how short his prognosis was. This may have been because he had survived an unexpectedly long time following the diagnosis of locally advanced bladder carcinoma. During his admission to GWM he seems to have realised himself that he was not going to return to independent living (and may have realised he was dying, but there is no mention of any discussion) and to have given his financial affairs into the hands of a close friend, with instructions to ask his solicitor to make a ward visit. Important parts of the record, particularly a second drug chart, are missing from the recording (and therefore from the original file). Without them, it is impossible to make an accurate reconstruction of the sequence of drug escalation. The only analgesic recorded on the drug chart which is preserved is paracetamol. There is a notes entry on 6.9.99 that he was now more comfortable on fentanyl. It seems likely, therefore, that his analgesia was taken straight from paracetamol PRN to fentanyl, presumably at 25mcg/hr, although again one cannot be certain. There are occasional mentions of intermittent abdominal pain, although the cause is not clear (and was not clear to the team caring for him). This does not seem to have been diagnosed at the time as necessarily cancer pain, and does not seem to have been severe enough to keep him awake. But it does seem to have been positional – he is recorded as "very uncomfortable if out of bed for any length of time". It is not clear, in the absence of the relevant drug chart, whether the deterioration noted between 1.9.99 and 6.9.99 antedated or followed the administration of fentanyl, so a causal relationship cannot be inferred. On the day of his death, a syringe driver was set up containing diamorphine 50mg and midazolam 20mg. Again, it is not clear why, given that fentanyl is transdermal, he was now felt to need diamorphine, nor why at least a 25% increase in opioid dosage was prescribed. The midazolam was doubled later that day. He deteriorated rapidly and died. I would be concerned that the drugs administered via syringe driver accelerated his inevitable death.	B3

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Blue - OE end

Expert Review

Walter Clissold

No. BJC/12

Date of Birth: Code A

Date of Death: 8 September 1999

Mr Clissold was admitted to Gosport War Memorial on 3 August 1999 following a resection of his prostate and a bladder biopsy at the Royal Haslar Hospital.

Although the original intention was that Mr Clissold would be transferred home with support, his condition deteriorated.

This case is made more difficult to analyse in the absence of a drug chart but it would appear that Mr Clissold's analgesia was advanced from Paracetamol to Fentanyl.

By 6 September 1999 Mr Clissold was deteriorating. In the absence of a drug chart it is not possible to draw any conclusions as to whether this was related to his medication. On the day of Mr Clissold's death, on 8 September 1999, a syringe driver was set up containing 50mgs of Diamorphine and 20mgs of Midazolam. The Midazolam was doubled later that day.

Mr Clissold deteriorated rapidly and died and Dr Naysmith raised concerns that the drugs administered via the syringe driver accelerated Mr Clissold's albeit inevitable death. Dr Naysmith was the only expert that rated this case as negligent. In the absence of the drug chart, it is not possible to draw firm conclusions as to any liabilities in this case and no further investigation is advised.

CPT DOCUMENTS
END

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: JZC/HJA/00492-14742/2180712 v1
Your ref: MK/2000/2047

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

9 January 2003

Dear Michael

Dr. Jane Barton

I refer to the above matter.

Since my letter through to you dated 17 December 2002 I have attempted to forward the missing enclosures through e-mail. Each time I have done so a few days later I receive an indication that the documents have not been received with you! My last effort was on 24 December 2003 and I returned to the office yesterday – my first day back in the office since the Christmas break – to find another rejection advice.

I have checked the e-mail carefully and am using the following address: Code A I wonder if the documentation I am supplying occupies too much 'space' to be allowed through the GMC's firewalls. As technology has failed me, I enclose hard copy versions and apologise for the earlier omission.

As I indicated, a copy has been forwarded through to Detective Inspector Nigel Niven. Nigel has indicated that they wish to clarify certain aspects of the note. I await his amendments for inclusion in the note and for discussion with you.

As you are aware, John and I are scheduled to attend at the offices of CHI next week and we shall update you at our meeting on 22 January 2003. Would a time of 2.00pm be suitable for you? Unless I hear from you to the contrary, I look forward to meeting with you again then at our offices.

Field Fisher Waterhouse 35 Vine Street London EC3N 2AA
Tel +44 (0)20 7861 4000 Fax +44 (0)20 7488 0084 e-mail info@ffwlaw.com london@thealliancelaw.com
www.ffwlaw.com www.thealliancelaw.com CDE 823

In your letter dated 18 December 2002 you request my thoughts on the inclusion of Mr Carby's complaint under a Rule 11(2) referral. I thought that I had addressed this issue with you at our pre-meeting on 20 November 2002 at which I indicated that the other matters received by the GMC did appear appropriate to be considered under Rule 11(2).

I do not, however, consider that it would be appropriate for us to undertake any investigation at the moment as this may prejudice the enquiries being undertaken by Hampshire Constabulary. To determine definitively whether the complaint should go through to the PCC (if, indeed, we end up following a charge of serious professional misconduct as opposed to a criminal conviction), further enquiries will need to be undertaken and expert evidence obtained to determine the exact validity of the complaint.

One of the issues mentioned at our meeting in November was whether the police should receive all documentation the GMC hold in relation to this matter. My initial advice to you was that it would be appropriate for the material, in particular the documents considered by the PPC, the letters received on behalf of Dr. Barton, the transcript of the IOC hearing and the additional papers received regarding the incident in 1991 to be disclosed. I confirm this advice. Within the Medical Act 1983 (as amended) the GMC made disclose "*to any person any information relating to a practitioner's professional conduct, professional performance or fitness to practise which they consider it to be in the public interest to disclose*" (Section 35B).

Are you content that it is in the public interest to disclose the material I have identified above? Should you confirm that the GMC consider it to be in the public interest, I shall pass the relevant documentation through to Detective Inspector Niven.

I hope that you had a restful Christmas and New Year break and that the move into your new home went smoothly.

See you next week!

Kind regards,

Yours sincerely

Code A

pp Judith Chrystie

Code A

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Meeting note

Name: **Judith Chrystie**	Call type: **Meeting**
Duration:	Date: **20 November 2002**

Barton - Pre-Meeting with FFW and GMC

JZC and JHO meeting with MK prior to the meeting with the Hampshire Constabulary.

JZC advising MK that this meeting was important to determine how FFW and the GMC could proceed with their enquiry. JZC advising that, to date, she had been reluctant to do anything other than read into the file owing to the possibility that action could prejudice the police enquiry.

JZC advising that she had identified the Chi documents she wished to obtain and, indeed, felt that it would be beneficial for her and JHO to go through to Chi and read the witness statements in order to identify who from the many statements taken should be proofed as part of the GMC enquiry. MK agreeing this would be useful providing the police permitted JZC to undertake this task.

MK advising that he had received a further letter from Alexander Harris (Solicitors for the relatives of the deceased elderly patients). Alexander Harris were concerned that the GMC should not proceed to a public hearing until the conclusion of the police matters. MK recognising the advice from JZC and JHO that we would be unable to do anything if the police were investigating the matter further.

JZC also stating that she and MSL had briefly considered the further complaints. Stating that these appeared to be of similar kind enough allegations to allow the matters to be presented under Rule 11(2). Stating that we would, of course, have to identify the matters to the police and to offer them the opportunity to investigate the cases.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Meeting note

Name: **Judith Chrystie**	Call type: **Meeting**
Duration:	Date: **20 November 2002**

Barton - Meeting with Hampshire Constabulary

Attendees:

GMC: Michael Keegan - MK

FFW: Judith Chrystie - JZC
John Offord - JHO

Police: DI Nigel Niven - NN
DC Owen Kenny - OK

Meeting

The attendees agreeing that JZC would make a brief minuted note of the meeting for circulation to all parties.

The parties introducing themselves and explaining their involvement in the case.

JZC explaining the situation within the GMC. Advising that the GMC would not proceed if NN indicated that to do so could prejudice any policy enquiry. JZC explaining the difference between running the case as a conviction matter and one in which we had to prove serious professional misconduct. JZC indicating the criminal rules of evidence were applied in GMC proceedings.

MK updating NN and OK as to the current position of the GMC enquiries. Indicating that the matter had both been screened and placed through the PPC.

JZC clarifying that the papers that the screener and the PPC had seen had been provided by Acting Detective Superintendent Burt. Noting that these papers had been forwarded through to the GMC when it appeared that the police were no longer pursuing any criminal investigation. NN advising that when, in 1998/1999 concern was raised by the death of Gladys Richards, an investigation had taken place which the police admitted was not as effective as it should have been. Advising that the CPS had considered the investigation and, in particular, the report prepared by Livesley on the Richard's case and had taken the view that causation could not be made out.

NN explaining that following the CPS's conclusion, the families of the elderly patients stated that they considered the police had been too quick to conclude the matter and that as a consequence four other cases were "dip sampled" by a new investigating officer, Detective Superintendent James. Those other cases were considered by two alternative experts Ford and Munday.

NN indicating that he was concerned about the issue of causation and whether proving causation may be just outside of the Constabulary's reach. Noting, however, that although the file had been prepared again for the CPS (by DI Stickler) and contained information on all five cases, there were a number of other incidents which still required full investigation. NN indicating that on statistical analysis and a similar fact basis it may be possible to establish causation. Noting that there were significant arguments about the appropriateness of the prescribing regime and the instructions left by clinical staff. The attendees noting that this was a particular issue for professional regulation given that it was not necessary to show that causation resulted in death merely of the inappropriateness of the prescribing regime amounted to bad practice.

NN advising that there were 50 other cases that the police may consider. One of the issues that would have to be resolved was whether a policy decision should be made to look at the hundreds of individuals who had died at the Gosport War Memorial Hospital. Noting that from 1994 to the period in which Dr Barton resigned from the hospital, there were thousands of deaths, 600 of which had been certified by Dr Barton. There were further cases in which Dr Barton had provided the care although the death may have been certified by a different practitioner.

Given the number of cases and the provisional views being provided by an alternative expert instructed by NN, Professor Robert Forest, NN stating that he was increasingly moving towards the view that he was entitled to argue that causation could be made out. NN noting, however, the difficulty in showing that death through bronchial illness of pneumonia was a consequence of diamorphine. Although it was noted that excessive diamorphine could cause respiratory difficulties, the victims were elderly patients who were, therefore, vulnerable in any event.

NN commenting that although there was a theme developing through the cases to suggest that Jane Barton had relied on diamorphine and syringe drivers, the police had to investigate the practices of the other practitioners working at Gosport Hospital. The attendees agreed that Jane Barton could not be seen to be persecuted alone.

JZC noting that the environment in which Dr Barton was working in which there were no prescribing policies may have allowed her to operate undetected.

OK identifying the fact that in 1991 concerns had been raised regarding the use of diamorphine by junior nurses. MK and JZC advising OK that these papers had been provided to the GMC but did not take the matter further in terms of the interim procedures. OK advising the circumstances in which the concerns had been made by the junior nurses and the fact that the medical practitioners and senior nurses had been opposed to any questioning of the clinical decision making. Noting that the fact that concerns had been raised some years previously did suggest that there was something amiss with James Barton's practice over a period of years.

NN noting that there appeared to be a lack of motive. OK was continuing to look at this element.

NN advising that Liam Donaldson had asked Professor Baker to consider the issues raised by the cases identified by the police. NN had persuaded Professor Baker to also expand his enquiries into Dr Barton's GP practice. NN noting that Professor Baker's analysis of the statistics would take some time.

JZC advising that the GMC had the power to make an interim order suspending or placing conditions upon a medical practitioner's registration notwithstanding the fact that he or she had not been found guilty of serious professional misconduct. Stating that in this instance the IOC had determined not to place any interim order upon Dr Barton's registration. Noting that this was based on a convincing argument by Dr Barton explaining the lack of resources and supervision and the poor conditions under which she had had to work. Stating that given that the police were suggesting that there was potentially hundreds of deaths caused by Dr Barton and were actively assessing whether a murder charge could be prosecuted, JZC would be concerned to protect the patients and the public interest by presenting new evidence to an IOC Panel.

The parties discussing the disclosure requirements for GMC. Noting that the GMC would be forced to disclose any document which they wished to present to an IOC hearing in reliance of a request for an interim order.

NN appreciating the vulnerability of the GMC to criticism if a patient was killed at the hands of Dr Barton when the GMC could have taken action to prevent her from practising. He was, however, concerned regarding disclosure of material which he would not wish revealed to the doctor at too early a stage. NN stating that it would possible for him to write a letter for the GMC indicating that police investigations were continuing and that there were a minimum of 50 patients whose deaths would be analysed. The letter could also advise that early medical advice suggested that the deaths had been hastened by the prescribing regime provided by Dr Barton. The attendees agreeing that the letter from NN would also formally request that the GMC state their proceedings.

JZC expressing concern that the defence could argue that Dr Barton was no longer working at Gosport War Memorial Hospital and, therefore, patients were not at risk from diamorphine prescriptions or syringe drivers. OK noting in this regard that Dr Barton's private practice would include elderly patients. JZC commenting that although she appreciated that it had not yet been determined whether the criminal enquiry should consider the private/GP practice, it would be helpful if the fact that investigations may be expanded in this direction could be included within the letter to the GMC. NN stating that whilst he would wish to assist the GMC as far as possible, it may be

difficult for him to add this element to any letter. Noting that Professor Baker had agreed to expand his analysis to include Barton's private practise, but this was not part of his specific remit established by Liam Donaldson.

NN advising that the letter to the GMC would also formally establish the Constabulary's commitment to liaise closely with the GMC. The parties agreeing that formal letters would be written outlining information that was possible for the GMC to disclose. There would also be contact through e-mail, telephone and further meetings. JZC advising that she was likely to phone NN on a monthly basis so that she could report back to the GMC in her monthly reports!

The parties noting that Alexander Harris had expressed concern that the individuals involved in the various investigations and enquiries were not liaising. Noting the commitment to liaise closely could be articulated to Ann Alexander at Alexander Harris - it would, however, be necessary to stress the different role that each of the particular stakeholders were bound to adopt. Detail would not be provided about the level of communication or the information being passed between the parties but Alexander Harris should be advised that formal channels of communication had been developed.

In this regard, NN advising that he had met with Ann Alexander last week. The meeting had been productive in that it had been on a non-adversarial basis. Stating that Ann Alexander had used the media to generate publicity for her firm following the meeting, however, formal channels of communication had been established and it had been agreed that the family could raise concerns regarding any police investigation through Alexander Harris. Hampshire Constabulary had also agreed to advise any new individuals that Alexander Harris were acting for relatives; NN stressing that this would not be a referral service but merely informative.

NN stating that an important date was his meeting with the CPS scheduled for 28 November 2002. This meeting would establish the Constabulary's expectations as to the speed with which the CPS should consider the papers. NN advising that if the CPS did not consider the matter should proceed to a prosecution, the case could be considered by Treasury Counsel (an alternative Treasury Counsel from that which considered the initial referral of the Richard's case).

OK querying whether the GMC had any record of Dr Barton's qualifications as he did not have a full history or CV. The GMC would attempt to track down as much information as possible.

The GMC also would pass on any Rule 6 response letter if appropriate. JZC also advising that the GMC had received two other complaints Carby and Batson. NN and OK did not recognise these names as individuals within the 50 cases being investigated by the Constabulary. JZC to pass the documents through to the Constabulary.

There appeared to be a culture of resorting to diamorphine care too quickly (perhaps for a easy life?). The parties identified the fact that there may be problems with other doctors. MK advising NN and OK that the case against Lord had been "screened" within the GMC procedures and a decision taken not to pursue the matter.

As regards disclosure, JZC stating that she would work on the assumption that any documents provided by the police would be undisclosable unless she was specifically advised otherwise in writing. JZC stating that the GMC enquiry, once it was permitted to proceed would, of course, have to disclose any documentation passed through by the police. NN and OK appreciating this fact and noting that at that stage, in any event, the policy enquiry would be concluded. NN stating that once the police enquiry was concluded it would be possible to pass JZC all relevant documentation and, indeed, this was the basis on which the police worked.

JZC explaining that we had received a report from CHI. She explained that we wished to obtain the documents that had been considered by the CHI investigation team and, moreover, visit CHI in order to analyse the witness statements taken. Stating that there would be no intention to interview the witnesses. NN agreeing that this would not prejudice any police investigation and JZC and JHO could proceed with this aspect of the GMC enquiry.

The parties summarising the fact that NN would provide a letter to the GMC which could be used by the GMC in an IOC hearing, which would formally ask the GMC to stay their investigations and which would state that the parties were committed to regular liaison. (JZC and MK noting that it may be difficult to persuade an IOC panel to place an interim order based only on a letter but identifying that this was the best position). NN advising that the police would advise the GMC of any significant event and would release information if it was appropriate for them to do so.

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

attendance note of meeting

Name:	**Judith Chrystie**	Call type:	**Meeting**
Att:	**Matthew Lohn**	From:	
Duration:		Date:	**3 October 2002**

Meeting re: Dr. Barton

Attendees:

GMC – Peter Swain
- Michael Keegan

FFW - MSL
- JZC

Issues

MSL identifying the fact that there were five issues that he particularly wished to discuss with the GMC and that these were as follows:

1. Dr. Lord

2. Police involvement

3. Further cases

4. 1991 allegations

5. Timescale

1991 Allegations

MSL indicating that he doubted that the other information received regarding the 1991 allegations would add anything to the case and would not be sufficient evidence to add weight to an argument for an Interim Order. MSL advising that, technically, the information regarding the 1991 allegations was new evidence and did show that the concerns were long-standing. MSL advising that although the new information could be regarded as "trigger papers" there was an abuse point and it was possible that the Screener would determine that they did not add anything to the weight of the existing allegations.

PS and MSL identifying the fact that there was a political aspect to this case and that local individuals, such as Mike Gill, were under some pressure. MSL advising that he would provide written advice on the issue on headed FFW paper.

Timescale

The attendees accepting that the speed with which the matter could be progressed would be affected by the police investigation and any prosecution by the CPS. It was identified that it may be helpful if the police could provide the papers on the understanding that the GMC would do nothing with the information until the conclusion of the prosecution or investigation. This would, however, enable the GMC to be ready to 'roll out' the matter quickly once there was no prejudice to the regulatory inquiry.

The parties discussing the level of Counsel to become involved in the case. The GMC accepting that owing to the public profile of the case it would be beneficial to instruct a QC at an early stage.

JZC suggesting that the matter could be listed for March.

Noting that the CHI Report may have helpful information and statements which could be utilised. In addition, CHI may have obtained the necessary consent and medical records.

General

MSL advising MK and PS that the case provided by Dr. Barton to the IOC was *"very powerful"*. Neither MK nor PS had read the IOC transcript or response letter. MSL advising that owing to the particular resource issues identified within Dr. Barton's response, it may be difficult to attach sole blame for hastening death to the doctor. Noting, however, that following receipt of the 1991 allegations there had been long-standing concerns regarding treatment which ended life. The parties agreeing that there did appear to be problems with the doctor's practice but this was not a Shipmanesque case.

PS stating that this was a case in which there was indirect pressure for the GMC to push on with its enquiries. PS emphasising that there was no agenda to achieve a particular result. The GMC would, however, have to ensure that all matters were fully explored.

MSL pointing out that the Report prepared by CHI would provide useful background information. We would wish to see everything that the investigators for CHI had obtained.

MSL requesting an update about the police investigation if the GMC had recently received one. MK stating that it appeared that nothing much had changed. The matter had been submitted to the CPS and unofficially it appeared that the matter would not proceed.

The parties agreeing that an early meeting with DSI Jane would be useful in order to establish what was going on.

The parties discussing the difficulties that would be presented by the fact that both Dr. Lord (Dr. Barton's consultant) and the nurses involved in the case may be the subject of regulatory proceedings through the GMC and the UKCC. Advising that it would not be possible for these individuals to give evidence at any regulatory proceedings as to do so would be to give evidence which could potentially self-incriminate the individual.

Note of meeting between the GMC and Hampshire Police at Great Portland St on 6 July 2004 regarding Dr Jane Barton (Operation Rochester).

Present:
DCS Steve Watts
DCI Dave Williams
Louise Povey
Toni Smerdon
Paul Hylton

1. The Police confirmed that, subject to their responsibilities as criminal investigators, they are willing to cooperate with the GMC. Both the Police and the GMC wish to ensure that the public are protected. The GMC's immediate concern is the ability to investigate the case and consider referral to the IOC.

2. The Police are unable to release certain information at present largely because they wish to avoid prejudice to their investigation. They are aware that information released to the GMC will be disclosed to Dr Barton. They wish to avoid disclosing information to Dr Barton before she is interviewed. The Police interview of Dr Barton is likely to take place in August/September 2004. The Police enquiries also concerned other individuals aside from Dr Barton and they are wary of disclosing any information to Dr Barton that might compromise those further investigations.

3. The Police have divided the cases concerning Dr Barton into 3 categories:

    i. Category 1 – Optimal care with no cause for concern.

    ii. Category 2 – Sub-optimal care (57 cases at present, possibility of 3 more being added).

    iii. Category 3 – Negligent care/cause of death unknown (9 cases).

4. The Police have engaged Mathew Lohn of Field Fisher Waterhouse to quality assure the Category 2 cases to ensure that the medical experts have examined all of the circumstances of the treatments. The quality assurance exercise is due to be completed by 16 July 2004. The Police have forwarded some of the information to the GMC previously. However, the experts' reports have not been forwarded to the GMC. Subject to CPS approval, the Police will agree to these cases being disclosed to the GMC. The GMC will then be in a position to investigate the issue of substandard care. The Police will also seek CPS approval for the GMC to use the Police's experts for the GMC case. The CPS will decide if Dr Barton's interview should include questions about Category 2 cases.

5. The GMC said that it wishes to consider the Category 2 cases as soon as possible with a view to referring the matter to the IOC. The Police remain willing to provide a statement for or attend an IOC. We discussed the limited nature of an application to IOC without the category 2 material but that is something the GMC will consider if the CPS consent is not forthcoming.

6. In the event that the CPS do not agree to disclose the category 2 material at this stage, the Police confirmed that category 2 and 3 material could be released after the August/September 2004 interview with Dr Barton.

7. The Police reported that Dr Barton is subject to restrictions locally regarding her prescribing, and that audits by the Trust had shown that she had adhered to those restrictions. The Police will send an email detailing the restrictions. The Trust's contact in that regard is Hazel Bagshaw, Pharmaceutical Advisor. The Police noted that the CHI report also raised questions regarding systems failures, particularly regarding the checking of Dr Barton's prescribing patterns.

8. Four of the Category 3 cases are expected to be with the CPS by the end of September 2004. The remaining five Category 3 cases are expected to be with the CPS by the end of 2004. The families of the patients in those case are represented by Alexander Harris Solicitors.

9. The Police are aware that one of the Category 3 cases is mentioned in the Baker report. If the GMC were to succeed in obtaining approval from the CMO for the use of the source material used in compiling the Baker report, then the Police would wish the GMC to liaise with them before carrying out any investigations to ensure that the criminal cases are not compromised.

10. DCI Williams is the main point of contact for the GMC.

Louise Povey

IOC Cases: Instructions

Name of doctor:	**BARTON, Jane Ann**
Type of case (new/review):	**New Case of Conduct**
Date/time of IOC hearing:	**Thursday 19 September 2002 11.30am**
If review hearing, date of initial IOC Order:	**N/a**
Date of any previous review hearings:	**N/a**
Date considered by PPC:	**29 August 2002**
Listing status: (provisional/working listing date?)	**Not yet listed for a hearing by the Professional Conduct Committee. GMC likely to await outcome of any police investigation**
Has notice of inquiry been sent?	**No**
Any significant developments since last IOC hearing:	**Although this case is a new case of conduct, it has twice before been before the IOC (in June 2001 and March 2002) when the IOC directed that no order was necessary. On 13 September 2002 the case was referred back to the IOC, by the President, on the basis of information that the CPS is now reconsidering the cases against this doctor. Also due to the fact that the status of the case has changed as it has now been referred for an inquiry by the Professional Conduct Committee.**
Do we need to ask the Committee to direct Registrar to apply to High Court for an extension to order?	**No**
Any other specific instructions:	**If the IOC is not minded to suspend this doctor, it may be appropriate for it to impose some conditions, perhaps in relation to her prescribing.**
Name and tel no of caseworker	**Venessa Carroll Conduct Case Presentation Section Code A**

IOC REFERRALS

DOCTORS FULL NAME :	**Barton, Jane**
FPD REFERENCE :	**2000/2047**
TYPE OF CASE : (Performance/Health/Conduct)	**Conduct**
CASE WORKER :	**Venessa Carroll/Michael Keegan**
DOCTOR'S PLACE OF PRACTICE :	**Gosport**
DOCTORS SPECIALTY :	**GP**
DATE COMPLAINT RECEIVED :	**July 2000**
DATE OF REFERRAL TO IOC :	**13 September 2002**
REFERRED BY :	**The President**
MEMBER(S) THAT HAVE SEEN CASE	**Screener: Dr Malcom Lewis** **PPC:** Mr Bob Nicholls, Professor Roger Green, Dr Richard Kennedy, Sir Roddy MacSween and Professor Nigel Stott, Dr Sheila Mann **Please note this case has twice been before IOC**
IS DOCTOR CURRENTLY PRACTISING :	**Yes**

SUMMARY OF ALLEGATIONS :

Inappropriate prescribing to elderly patients – suggestion that death precipitated if not caused by prescribing

Read Out

Dr Barton

IOC 19 September 2002

Dr Barton: The Committee has carefully considered the information before it today and has determined that it is not necessary for the protection of members of the public, in the public interest or in your own interests that an Order under Section 41A of the Medical Act 1983, as amended, should be made in relation to your registration whilst the matters referred to the GMC are resolved.

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

Dr Barton

IOC 19 September 2002

Dr Barton: The Committee has carefully considered the information before it today and has determined that it is not necessary for the protection of members of the public, in the public interest or in your own interests that an Order under Section 41A of the Medical Act 1983, as amended, should be made in relation to your registration whilst the matters referred to the GMC are resolved.

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

E:\C\PPC\Forms\AttendS.doc

IOC Attendance Sheet C

Doctor present and represented by solicitor

Dr Barton is present and is represented by Mr Jenkins (counsel, instructed by) Mr Ian Barker of the Medical Defence Union

Miss Fiona Horlick Counsel, instructed by the Solicitor to the Council, represents the Council.

Annex A

Investigation Instruction Sheet (IIS)

Post Preliminary Proceedings Committee Case

Section A – to be completed by the GMC

Priority Band:
A – also referred to IOC. The doctor is to be offered voluntary erasure so please do not list yet.

1. Date of instructions to solicitor:	Field Fisher Waterhouse
1. Name of doctor:	Dr Jane Ann BARTON
2. GMC file number:	2000/2047
3. Name of GMC CW: Direct line	Michael Keegan Code A
4. Type of case:	Conduct
5. Date for instructed solicitor to complete Section B (one week from the date of these instructions):	23 September 2002
6. Other comments:	London

Section B – to be completed by the instructed solicitor within one week of the date of these instructions.

7. Name of investigator:	John Offord (Investigator); Judith Chrystie (Solicitor)
8. Estimated number of witnesses:	12 - 15 witnesses of fact 1-3 expert witness
9. Class of case (1-5, see protocol):	Class 4
10. Target date for completion (see protocol):	6 January 2003
11. Earliest date case may be listed (taking into account the Carlile protocol):	Mid-late March 2003
12.Listing comments:	London Venue preferable owing to location of witnesses
13. Date IIS submitted by solicitor:	23 September 2002

PCC date (mid-March) requested 4.10.02.
Duration: 15 days

					returned the gifts. The Committee was in no doubt that it is unprofessional to accept gifts of this value. It recognised that Mrs Breese was clearly very fond of the doctor, but questioned whether he was taking advantage of a vulnerable elderly patient. It noted that he had moved to a different practice by the time the gifts were received, but considered that this and the return of the goods does not negate the point that he behaved unprofessionally. It considered that the major issues that arose in this case could bring Code A registration into question. Whilst at best his behaviour was foolish, naïve and ill-advised, at worst it could amount to inducing a vulnerable elderly lady to give him money and gifts, which could amount to spm if proved. The Committee noted that it was clear in GMP that doctors should not accept large gifts from patients, and determined that the case should be referred to the PCC. It asked however that we look at the charges, as we need to concentrate on the major issues – superfluous charges can weaken the case (i.e. charge 2f regarding the complainant's dog).
16.	**2001/2624**	Code A			
17.	**2000/2047**	**BARTON, J A**	**Refer to PCC**	**CCPS**	The Committee initially was informed by the Committee Secretary that the case of patient Gladys Richards has been referred back to the CPS. It noted that the case related to five patients between the ages of 75–91 who were attending Gosport War Memorial Hospital, mainly for rehabilitation. One person (Mrs Lack) who was an experienced nurse in elderly care was concerned about the treatment of her elderly mother (Mrs Richards) in the ward, which precipitated the reviews of other patients. The Committee noted the fairly brief report of Dr Mundy, and Professor Ford's report which looked at all five cases. It noted the background to the case as a whole, which was that Dr Barton was a visiting clinical assistant who was responsible for the day-to-day management of these five cases. It noted that overwork had apparently affected patient care. It noted that in the case of Mrs Richards she had lost a hearing aid and her spectacles, and was

					brought in in an agitated state, probably because of sensory deprivation. She became ambulant with a Zimmer, but her hip replacement became dislocated following a fall. This patient was prescribed the same set of drugs which was used in each of the other cases: Oramorph, hyoscine and midazolam. It noted that some patients had up to 60–80 mg in 24 hours via subcutaneous injection with a syringe driver. Patient Richards received no foods or fluids between 18 – 21 August and died because of the combination of lack of nutrition and sedation. The Committee considered that the administration of these drugs may have shortened the patient's life (which was not the same as suggesting that it killed her). Professor Ford says that the prescribing regime was variously reckless, excessive or highly inappropriate. It noted with concern that the medical records are not signed regarding the subcutaneous drugs regime. It noted the pattern in which an elderly group of patients, dealt with by a clinical assistant, were the subject of apparently reckless and inappropriate prescribing. Death appeared to have been precipitated if not caused by the drug regime in each case. The Committee noted that Dr Barton's post was supervised by a consultant, Dr Lord, who must therefore assume some responsibility for the events. It noted that palliative care is now a well-developed clinical area. If death is accelerated as a result of carefully titrated, good symptoms control, then as a side-effect it may be acceptable. This did not appear to be the case here, and the Committee was of the view that the matter unequivocally needs to be tested by the Professional Conduct Committee. Dr Barton moved patients very quickly onto a regime where they were receiving terminal care, and ignored the recommendations regarding doses in the BNF, rapidly prescribing excessive doses. It noted that there was a major public interest in the case. It asked that we look at charges 2 (b) ii) and iii) regarding Eva Page, as these would not raise an issue of spm (ask solicitors to look at charges). It noted that the case had been before the IOC which had made no order. The Committee considered that the case of Dr Lord should be screened if it hasn't already been. It further suggested that if the allegations against Dr Lord have already been screened, we might now have more information than the screener had at the time, and it may need to be re-screened. It considered that the nurses involved were open to criticism for withholding nutrition and for failing in their own whistle-

					blowing responsibilities, and should be referred to the UKCC. It noted that there has already been a CHI report. The Committee noted that the documentation which was not included may contain information about the identity of the nurses concerned, and that a Nurse Philip Beed is named at p236. If we cannot identify other nurses we should ask the Trust for the names so they can be reported to the UKCC. We should also warn the press office about the case given the potential public interest, mentioning that other doctors and nurses might become involved. The Committee would like the case to be fast-tracked. Professor MacSween requested that a charge be added at 5 a. iii to reflect the inappropriate use of the word "happy" in the context of confirming death as this was at best inappropriate and reflected an attitude which caused considerable concern.
18.	**2001/3159**	**Code A**	**No Further Action**	**CCPS**	The Committee noted the allegation that Code A prescribed Erythromycin to the patient, Code A over the telephone, and may have allowed an earlier personal encounter with Code A to interfere with her clinical judgement. It was alleged that she did not want to make a home visit because she had had a row with Code A about planning permission. The Committee considered that there was no issue of spm or any chance of proving the charge in this case. There was nothing wrong with prescribing antibiotics over the phone or refusing to visit in certain circumstances, and the Committee took issue with the charges in this respect. It determined that we should take no further action. We should tell the complainant that doctors are entitled to decide whether or not to refuse to make a visit, say that this did not reach the threshold of spm, and explain the PPC's role.

DR. BARTON

ROUGH NOTE OF MTG. WITH FFW + POLICE 20.11.02 ... JUDITH TO PROVIDE (AGREED?) NOTE

PATIENT	RELATIVE	
Stanley Carby	Mrs RE Carby	Incl. under Rule 11 ?
Eva Page	Mr B. Page	
Alice Willie (complaint ?)	Mrs M Jackson X → Miss E Yeats	write to Yeats
Gladys Richards	Cillian McKenzie + Lesley Lacle	Initial Police complaint
Arthur Cunningham	Mr CRS Farthing (?)	
Robert Wilson	Mr I Wilson	
(?) Mrs Gilbertson	Barton ?	Incl. under Rule 11 ?

POLICE:

Nurses + families' statements (NFA until CPS "final" decision) ?!

→ Are Police investigations actively ongoing? When likely to concl.?

Alexander Solicitors – act for Ann Reeves + 18 x families

↓

Closed @ Screening

7

Hampshire Constabulary

Mrs Richards complaint → CPS

↓

10/8/01 : Insufficient evidence

↓

DS J. James accepted that advice

↓

(random) Expert report ⇐ Prelim inquiries re: other deaths

re: 4 x patients + ~~incl~~ Richards

↓

NP (Psych) A subject to substantial new evidence

BUT raises concerns re: prof. conduct

CHI ← what info. / doc's ?

Staff concerns raised in 1991 ? Relevant to these 5 - 7 cases?

Sally Smith QC ?
medical ethics exp.

DI Nigel Niven (St George's Hospital)

DS Owen Kenney

wed 8/1/03 – mtg. c PFW : CONFIRM
PFW to visit Cth to see their docs
what's relevant ? – statements

Conviction or spec route @ pcc ?
← depends on police

Additional

Prof. Butler Sturdy – long time !

Prof Robert Jones approached by Police to report on 5 x cases referred.

? review of 50 + / 500 + cases ? To be decided upon
→ potentially protracted ... 1/2 years.

Time
1) Police = seeing Crown (c/s) on 28/4 ... Confirmation of course of inquiries will follow in writing.

2 what has Barton seen ? 3 x reports.

20/11/02

IOC — Return to IOC with Police ref. to more cases (+ post. extra expert reports)

What the minimum amt. of evidence IOC needs? ... ① to refer back, or ② make an order

CH1 — Police agreed to FFW reviewing CH1 docs.

Barton's CV — Barton's CV? / Qualifications? ?

Barton ✓ Lord X others? — Numbers (?!) = ? ?

Identified in (50) strew complaints

Only one id'ed as inappropriately prescribing diamorphine by syringe driver.

Ann Alexander (SO's): we can say that monthly liaison between Police & GMC (FFW) is ongoing.

Police have agreed that AA = contact point with families

whilst independent + with different agendas, Police + GMC are communicating"

10c transcript _ disclosure to police

/

crime murder investigation ?

CPT DOCUMENTS BEGIN

FITNESS TO PRACTISE DIRECTORATE

CONDUCT & REFERRALS

TELEPHONE MESSAGES

Call taken by: Paul Hylton	
Date: 16 January 2006	Time: 13:00
Name of caller: Hampshire Police (*Operation Rochester*)	Caller's status: (eg MP, patient's mother)
'Phone number of caller: Code A	Address of caller: (if necessary)
Doctor(s) complained/enquired about Dr Jane Barton	If we have file already open - file reference: 2000/2047

Summary of 'phone call:

1. I called Operation to ascertain whether Police had interviewed Dr Barton. I was informed that she had been but that the Police were reluctant to disclose any further details at this time.

For next action by:

Paul Hylton Code A

From: Paul Hylton Code A
Sent: 09 May 2005 10:55
To: Paul Philip Code A
Subject: RE: Gosport

Paul

I will draft a letter for Toni's signature today.

Paul

-----Original Message-----
From: Paul Philip Code A
Sent: 06 May 2005 15:34
To: Paul Hylton
Cc: Toni Smerdon Code A
Subject: Gosport

Where are we on getting advice from Mark Shaw on the police response please?

Paul

Sent from my BlackBerry Wireless Handheld

GMC Legal

TELEPHONE NOTE

1.	**DATE:**	Friday 15 April 2005
2.	**TIME:**	*16:00*
3.	**SPOKE TO:**	DCI David Williams - Hampshire Constabulary
4.	**GMC OFFICER:**	Paul Hylton
5.	**RE:**	Response to letter from Paul Philip dated 25 January 2005
6.	**MESSAGES:**	

I called DCI Williams to further chase up a response to the letter from Paul Philip dated 25 January 2005, in which we sought disclosure of information in respect of Elsie Devine. I had previously telephoned the Police on 3 occasions, however this was the first time that I had been able to speak with DCI Williams direct.

DCI Williams reported that they had consulted with Counsel and that Counsel had advised them of various points that should be included in a response to the GMC. He added that they expected Counsel to have drafted a response within a week, but that he would email me a summary of the current position over the weekend so that I could have it for Monday 18 April 2005.

I advised him that the GMC were concerned at the time taken to receive a response to our letter, and that I would copy his summary to Paul Philip once I received it.

7.	**TIME ENGAGED ON CALL:**	10 mins.

Valerie Bar Code A

From: Valerie Bar Code A
Sent: 11 Jan 2005 16:15
To: Paul Hylton Code A
Subject: phone message

Paul

Could you ring Claire Strickland, lawyer with Nursing and Midwifery Council, on Code A re operation Rochester, please.

Val

Code A

Call with update re investigation, was some vague complaints ⇒ ward full after gmc case, Shand have challenged Prescribing regime

Paul Hylton Code A

From: Paul Hylton Code A
Sent: 22 Dec 2004 11:16
To: Paul Philip Code A
Cc: 'Peter and Patricia Swain'
Subject: Dr Jane Barton

Importance: High

Dear Paul

I have just spoken with the Chief Constable's Office regarding Finlay's letter.

They confirmed, very tersely, that they have received the letter and that it is "being progressed". When I pressed them as to what "being progressed" meant, they were either unable or unwilling to give such an explanation.

Paul

Paul Hylton Code A

From: Finlay Scott Code A
Sent: 17 Nov 2004 11:42
To: Peter Swain
Cc: Paul Hylton Code A Paul Philip Code A
Subject: RE: Barton

Peter

Thanks. Could you fax a copy of the police letter to me Code A please.

Finlay

-----Original Message-----
From: Peter Swain Code A
Sent: Wednesday, November 17, 2004 10:59 AM
To: Finlay Scott
Cc: Paul Hylton Code A Paul Philip Code A
Subject: RE: Barton

Finlay

Hampshire Police wrote to us on 2 December 2002 formally requesting that we defer the PCC hearing until further notice pending the conclusion of the police investigation. This was agreed by the Conduct Case Presentation caseworker at the time, Michael Keegan.

Peter

-----Original Message-----
From: Finlay Scott Code A
Sent: 17 Nov 2004 09:44
To: Peter Swain
Cc: Paul Hylton Code A Paul Philip Code A
Subject: RE: Barton

Peter

Thanks. Paragraph 5 of the attachment refers to a decision not to proceed with the PCC cases, pending the outcome of the police investigations. Who took that decision, please?

Paul and I will aim to discuss the best way forward, probably later today.

Finlay

-----Original Message-----
From: Peter Swain Code A
Sent: Monday, November 15, 2004 2:52 PM
To: Paul Philip Code A Finlay Scott Code A
Cc: Paul Hylton
Subject: Barton

Paul, Finlay

I attach Peter Jones' advice about the Barton case. It contains a useful summary of the chronology to date.

<< File: lett to Peter Swain_v1.doc >>
The brief outline is that we have 5 cases awaiting PCC which the police are re-investigating. We have therefore been waiting for the outcome of that investigation. We have tried and failed three times to get an IOP order in relation to what we currently have. Meanwhile, the police are investigating 15 other cases of which we have no specifics at all. The police have hinted that 7 or 8 of these cases are more serious than the 5 we have awaiting PCC. We cannot do anything with those cases, including IOP referral, until we get at least some basic information. Previous efforts at diplomacy have failed to secure the release of the type of material we would need. We therefore need to consider how best to cover our current position.

Paul Hylton Code A

From: Peter Swain Code A
Sent: 09 Nov 2004 18:39
To: Paul Philip
Cc: Paul Hylton Code A
Subject: Dr Barton

Paul

Paul Hylton and I met with Peter Jones of Eversheds to discuss his views on this case.

Peter' s view is that we have acted entirely reasonably in taking these matters to the IOC when we have but that there is currently no basis on which to return for another try at the IOC.

By contrast, he considers that the police investigation can be severely criticised for its delay. We are therefore entitled to take the view that whereas a conciliatory line was appropriate towards the receipt of material, it is now vital that we 'up the ante' given the severe delays in the police investigation and the lack of any clear indication as to future timetable or likely outcome.

We therefore agreed that Eversheds will progress the 8 cases we have evidence on towards a PCC hearing. At the same time, we will issue Section 35 notices in respect of the 8 other (allegedly more serious) cases which the police are investigating and on which we currently have no further details. Eversheds suggest, and I agree, that our communication should be to the Chief Constable so as to ensure he is fully alerted to the potential criticism of his force at the lengthy delays in the investigation to date.

If the police comply with the S35 notice, or if disclosure is ordered following High Court proceedings, we will review the new material as it arrives to assess if and when IOC referral becomes warranted.

Peter Jones will provide us with written advice by Friday which will then form the basis of our draft letter to the Chief Constable.

Peter

Coloured Sticky Tab

Green - OE start

Notes from meeting with Dr J Barton

3rd November 2004

Details of the voluntary agreement - from October 2002 as confirmed in an e-mail from Dr Sommerville. It was agreed that this should run until Dr Barton had been before the Conduct Committee. The agreement was for a restriction on the prescribing of opiates and for benzodiazepines to only be prescribed in line with BNF guidance.

The Prescription Pricing Authority data was examined for the period October 2002 until August 2004 (the latest data on the system at the time of the meeting). Dr Barton had made great efforts to transfer patients requiring opiates or benzodiazepines to other partners within the practice. The practice data analyst had produced a list of the prescriptions for diazepam 2mg, which had been issued with Dr Barton's name as the prescriber. Dr Barton had written 5 prescriptions and a reason for the treatment was documented. The remaining prescriptions had been issued during consultations with other partners.

Only 3 of the opiate prescriptions were for controlled drugs in tablet form. Dr Barton will ask the practice data analyst to follow up this matter. The remainder of the prescriptions were for drugs such as codeine phosphate, tramadol and dihydrocodeine tablets or capsules.

Dr Barton will also ask the data analyst to follow up the diazepam 10mg prescriptions.

As far as Dr Barton is concerned, the voluntary agreement is still in place. The agreement for opiates was a restriction on controlled drugs, in particular, for injection.

The PPA data is recorded against the GP name printed in the bottom of the prescription not against the signature. Dr Barton continues to assure me that all patients requiring long-term treatment with opiates or benzodiazepines are asked to see other partners within the practice.

Hazel Bagshaw
Pharmaceutical Adviser
Fareham and Gosport PCT
04.11.04

Paul Hylton Code A

From: Paul Hylton Code A
Sent: 08 Oct 2004 11:21
To: Nilla Varsani Code A
Cc: Helen Whitford Code A
Subject: RE: Dr Barton

Nilla

I have drafted a letter to the CMO and am awaiting Paul Philip's agreement to send it.

I have informed Hants Constabulary by email, the contact details are: Detective Chief Inspector David Williams, Fareham Police Station, Quay Street, Fareham, Hampshire, PO16 0NA.

The PCT contact details are: Mr Ian Piper, Chief Executive, Fareham & Gosport PCT, Unit 180 Fareham Reach, 166 Fareham Road, Gosport, Hampshire, PO13 0FH.

Paul

-----Original Message-----
From: Nilla Varsani Code A
Sent: 08 Oct 2004 11:08
To: Paul Hylton Code A
Cc: Helen Whitford Code A
Subject: Dr Barton

Paul,

Can you let Helen have the current contact names and addresses of the interested parties.

1 Fareham and Gosport PCT
2. Hamsphire Constabulary
3. CMO

Thanks
Nilla

FW: FGM Details for attention of Paul Hylton GMC

[redacted] Hylton Code A

From: Paul Hylton Code A
Sent: 08 Oct 2004 10:19
To: Code A
Subject: RE: FGM Details for attention of Paul Hylton GMC
Importance: High
Sensitivity: Confidential

Dear Owen

I had planned to tell you about the IOC's decision this morning, but it would appear that it has already leaked out.

Please find attached a copy of the IOC's determination. The determination is confidential, however, I will be writing to the relativ today to give them the decision, although I will not be able to give then the reasons. I will also update them as to the position of [redacted] cases already referred to the Professional Conduct Committee, which is that we will hold our investigations in abeyance unt the Police investigation is completed.

[redacted]

-----Original Message-----
From: Code A
Sent: 04 Oct 2004 14:32
To: Code A
Subject: FW: FGM Details for attention of Paul Hylton GMC

From: Robinson, Kathryn
Sent: 04 October 2004 15:28
To: Kenny, Owen
Subject: FGM Details for attention of Paul Hylton GMC

[redacted]

Owen,

[redacted] As discussed , can you please forward this to Paul.

Dear Paul,

Please find enclosed the contact details for the family group members which were forwarded to you 10/09/04. I have not provided any details for Charles BATTY, Catherine LEE AND Walter CLISSOLD as the relevant people do not wish any further contact from us in relation to this matter.

I hope that this information is of assistance to you and as I have previously mentioned, please don't hesitate to contact me if you require any further information. I will refer any queries from Family Group Members relating to the GMC to you.

Best wishes,

Kate Robinson
DC424
Operation Rochester.

Coloured Sticky Tab

Green - OE end

DECEASED	FAMILY GROUP MEMBER	ADDRESS
Victor ABBATT:	Mrs Pauline GILMORE,	
Dennis AMEY: (Daughter)	Mrs Lesley LOWE,	
Dennis BRICKWOOD: (Son)	Mr Anthony BRICKWOOD	
Stanley CARBY: (Wife)	Mrs Rita CARBY,	
Sydney CHIVERS:	Mr Martin CHIVERS,	
Cyril DICKS : PO13OVE.	Mrs Sandra TAYLOR,	
Harry HADLEY:	Mrs Sandra HOWELL.	
Charles HALL:	Mrs Diane HARCOURT,	
Alan HOBDAY:	Mr Michael HOBDAY,	
Gwendoline PARR	Mr Colin PARR	
Eva PAGE	Mr Bernard PAGE	
Edna PURNELL (Son)	Mr Michael WILSON	
Margaret QUEREE	Mrs Rita HOARE	
Violet REEVE	Mrs Alexander MOORE	
James RIPLEY	Mr James RIPLEY	
Daphne TAYLOR (Husband)	Mr John TAYLOR	

Code A

Code A

please notify us by telephone
[redacted]44 (0) 845 045 45 45 or email to postmaster@hampshire.pnn.police.uk immediately. Please then delete this email and destroy any copies of it.
All communications, including telephone calls and electronic messages to and from the Hampshire Constabulary may be subject to monitoring. Replies to this email may be seen by employees other than the intended recipient.
****

[redacted] Hylton Code A

From: Jo Tupper Code A
Sent: 08 Oct 2004 09:36
To: Paul Hylton Code A
Subject: FW: Gosport War Memorial Hospirtal case

-----Original Message-----
From: Nicholas Brooks Code A
Sent: 07 Oct 2004 21:05
To: pressoffice Code A
Subject: Gosport War Memorial Hospirtal case

Sorry about the timing, but I'm keen to chase something first thing in the morning (Fri) and wanted to make sure you had an earl heads-up on it.

[redacted]

I gather that the GMC wrote to various parties, who have up until now been involved with police investigations into a number of [redacted]ths at the Gosport hospital, advising them that the suspension of a certain Dr B was being considered. Then, on the very da[redacted] that these letters arrived the people concerned were told that the doctor would not be suspended.

I'm looking to try and find out what is going on, why the letters were sent, why then the announcement was made that there was be no suspension after all. In short, I'm as confused as the individuals themselves, who went from extremely happy to utterly gutted in about 12 hours.

Can you enlighten me?

Many thanks,

Nick Brooks
Health reporter
The News, Portsmouth
Code A

[redacted]

[redacted]

[redacted] Hylton Code A

From: Jo Tupper Code A
Sent: 08 Oct 2004 09:36
To: Paul Hylton Code A
Subject: FW: Dr Jane Barton

-----Original Message-----
From: Lesley Lowe Code A
Sent: 07 Oct 2004 18:46
To: pressoffice Code A
Subject: Dr Jane Barton

I am a family member enquiring about the outcome of Dr Jane Barton's interim order committee hearing please may I see it. Thankyou Mrs Lesley Lowe.

Paul Hylton Code A

From: Paul Hylton Code A
Sent: 07 Oct 2004 18:05
To: Paul Philip Code A
Cc: Toni Smerdon Code A
Subject: RE:

Paul

The panel did ask about the President's referral, noting that it had been made before the police statement was received.

We answered by saying that the info considered by the President included that given to the GMC by the Police in our July meeting, and that the subsequent Police statement may not have necessarily reflected what we had been led to believe would be disclosed.

Toni and I discussed this point at the time we received the Police statement, and agreed that as the GMC had no power to withdraw the referral, we would have no choice but to let it run.

Paul

-----Original Message-----
From: Paul Philip Code A
Sent: 07 Oct 2004 17:56
To: Paul Hylton Code A; Toni Smerdon Code A
Subject: Re:

Paul/Toni,

Roger's view last night was that there was very little new in all of this which has not already been considered by the IOC apart from a rather weak police statement.

Are we all agreed that there is little if anything new in what the police have disclosed to us?

Paul

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Paul Hylton Code A
To: Paul Philip Code A
Sent: Thu Oct 07 18:52:13 2004
Subject: RE:

Paul

There are medical records relating to these cases, which have been analysed and summarised by the Police's medical experts. I disclosed the summaries to the defence and told them that the complete records would be available at the hearing. When I disclosed the Police statement on 30/9 I asked the defence whether they wished to have a copy of the medical records (which are 2 crates full of paper) disclosed to them. After checking with Dr Barton they asked for disclosure. Unfortunately they did not confirm that they wanted them until 11:30 am on 1/10, by which time reprographics were in the process of moving.

I considered using a commercial company, however the nature of the info made that an unacceptable option. Reprographics were unable to make the necessary copies until this morning. I disclosed the records to the defence before the hearing.

The records were not used by either side today. However, Toni has told me that you wish them sent to Mills & Reeve for analysis and I will do so once I get them back from the IOC team.

Code A

-----Original Message-----
From: Code A
Sent: 07 Oct 2004 17:43
To: Code A
Cc:
Subject: Re:

Code A

Code A spoke last night of about " 3 foot worth" of paper which we have not analysed or disclosed to the defence in relation to this. Do you know what he is talking about?

Code A

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Code A
To: Code A
Sent: Thu Oct 07 17:56:42 2004
Subject:

Paul

The IOC made no order in the Barton case. I have drafted the attached to the CMO for your consideration.

Paul

Paul Hylton Code A

From: Paul Hylton Code A
Sent: 07 Oct 2004 18:00
To: Paul Philip Code A
Cc: Toni Smerdon Code A
Subject: RE:

Paul

Unless there is something hidden in the medical records, which is extremely unlikely as they have already been looked at by two sets of medical experts.

Our presentation to the IOC lasted 2.5 hrs, the defence's lasted 20 mins and focused on the fact that there was nothing new in the info provided by the Police.

Paul
-----Original Message-----
From: Paul Philip Code A
Sent: 07 Oct 2004 17:56
To: Paul Hylton Code A; Toni Smerdon Code A
Subject: Re:

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Paul

-----Original Message-----
From: Paul Philip (020 7189 5124)
Sent: 07 Oct 2004 17:43
To: Paul Hylton
Cc: Toni Smerdon Code A
Subject: Re:

Paul,

Roger spoke last night of about " 3 foot worth" of paper which we have not analysed or disclosed to the defence in relation to this. Do you know what he is talking about?

Paul

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Paul Hylton Code A
To: Paul Philip Code A
Sent: Thu Oct 07 17:56:42 2004
Subject:

Paul

The IOC made no order in the Barton case. I have drafted the attached to the CMO for your consideration.

Paul

Paul Hylton Code A

From: Paul Hylton Code A
Sent: 07 Oct 2004 17:52
To: Paul Philip Code A
Subject: RE:

Paul

There are medical records relating to these cases, which have been analysed and summarised by the Police's medical experts. I disclosed the summaries to the defence and told them that the complete records would be available at the hearing. When I disclosed the Police statement on 30/9 I asked the defence whether they wished to have a copy of the medical records (which are 2 crates full of paper) disclosed to them. After checking with Dr Barton they asked for disclosure. Unfortunately they did not confirm that they wanted them until 11:30 am on 1/10, by which time reprographics were in the process of moving.

I considered using a commercial company, however the nature of the info made that an unacceptable option. Reprographics were unable to make the necessary copies until this morning. I disclosed the records to the defence before the hearing.

The records were not used by either side today. However, Toni has told me that you wish them sent to Mills & Reeve for analysis and I will do so once I get them back from the IOC team.

Paul

-----Original Message-----
From: Paul Philip Code A
Sent: 07 Oct 2004 17:43
To: Paul Hylton
Cc: Toni Smerdon Code A
Subject: Re:

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To: Paul Philip Code A
Sent: Thu Oct 07 17:56:42 2004
Subject:

Paul

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Paul

[redacted] Paul Hylton Code A

From: Paul Hylton Code A
Sent: 07 Oct 2004 16:57
To: *Paul Philip* Code A

Importance: High
Sensitivity: Confidential

Paul

The IOC made no order in the Barton case. I have drafted the attached to the CMO for your consideration.

Dr Barton CMO update 06-10-04....

[redacted]aul

Paul Hylton Code A

From: Guy Wilkinson Code A
Sent: 07 Oct 2004 16:43
To: Paul Hylton Code A
Subject: Dr Barton

Paul

A Mrs Grant called today and explained that she had been informed of the IOC hearing as an interetesed party and I have told her the no order outcome.

She would like to discuss the case with you. Could you call her on:

Code A

Thanks

Guy

Paul Hylton Code A

From: Paul Philip Code A
Sent: 07 Oct 2004 17:43
To: Paul Hylton Code A
Cc: Toni Smerdon Code A
Subject: Re:

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Sent: Thu Oct 07 17:56:42 2004
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Paul

Paul Hylton Code A

From: Paul Philip Code A
Sent: 07 Oct 2004 17:56
To: Paul Hylton Code A Toni Smerdon Code A
Subject: Re:

Paul/Toni,

Roger's view last night was that there was very little new in all of this which has not already been considered by the IOC apart from a rather weak police statement.

Are we all agreed that there is little if anything new in what the police have disclosed to us?

Paul

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Paul Hylton Code A
To: Paul Philip Code A
Sent: Thu Oct 07 18:52:13 2004
Subject: RE:

Paul

There are medical records relating to these cases, which have been analysed and summarised by the Police's medical experts. I disclosed the summaries to the defence and told them that the complete records would be available at the hearing. When I disclosed the Police statement on 30/9 I asked the defence whether they wished to have a copy of the medical records (which are 2 crates full of paper) disclosed to them. After checking with Dr Barton they asked for disclosure. Unfortunately they did not confirm that they wanted them until 11:30 am on 1/10, by which time reprographics were in the process of moving.

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Paul Hylton Code A

From: Guy Wilkinson Code A
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To: Paul Hylton Code A
Subject: Dr Barton

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A Mrs Grant called today and explained that she had been informed of the IOC hearing as an interetesed party and I have told her the no order outcome.

She would like to discuss the case with you. Could you call her on:

Code A

Thanks

Guy

Meetings with Dr J Barton.

The meetings were held to discuss matters raised in the CHI report on Gosport War Memorial Hospital. PACT data was obtained for 2001-2 to establish Dr Barton's prescribing patterns for benzodiazepines and opiates (see attached PPA data and analysis table). PACT catalogue data is also available on file.

Meeting on November 1st 2002.
Dr Barton has undertaken not to prescribe benzodiazepines or opiate analgesics from October 1st 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.
Dr Barton will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health Call as a prescription may be required for a 14-day supply of benzodiazepines for bereavement.
Dr Barton also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patients' notes.
The next meeting will be in 6 months time

Visits to local pharmacies for spot checks on Dr Barton's prescriptions was discussed and deemed to be impractical.

Meeting on June 27th 2003
Data was available from the PPA up to and including April 2003. 12 months data was discussed.
Dr Barton had initiated searches on the practice computer system and the data collected by the practice IT manager for the 4th quarter of 2002-3 was studied. 7 of the 8 diazepam prescriptions had been prescribed by other partners for Dr Barton's patients.
Copies of the breakdown of PACT data from October 2002 to April 2003 for nitrazepam, temazepam, diazepam and opiates were given to Dr Barton. Monthly reports on these drugs will be prepared for Dr Barton.

Hazel Bagshaw
Pharmaceutical Adviser
Fareham and Gosport PCT
05.09.03

CPT DOCUMENTS
END

DR JANE BARTON

DRAFT LETTER TO POLICE

Our ref: PS/PCC/Barton
Your ref: Op Rochester

[ ] June 2004

Detective Chief Superintendent Steve Watts
Head of CID
Police Headquarters
West Hill
Romsey Road
Winchester
Hampshire
SO22 5DB

Dear DCS Watts,

Operation Rochester – Investigation into Deaths at Gosport War Memorial Hospital

On 5 May 2004 I wrote to you to, at some length, to express the GMC's serious concern at the police delay in the above investigation. I explained that the predicament in which this put the GMC (waiting for developments in a very long police investigation without the guidance of even a rough timetable for its future course) was "deeply unsatisfactory". I asked you, therefore, to take steps to resolve the problem and urged your "early reply".

That was about six weeks ago. But I still have not had the courtesy of an acknowledgement, still less a substantive reply.

The purpose of this letter is two-fold to underscore the urgency of the situation and to clarify the position of the police with a view to removing/reducing obstacles to the GMC's pursuit of its fitness to practise procedures.

With this aim in mind I should be grateful if you could deal with nine questions, which you should please treat as superceding (and encompassing) the two requests set out at the top of the last page of my letter dated 5 May 2004. (For ease of reading, the questions themselves appear in bold type below. Matters of commentary or refinement appear in normal type.)

1. **What event, precisely, will remove the current police objection to revealing information about the investigation to the GMC (and, through the GMC, to others including Dr Barton)?**
   In short, what is the cause of the impasse?
   I understand, in general terms, that the police consider that the on-going investigation prevents them from disclosing material to the GMC. But I do not understand precisely which event needs to take place to bring this situation to a close. Is it the police interview of Dr Barton? The police interview of someone else? The submission of a file to the CPS? The CPS decision? The charge? The giving of primary prosecution disclosure? The committal? The plea and directions? The service of the defence statement? The giving of secondary prosecution disclosure? The conclusion of the trial? The last few paragraphs of your letter dated 6 October 2003 indicate that the objection will dissolve when you have interviewed Dr Barton. Please confirm. It is difficult to see how the objection could survive beyond any prosecution disclosure because the very disclosure in issue would by then have been given to Dr Barton in the criminal proceedings themselves.
2. **If the police consider that the critical event is the police interview of Dr Barton, why would it be undermined by prior disclosure?**
   What, precisely, is the vice which the police fear and what is the public interest promoted by refraining from disclosure before this interview?
   In some cases the police may wish to take an interviewee by surprise by not alerting him in advance to some of the facts/issues. But does this really apply hear? The facts/issues affecting Dr Barton have been examined by several inquiries over recent years. Is it not a little fanciful to suppose that Dr Barton is not already well aware of the relevant facts/issues?
3. **What are the future stages in the investigation (up to and including any criminal trial)?**
   And what (as precisely as can currently be stated) is the timetable for these stages?
   In particular, when do you plan to interview Dr Barton?
   It is important that the GMC should have some guidance on the main future events and the rate of progress towards them.
4. **If Dr Barton were again to be referred to the GMC's Interim Orders Committee ("the IOC") what would you feel able to say in writing to the IOC regarding the speed of the investigation and the extent of the police's concerns about Dr Barton and the reasons for those concerns?**
   Would you or any colleague be prepared to attend the IOC meeting in order to provide information or answer questions orally? Consideration will soon be given to referring Dr Barton to the IOC. At the meeting on 27 February 2004 you expressed a willingness to help with information for this purpose. In order to decide whether there is sufficient new material to revert to the IOC, the GMC needs to know what you could say. It would be very helpful to see the wording for a draft statement.
5. **What information from its own investigation can the police disclose to assist the GMC's own inquiries?**

For example, could the police identify the 15-16 cases which have given its team of five experts most cause for concern? This would help to focus the GMC's inquiries.

6. **Which potential witnesses would the police object to the GMC approaching, which would it not object to and why?**
7. **Would the police object to the GMC seeking documents from bodies such as the Department of Health and the relevant NHS Trust?**
   If so, why?
8. **What problems has the police investigation encountered and what, if any, further problems are feared/anticipated?**
   The GMC would like to understand what are the reasons for the delay so far and what further problems might arise.
9. **Would any of your above answers be different if Dr Barton were permitted to prescribe opiates?**
   The top of the second page of your letter dated 6 October 2003 record your understanding that Dr Barton is not allowed to work at the Gosport War Memorial Hospital ("the GWMH") and is not authorized to prescribe opiates. In fact, there is no bar on Dr Barton doing either of those things. In respect of the first, Dr Barton resigned from the GWMH on 5 July 2000 but there is no legal bar on her returning there if she were to be offered a post. More importantly, in respect of the second, the GMC understands that in early 2002 Dr Barton gave the Health Authority a voluntary undertaking not to prescribe opiates or benzodiazepines but that this lapsed later in 2002 and has never been renewed. The GMC wonders whether this affects your view of the need to disclose information to the GMC.

In view of the delay that has already plagued this investigation (which the GMC understands first began in September 1998) and the GMC's enthusiasm to press on as much and as quickly as it possibly can with the pursuit of its fitness to practise procedures assisted by information from the police, I really must ask for your immediate response to these questions. The slow pace of progress in the police investigation has persuaded the GMC that it cannot any longer refrain from pursuing its inquiries: see Linda Quinn's letter dated 6 February 2004. It would very much prefer to do this in collaboration with the police and it is in that spirit that the above questions are put forward. **[Depending on how threatening or emollient the GMC wants to be, add a final sentence from the following suggestions or insert GMC's own preference or use a hybrid:**

- **"Accordingly, I suggest that we might usefully meet to identify a strategy for pushing this matter forward."**
- **"The GMC is very eager to ensure that it is taking all reasonable steps to protect the public. In this it currently considers that it is being more hindered than helped by the police. We should both try to rectify this."**
- **"The GMC is considering the options open to it (including litigation against the police) to push this matter forward and will, of course, take your responses into account when reviewing those options."**
- **"Such is the gravity with which the GMC views this matter generally, and the delay in the investigation particularly, that it is**

considering the use of litigation against the police in order to push things forward."

- "In the absence of a timely or satisfactory response, the GMC may [will?] have no option but to commence litigation in order to push things forward - such is the gravity with which it views this matter generally and the delay in the investigation particularly."

Yours sincerely,

Peter Steel

Director of Fitness to Practice

Code A

MARK SHAW Q.C.

Blackstone Chambers

14 June 2004

DR JANE BARTON

DRAFT LETTER TO POLICE

GENERAL MEDICAL COUNCIL
178 Great Portland Street
LONDON
W1W 5JE

Solicitor's ref: Peter Steel
Counsel's ref: BARTON – letter to police (14.6.4)

Code A

14 June 2004

THE EUROPEAN LEGAL ALLIANCE

Case Report
September 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is part of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~Low~~/Medium/~~High~~

THE EUROPEAN LEGAL ALLIANCE

Case Report
August 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is part of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~Low~~/Medium/~~High~~

THE EUROPEAN LEGAL ALLIANCE

Case Report
June 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is part of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

The Constabulary are providing updates as to the progress of the investigation.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~Low~~/Medium/~~High~~

THE EUROPEAN LEGAL ALLIANCE

Case Report
May 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Linda Quinn
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is part of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

The Constabulary are providing regular updates as to the progress of the investigation.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~Low~~/Medium/~~High~~

THE EUROPEAN LEGAL ALLIANCE

Case Report
April 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael ~~Keegan~~ Linda
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daedalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is part of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations:

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that could prejudice the criminal enquiries.

The Constabulary are providing regular updates as to the progress of the investigation.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: ***Prospects of Success:*** ~~Low~~/Medium/~~High~~

File Note
Dr J A Barton
2000/2047

Dr Barton is a GP who held a part-time clinical assistant role in elderly medicine at Gosport War Memorial Hospital (Daedalus and Dryad wards). The Hampshire Constabulary originally referred the information for this case.

The allegations concern high levels of opiate and sedative drugs prescribed and administered to elderly patients, often by syringe driver, most of whom were admitted for rehabilitative and not palliative care.

The Screener had already closed complaints about Dr Barton, failures of communication at the hospital and other matters from relatives, following local / Health Service Ombudsman's reviews with independent medical advise that raised no concerns, as follows:

Case Number	Patient	Relative
2000/0247/03	Mrs Purnell	Mike Wilson
2002/0553	Elsie Devine	Ann Reeves
2002/1345	Stanley Carby	Mrs R E Carby

2002/1608 This arose from the CHI report about the treatment of elderly patients between 1998 and 2001, which makes reference to 10 complaints to the Trust (which are either known or not of concern to us).

PPC considered matter on 29/08/2002 in relation to the following patients, whose names are shown alongside relatives with whom we have been in contact:

Patient	Relative
Eva Page	Bernard Page
Alice Wilkie	Emily Yeats (for her mother, Mrs M Jackson)
Gladys Richards	Gillian McKenzie
Arthur Cunningham	Charles Farthing
Robert Wilson	Iain Wilson

(FFW have been asked to advise on including the case of Mr Carby under Rule 11.)

Screening closed a case concerning patient Dulcie Middleton made by Marjorie Bulbeck.

IOC considered the case on 21 March 2002 and made no order.

Mike Gill, Regional Director of Public Health, took an early interest (as did the CMO) and suggested that the IOC reconsider the matter. The President subsequently referred the case to IOC, which considered it on 19/09/2002, but again made no order on the basis that no new material had come to light since its earlier decision. Simon Tanner of the Isle of White Health Authority then submitted a 'dossier' containing information about concerns raised by nursing staff about prescribing practices in the early 1990's that had, apparently, not been acted upon in any substantive way. Consideration was given to reverting to IOC but it was decided that they did not provide sufficient grounds for such a course (a view subsequently endorsed by Matthew Lohn at FFW).

The CMO commissioned a clinical audit of the hospital to be undertaken by Prof Richard Baker. Police indicated that this was not likely to be concluded in the near future.

Police inquiries, based on one case (Gladys Richards), were closed but then reopened, with an increasingly wide scope of inquiry with the backing of CPS counsel. Initially an additional four cases were considered and, in conjunction with Baker's audit, a larger number of deaths has, and is, being investigated. DCS Watts was appointed the Senior Investigating Officer following some criticism of the earlier SIO. FFW and I have had meetings with DI Nigel Niven and DS Owen Kenny.

A police investigation remains open and, hence, our inquiries are in limbo.

Judith Chrystie at FFW is dealing and has visited CHI, who conducted a review of the hospital, to obtain records of interviews, etc. that might be of use when we can progress our investigation (in the event that the police investigation does not result in a conviction).

All of the relatives of patients whose cases we are progressing are now represented by Messrs Alexander Harris. A number of the relatives were concerned that any GMC inquiry could potentially adversely effect on a criminal prosecution. I reassured them and then Alexander Harris that we had no intention of holding our inquiry until the criminal investigation had finished. Alexander Harris queried why we are dealing with this as an information case when the original concern was raised by relatives. I responded on 18/12/2002 that the information for this particular case (2002/2047) came from the Hampshire Constabulary.

The Police requested from FFW a number of documents, including a copy of the last IOC transcript, in which is recorded Dr Barton's explanation of events. I asked FFW to ask the Police to make their request formally so that consideration could be given to that at a senior level. The Police, in turn, asked FFW to formally request that ! Police have also formally requested that we stay proceedings until the resolution of the criminal investigation.

This case had been listed for PCC on 07/04/2003 but then removed from the list for the above reasons. If and when it is ready to be heard an initial pro-forma should be submitted.

Code A

THE EUROPEAN LEGAL ALLIANCE

Case Report
February 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:
The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daelalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that cannot prejudice the criminal enquiries.

Investigations

Meeting with case worker in order to provide an update as to the meeting with Hampshire Constabulary and the visit to the offices of the CHI.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~**Low**~~/**Medium**/~~**High**~~

THE EUROPEAN LEGAL ALLIANCE

Case Report
January 2003

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:
The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daelalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Matter now held in abeyance pending conclusion of a comprehensive investigation being pursued by Hampshire Constabulary into approximately 60 deaths. Constabulary have sanctioned investigations that cannot prejudice the criminal enquiries.

Investigations

Visiting offices of CHI in order to work through documents and statements held by the organisation following their own investigation. This investigation did not focus on prescribing habits or Dr Barton's conduct.

Meeting with officers from Hampshire Constabulary to further discuss matter and to receive an update regarding the progress of the police investigation.

Recommendation:

Continue to maintain watching brief over criminal investigations and request updates and to pursue investigations where and when appropriate to do so.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~**Low**~~**/Medium/**~~**High**~~

2000/2047
Dr J A Barton

Chronology for GMC case (to 18 May 2004)

27/07/00	Hampshire Constabulary notify GMC of allegation by Gladys Richards' family that she had been unlawfully killed as a result of treatment received at Gosport War Memorial Hospital and confirmed that Dr Barton appeared to be responsible for her care.
June 2001	IOC considered and made no order.
February 2002	CPS decide not to proceed with criminal case. Disclosure to GMC of Crown's papers which includeda report on the management of a further four patients at Gosport War memorial Hospital.
21 March 2002	IOC considered again, including the additional information on the four patients, and made no order.
29 August 2002	PPC considered and referred the five cases to PCC.
August 2002	Police send their case papers to CPS because of concerns by family members that there was no case to be raised against Dr Barton.
19 September 2002	IOC considered and made no order.
19 September 2002	Hampshire and Isle of Wight NHS Health Authority sent to GMC a file of correspondence relating to concerns about the use of diamorphone on patients in 1991. GMC consulted Matthew Lohn as to whether this merited a further referral to IOC.
9 October 2002	Matthew Lohn replies that "... Screeners would be *misdirecting themselves if, having seen the new papers,* they were to refer the matter for further consideration by the IOC".
September/October 2002	Police reopened their investigation and the GMC's investigation put on hold. Police decide to investigate all deaths of patients under Dr Barton's care at the Hospital.

30 September 2003	Police meet with Linda Quinn, GMC, and said that following a review by experts, the findings in respect of the patients' deaths were that 25% were optimal, 50% were sub-optimal but causation unclear, 25% cause of death unclear (all percentages approximate). Police asked whether the case would be reconsidered by IOC on the basis of this information, but would not agree to disclose any of their papers because they knew that GMC would have to disclose to doctor if the case were to go back to IOC.
October 2003	Matter referred to Screener, with all available information. Screener does not consider that it should go back to IOC.
7 January 2004	LQ requests update on progress from police.
28 January 2004	Police indicate that unable to provide further information at that point.
6 February 2004	LQ confirms to police that GMC inquiries on hold pending conclusion of their investigations.
February 2004	Paul Philip meets with CMO, at CMO's request, to discuss Barton case and Richard Baker's report (which PP had not seen in advance of meeting).
27 February 2004	Meeting between GMC (Paul Philip, Jackie Smith and Linda Quinn), Hampshire Constabulary (DCS Watts, DI Niven and one other) and FFW (Matthew Lohn). To summarise police's position, they were still investigating, did not know when the investigation would be complete, did not know when they would be ready to interview Dr Barton, and were not willing to give the GMC any information/evidence unless the GMC guaranteed not to pass it on to Dr Barton.
5 May 2004	Peter Steel wrote to Hampshire Constabulary.

THE EUROPEAN LEGAL ALLIANCE

Case Report
September 2002

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 2
Target date for completion of investigation:	6 January 2003
Interim Order Expires:	N/A

Summary:
The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daelalus and Dryad Wards at Gosport War Memorial Hospital. The allegations suggest that patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of five patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement.

Investigations

Papers considered by PPC analysed together with transcript of IOC hearing, documents relating to further complaints received at Screening Section and the Investigation report of CHI.

Case conference with the GMC.

Fax - and chasing fax – sent to Hampshire Constabulary requesting a meeting date and information regarding progress of investigations.

Recommendation:

Meet with Hampshire Constabulary.

Liaise with CHI regarding utilising aspects of their investigation – such as witness statements.

Contact relevant witnesses (after determining status of police investigations).

Retain expert.

Listing time estimate: 2-3 weeks.

Earliest date case may be listed: Matter provisionally listed for 7-25 April 2003.

Conclusions of Review Meeting:

Date of Next Review: ***Prospects of Success:*** ~~**Low/Medium/High**~~

Form Confirmation

Thank you for submitting the following information:

FPD_Case_Ref: 2000/2047
Caseworker: Michael Keegan
Doctor_Name: BARTON, Jane Ann
Provisional_Listing_Date: 17 March 2003
Current_Employer:
Duration: 15 days
Location_Practise: Hampshire
Council_S_Firm: FFW
Council_S_Name: Judith Christie
Council_S_Reference:
Defence_S_Firm: MDU
Defence_S_Name: Ian Barker
Defence_S_Reference:
Defence_S_Add_Info:
Amber:
Submit_B: Submit

Correspondence_Add

see IRS

New_IOC_Hearings

Other_Changes

Please relist for 15 days beginning 7 April 2003.

Case_Summary

inappropriate/irresponsible prescribing

Return to the form.

2000/2047
Dr Jane Barton

Date of PPC referral to PCC: 28 August 2002

Considered by IOC on three occasions – June 2001, March 2002 and September 2002 – no order made

GMC solicitors: None at present

The GMC's case against Dr Barton began in July 2000 following referral by the Hampshire Constabulary which had started an investigation into the circumstances surrounding the death of Gladys Richards, a geriatric patient at Gosport.War Memorial Hospital. The police investigation was subsequently extended to four other deaths, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

In February 2002, the Crown Prosecution Service decided against a criminal prosecution. At this point the relevant papers were disclosed to the GMC to decide on any issues of serious professional misconduct or seriously deficient performance. In August 2002, the case was referred by the GMC's Preliminary Proceedings Committee for hearing before the Professional Conduct Committee ('PCC').

The case has been referred to IOC on 3 occasions (June 2001, March 2002 and September 2002) for consideration of whether Dr Barton's registration should be restricted prior to hearing before the PCC.

On 28 May 2002, Mrs Mackenzie (daughter of the late Gladys Richards) wrote to the GMC. She copied the letter to David Blunkett MP, Hampshire Constabulary, Nigel Waterson MP, Peter Viggers MP, the Police Complaints Authority, the CPS and David Parry of Treasury Counsel. She was concerned about the failures of the police investigation. As a result, the police investigation was reopened. In July 2002, the then Commission for Healthcare Improvement published a report entitled "Gosport War Memorial Hospital Investigation into the Portsmouth Healthcare NHS Trust". The report did not name Dr Barton specifically, but referred to the criminal investigations and criticised the systems in place at the time.

On 30 July 2002, Mrs Mackenzie informed the GMC that the police were seeking advice from the CPS about the investigations and as a result were reconsidering the 5 cases. In November/December 2002, following discussions between the police and the CPS, it was decided that the police investigation should be continued and expanded, and FFW was asked to consider postponing the PCC hearing (which at that point was anticipated to take place in April 2003). Accordingly the case was removed from the GMC's lists.

On 30 September 2003, I met with the police who reported that the review of all the deaths of patients under Dr Barton's care at the hospital had suggested that the treatment of some 15 or 16 fell into the category of "negligence, cause of death unclear". At that point, the police anticipated interviewing Dr Barton, once a second team of experts had reviewed these cases, which they believed would be January 2004. They indicated that they were unable to provide full details of their

investigation, as this could jeopardise further investigations and the proposed interview of Dr Barton.

Until end September 2003, the GMC had been represented by FFW in this matter. However as Matthew Lohn had by that time been appointed by the police to assist in the quality control check on the experts findings, FFW withdrew from the GMC side to avoid and conflict of interest.

On 2 October 2003, I wrote to the police indicating that the GMC was considering referring Dr Barton's case yet again to the Interim Orders Committee and requesting a detailed written summary of the evidence they had obtained, including any report prepared by the team of experts. The police replied on 6 October 2003, confirming the content of their discussions with me on 30 September 2003 and stating: *"... our primary concern always is the safety of the public. That said, we are also expected to investigate serious allegations such as those involved here in a professional and ethical manner. We therefore have to strike a balance between conducting our investigation in the appropriate fashion whilst realistically assessing the risk to public. Put simply, our ability to disclose information would need to be based on an assessment of the risk that was presented now by Dr Barton."*

A Medical Screener of the GMC again considered the case with a view to referring Dr Barton to the Interim Orders Committee in November 2003. However, the Screener felt that as a result of the lack of new evidence, the IOC would come to the same decision as previously.

On 7 January 2004, I wrote to the police, asking for an update on progress. They replied on 28 January 2004, indicating that they were unable to provide any further information at that point.

I wrote again on 6 February 2004 saying that the GMC had no further information about the case and that the GMC's inquiries were on hold pending conclusion of the police investigations.

On 27 February 2004 there was a meeting between the GMC (Paul Philip, Jackie Smtih and LQ), Hampshire Constabulary (DCS Watts and DI Niven) and FFW (Matthew Lohn). A summary of the police's position is that they were still investigating, did not know when the investigation would be complete, did not know when they would be ready to interview Dr Barton, and were not willing to give the GMC any of the information they have so far unless we guarantee not to pass it on to the doctor (which they know we cannot guarantee).

At Paul's request, Peter Steel wrote to the Hampshire Constabulary on 5 May 2004 setting out our position and asking when they think their investigations will be concluded, with what result, and to reconsider whether there is any information they can release to us now.

There is a patients' group in connection with Dr Barton's case, and it is represented by Alexander Harris.

Linda Quinn
7 May 2004

THE EUROPEAN LEGAL ALLIANCE

Case Report

November/December 2002

Doctors name:	Dr Jane BARTON
GMC case reference:	2000/2047
GMC case worker:	Michael Keegan
Instructed Solicitor:	Judith Chrystie
Date of Rule 6 letter:	11 July 2002
Date of PPC:	29/30 August 2002
Date IIS issued/FFW Instructed:	23 September 2002
Class of Case (1-5)	Class 4
Target date for completion of investigation:	6 January 2003 – case now to be held in abeyance
Interim Order Expires:	N/A

Summary:

The allegations relate to excessive and irresponsible prescribing by Dr Jane Barton – a general practitioner who provided care to elderly patients on the Daelalus and Dryad Wards at Gosport War Memorial Hospital.

The allegations suggest that five patients may have died owing to excessively high doses of opiate and sedative drugs being prescribed. Dr Barton's management of patients is the subject of an enquiry by Hampshire Constabulary and an investigation by the Commission for Health Improvement (CHI).

Investigations

Lengthy meeting with officers from Hampshire Constabulary. Constabulary indicated the nature of the ongoing criminal enquiry had expanded beyond the five patients considered by the PPC. The investigations may include analysis of over 600 deaths. The officers informally requesting that the GMC stayed its proceedings pending the outcome of the criminal enquiries. Permission provided for FFW to visit CHI in order to review the documents held by the Commission but take no further action.

Visit arranged to review statements and papers held by CHI for 14/15 January 2003. Copies of a number of documents appearing in the appendices to the CHI report requested.

Recommendation:

Review documents held by CHI and hold matter in abeyance until conclusion on the criminal enquiries.

Listing time estimate: Unknown.

Earliest date case may be listed: Unknown.

Conclusions of Review Meeting:

Date of Next Review: **Prospects of Success:** ~~Low~~/Medium/~~High~~

Dr Jane BARTON

Analysis concerning cases that have previously been seen by the GMC

Patient Name	Expert/Police information	Seen by IOC/PPC (inc. date)
Eva Page	• Expert Report – Dr Mundy • Expert Report – Professor Ford	PPC (30/8/02) IOC (19/9/02)
Alice Wilkie	• Expert Report – Dr Mundy • Expert Report – Professor Ford	PPC (30/8/02) IOC (19/9/02)
Gladys Richards	• Expert Report - Prof. Livesley • Expert Report – Professor Ford • Police Statement – Jane Barton • Police Interview – Dr Althea Lord (Consultant at Gosport War Memorial Hospital) • Police Interview – Philip Beed (Clinical Manager at Gosport War Memorial Hospital)	PPC (30/8/02) IOC (19/9/02) IOC (21/3/02) IOC (19/9/02)
Arthur Cunningham	• Expert Report – Dr Mundy • Expert Report – Professor Ford	PPC (30/8/02) IOC (19/9/02)
Robert Wilson	• Expert Report – Dr Mundy • Expert Report – Professor Ford	PPC (30/8/02) IOC (19/9/02)

Category 2 cases where expert evidence indicates that it may be properly arguable that Dr Barton's alleged conduct is capable of constituting spm

Patient Name	Expert/Police information	Seen by IOC/PPC (inc. date)
Victor Abbatt		
Dennis Amey		
Charles Batty		
Dennis Brickwood		
Charles Hall		
Catherine Lee		
Stanley Carby		
Walter Clissold		
Harry Hadley		
Alan Hobday		
Eva Page	• Expert Report – Peter Lawson	PPC (30/8/02) IOC (19/9/02)
Gwendoline Parr		
Edna Purnell		
Daphne Taylor		

GENERAL

TELEPHONE MESSAGE PAD

FROM .....

TO .....

TIME/DATE .....

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

File Note

Rec'd a call from Inspector Mark Wise, Hampshire police re Barton. Calling on behalf of Deputy Chief Constable who is meeting relatives of patients who died under her care this pm.

I confirmed in strict confidence that Dr Barton had been referred to PCC - stressed that letters not yet sent + relatives must NOT be told.

Case to be handled by Superintendant Paul Stickler Code A

Code A

11/9

Message taken by .....

Linda Quinn Code A

From: Paul Philip Code A
Sent: 15 Mar 2004 15:52
To: Linda Quinn Code A Jackie Smith Code A
Subject: Re: Dr Barton

Linda,

Thank's for this. Could you chase up Mary in relation to her writting the letter I wanted to send to the police.

Thanks

Paul

Sent from my BlackBerry Wireless Handheld

-----Original Message-----
From: Linda Quinn Code A
To: Paul Philip Code A Jackie Smith Code A
Code A
Sent: Mon Mar 15 15:16:00 2004
Subject: Dr Barton

Paul, Jackie

I have checked the Barton files to ascertain what we know about Dr Barton having made a voluntary undertaing not to prescribe opiates and benzodiazepines. From our information, it does not appear that she is subject to any undertaking at present, although she has been in the past, as follows:

We have a copy of a letter from Dr Old, Acting Chief Exec of the Health Authority, to Dr Barton, dated 13 February 2002, in which it is noted that Dr Old and Dr Barton had agreed on 12 February 2002 that she "would voluntarily stop prescribing opiates and benzodiazepines with immediate effect" and that "We were unable to put a timescale on these restrictions but agreed to review the situation monthly." On 21 March 2002 Dr Barton confirmed to IOC under oath that she was "not prescribing any opiates or benzodiazepines at the moment".

At IOC in September 2002 Dr Barton's counsel informed the Committee that Dr Barton "continues to work full time as a GP subject to other matters. She does not routinely prescribe benzodiazepines or opiates." Counsel then referred to the condition Dr Barton had previously agreed with the Health Authority and said that the HA had lifted the condition. He then noted that that was the only change in Dr Barton's circumstances since March 2002.

We have had not information on this prescribing point since the last IOC meeting in September 2002.

However I have recently clarified with Fareham and Gosport PCT Dr Barton's relationship with the Gosport War memorial Hospital. They have confirmed that Dr Barton was never an employee of the hospital, but that her GP practice is part of a bed fund (enabling local GP practices to admit their patients for appropriate care, supervised by the GP and paid for by the PCT. Approximately 19 months ago Dr Barton agreed voluntarily not to admit patients to the hospital nor supervise any patients n the hospital, and this is the current position.

I will confirm to the police that Dr Barton has not made any voluntary undertaking to the GMC.

Linda

HAMPSHIRE Constabulary

Chief Constable Paul R. Kernaghan CBE QPM LL.B MA

CONFIDENTIAL

Our Ref. : Operation Rochester
Your Ref. :

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

Tel: 0845 045 45 45
Direct Dial: Code A
Fax: 023 9289 1663
Email:

25 November 2005

Mr.Paul Hylton.
General Medical Council,
Regents Place,
350,Euston Road,
London.
NW15JE

Dear Paul,

Please find enclosed the contact details for the family group members in relation to the patient files delivered to you on 21st November 2005.
For your information, Mr Leslie Hall did not wish for any police action to be taken and Miss Margaret Brennan had no concerns about her mother's treatment.

Yours sincerely,

Code A

Kate Robinson.
DC424
Operation Rochester.

CONFIDENTIAL

DECEASED.	FAMILY GROUP MEMBER.	ADDRESS.
Dorothy VINCE	Mrs. Jean MATTHEWS Daughter	
Norah HALL	Mr. Leslie HALL Son	
Jack WILLIAMSON	Mr. Ian WILLIAMSON Son	
Ivy WILLIAMSON	As Above	
Eileen HILLIER	Mrs Doris RHODES Sister	**Code A**
Alice CLIFFORD	Mr Alan CLIFFORD Son	
Ellen BAKER	Mrs Ann TUFFNELL Daughter	
Hubert CLARKE	Mrs Rose Marie THOMPSON Daughter	
Mary GERMAN	Mrs Marie EARLE Daughter	

Kathleen ELLIS	Mr David ELLIS Son	
Dulcie MIDDLETON	Mrs Marjorie BULBECK Daughter	
Frank WALSH	Mr Roy WALSH Son	
Francis MIDFORD-MILLERSHIP	Mr. Barry MIDFORD-MILLERSHIP Son	
Lilly ATTREE	Mrs Gail BRAGGINGTON Daughter	**Code A**
Ronald CRESDEE	Mr Jack CRESDEE Son	
Albert HOOPER	Mrs Ann RAY Daughter	
Stanley MARTIN	Mr Ernest MARTIN Son	
Walter WELLSTEAD	Mr Timothy WELLSTEAD Son	
Walter WELLSTEAD	Mrs Gillian EVERTS Daughter	

Irene BRENNAN	Miss Margaret BRENNAN Daughter	Fl. 7, 48, Bury Rd, Gosport, Hampshire. PO123UB.

HAMPSHIRE Constabulary

Chief Constable Paul R. Kernaghan CBE QPM LL.B MA

CONFIDENTIAL

Our Ref. : Operation Rochester
Your Ref. :

Fareham Police Station
Quay Street
Fareham
Hampshire
PO16 0NA

Tel: 0845 045 45 45
Direct Dial: Code A
Fax: 023 9289 1663
Email: Code A

Mr Paul Hylton
General Medical Council,
Regents Place,
350,Euston Road,
London.
NW15JE

04 October 2005

Dear Paul,

Please find enclosed the contact details for the family group members in relation to the patient files delivered to you on 16th December2004.

I have not includeded the details relating to Catharina ASKEW, they are as follows.

Mr. Michael ASKEW, Code A

Yours sincerely,

Code A

DC424
Operation Rochester.

CONFIDENTIAL

DECEASED.	FAMILY GROUP MEMBER.	ADDRESS.
Edith AUBREY	Mrs. Margaret BARNEY Daughter	
Henry AUBREY	As above	
Doreen COX	Mr. Fredrick COX Spouse	
Joan RAMSEY (Alive)	Mrs Frances WELLS. Daughter	
Elizabeth ROGERS	Mrs.Diane DAVIES Daughter	
Sylvia TILLER	Mrs Josephine TICKNER Daughter	
Alice WILKIE	Mrs Marilyn JACKSON Daughter	
James CORKE	Mrs P. SARGINSON Daughter	
Mary Ann COX	Miss Aideen DARCY Niece	

Code A

Dorothy STANDFORD	Mrs Mildred HART Daughter
Norman WILLIS	Mrs Carole WILLIS Wife
Margaret BURT	Mr Ian BURT Grandson
Vera MILLER	Mrs Pauline CASTLE Daughter
Mable LEEK	Mrs June USHER Daughter
Euphemia SKEENS	Mr McLEAN SKEENS Son
Rhoda MARSHALL	Mr Michael ROBINSON Nephew
Pamela BROWN	Mrs Doris WATSON Sister
Harry DUMBLETON	Mrs Lila DUMBLETON Spouse
Wilfred HARRINGTON	Mr Richard HARRINGTON Son
Horace SMITH	Mr Alan SMITH Son

Code A

Mary DONAGHUE	Mrs Sharon HERRIDGE. Daughter
Mary BENSON	Mrs Mary ADAMS Daughter
Olive CRESDEE	Mr Jack CRESDEE Son
Joan HURNELL	Mrs Gill HURNELL Daughter
Frank HORN	Mr Ewart COLYER Son in law
Phyliss HORNE	Mr Anthony HORNE Son

Code A

Print Document | Close

ipcc independent police complaints commission

21 October 2005
For Immediate Release

IPCC Publically apologises to six complainants

The Independent Police Complaints Commission has today issued an apology to six complainants, who complained in 2002 about an investigation by Hampshire Police.

The complaints were against the investigation by Hampshire Police of allegations of unlawful killing against Gosport War Memorial Hospital. The case was inherited by the IPCC from the Police Complaints Authority when it was set up on 1 April 2004.

[redacted] deputy chair John Wadham said: "The usual high standards that the Commission has set itself have not been applied in this case and I wish to publicly apologise to the complainants for that.

"There have been a number of problems with the way that this case has been handled, not least the unacceptable length of time it has taken.

"I have also today offered to meet with all the complainants with IPCC Commissioner Rebecca Marsh, who has recently been given responsibility for this case.

"We will assure the complainants that the IPCC will now move quickly to deal with their complaints.

"Rebecca Marsh will also be reviewing the handling of this case."

-ends-

Notes for editors

[redacted]

- The IPCC is the body with overall responsibility for the police complaints system in England and Wales. It has the task of increasing public confidence in the system and aims to make complaints investigations more open, timely, proportionate and fair. The 17 IPCC Commissioners guarantee the independence of the IPCC and by law can never have served as police officers.
- Since April 1 2004 the IPCC has used its powers to begin 62 independent and 222 managed investigations into the most serious complaints against the police. It has also set new standards for police forces to improve the way the public's complaints are handled. Since 1 April 2004 it has upheld 363 appeals (out of 1102 valid appeals) by the public about the way their complaint was dealt with by the local force.
- The IPCC is committed to getting closer to the communities it serves. It has regional offices in Cardiff, Coalville, London and Sale plus a sub office in Wakefield. Commissioners are regionally based and supported by 84 independent investigators, as well as case workers and specialist support staff.
- The IPCC web site is constantly updated at www.ipcc.gov.uk or members of the public can contact the IPCC on 08453 002 002.

For further information please contact:

David Nicholson, IPCC Press Officer on 020 7166 3250 or the out-of-hours duty press officer on Code A

MG

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

Home Address:

Post Code :

Home Telephone No: **Mobile / Pager No:**

E-Mail Address *(if applicable and witness wishes to be contacted by e-mail)*:

Contact Point *(if different from above)*:

Address:

Work Telephone No:

Male ☐ **Female** ☐ **Date and Place of Birth:** Place

Maiden name: **Height:** **Ethnicity Code:**

State dates of witness non-availability:

I consent to police having access to my medical record(s) in relation to this matter	**Yes** ☐ **No** ☐ **N/A** ☐
I consent to my medical record in relation to this matter being disclosed to the defence	**Yes** ☐ **No** ☐ **N/A** ☐
The CPS will pass information about you to the Witness Service so that they can offer help and support, unless you ask them not to. Tick this box to decline their services.	☐

Does the person making this statement have any special needs if required to attend court and give evidence? *(e.g. language difficulties, visually impaired, restricted mobility, etc.).* **If 'Yes', please enter details.**	**Yes** ☐ **No** ☐
Does the person making this statement need additional support as a vulnerable or intimidated witness? If 'Yes', please enter details on Form MG2.	**Yes** ☐ **No** ☐
Does the person making this statement give their consent to it being disclosed for the purposes of civil proceedings *(e.g. child care proceedings)*?	**Yes** ☐ **No** ☐

Statement taken by *(print name)*: SWA

Station: HQ

Time and place statement taken:

Signature of witness:

Code A

Signed : S.A.WATTS. Signature witnessed by : ~/1.

MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

Age if under 18: *(if over 18 insert 'over18')* **Occupation:** Police Officer

This statement (consisting of 11 page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature: Code A **Date:** 30TH September 2004.

Tick if witness evidence is visually recorded ☐ *(supply witness details on rear)*

I am Detective Chief Superintendent Steven WATTS, Head of Hampshire Constabulary Criminal Investigation Department and am the senior investigating officer in respect of a police investigation named 'Operation ROCHESTER', an investigation into the circumstances surrounding of death of 88 patients occurring principally during the late 1990's at Gosport War Memorial Hospital, Hampshire.

This investigation followed allegations that during the 1990's elderly patients at Gosport War Memorial Hospital received sub optimal or sub- standard care, in particular with regard to inappropriate drug regimes, and as a result their deaths were hastened.

The strategic objective of the investigation is to establish the circumstances surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service (CPS), to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths.

During the investigation, a number of clinical experts have been consulted.

MG1

HAMPSHIRE CONSTABULARY

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WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

On the 9th November 2000 Professor Brian LIVESLY reported on the death of a patient, Mrs. RICHARDS.

On the 12th February 2001 Professor FORD reported in respect of the deaths of five patients RICHARDS, CUNNINGHAM, WILKIE, WILSON and PAGE

On the 18th October 2001 Professor MUNDY reported on the deaths of patients CUNNINGHAM, WILKIE, WILSON and PAGE.

The aforementioned reports have all previously been made available to the General Medical Council.

Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths, and concluded that, "a number of factors contributed to a failure of trust systems to ensure good quality patient care".

Between September 2002 and May 2004 the cases of 88 patients including those named above, at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxicology, general medicine, palliative care, geriatrics and nursing.

Signed : Code A

Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of: STEVEN ALEC WATTS

All the cases examined were elderly patients (79 to 99yrs of age) theirs deaths occurring at Gosport War Memorial hospital between January 1996 and November 1999. A common denominator in respect of the patient care is that many were administered Opiates authorized by Dr Jane BARTON prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patients concerned, examining in detail patient records, and to attribute a 'score' according to their findings against agreed criteria. A further group of cases were included in this review following a report by Dr BAKER, commissioned by the Chief Medical Officer. That report is confidential to the CMO and may not be discussed further without his agreement.

The team of experts has 'scored' the cases as follows.

Category one- **There were no concerns in respect of these cases upon the basis that 'optimal care' had been delivered to patients prior to their death.**

Category two - **Specific concerns that these patients had received 'sub optimal' care.**

These cases are currently undergoing a separate quality assurance process by a medico legal expert to confirm their 'rating'. Nineteen of these cases that have been 'confirmed', have been formally released from police investigation and handed to the General Medical Council for their consideration. A number of cases

Signe Code A Signature witnessed by :

MG

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.

Category three **Patient care in respect of these cases has been assessed as 'negligent, that is to say outside the bounds of acceptable clinical practice'.**

The police investigation into these cases is, therefore continuing.

The five experts commenced their analysis of patient records in February 2003. It is anticipated that their work will be finalized in October 2004 as will the quality assurance process by the senior medico legal expert.

As part of the ongoing investigative strategy, since May 2004 a further tier of medical experts, in Geriatrics and Palliative Care have been instructed to provide an evidential assessment of the patient care in respect of in the 'Category three' cases. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service.

At the same time, the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness/suspect interviews, deal with exhibits, complete disclosure schedules, and populate the major crime

Signed : Code A

Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

investigation 'Holmes' system a national police IT application used to record and analyze information relating to serious/complex police investigations.

To date 330 witness statements have been taken and 349 officer's reports created. 1243 'Actions' have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of the Hampshire Constabulary.

Whilst investigations will be fully completed in respect of all of the 'Category three' cases, a small number of sample cases have been selected and work is being prioritized around those with a view to forwarding papers to the CPS as soon as possible by way of expedition. Timescales for this action are clearly dependant upon completion of expert review of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process,

In the event that there is considered a sufficiency of evidence to forward papers to the CPS, it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.

I understand that the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Order Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee.

Signed : Code A

Signature witnessed by : _____

MG

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

In my view, this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professionals involved in this enquiry.

Police investigative interviewing operates from seven basic principles, which are laid out in Home Office Circular 22/1992. The first of these being that

"Officers seek to obtain accurate and reliable information from suspects, witnesses or victims in order to discover the truth about matters under police investigation."

Investigative interviewing should be approached with an open mind. Information obtained from a person who is being interviewed should always be tested against what the interviewing officer already knows or what can be reasonably established.

This investigation is currently following various lines of enquiry seeking to establish whether or not any criminal offence has been committed. At present it has not been established that this is the case or in fact whether or not any person is potentially culpable. Once an individual has been identified then decisions have to be made as to what they need to be interviewed about and what information it is proper to disclose to that person prior to their being interviewed.

Decisions as to what the police have to disclose prior to interviews under caution are covered by various aspects of case law, in particular R v Argent (1997). The court commented in this case that the police have

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WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

no obligation to make disclosure. In R v Imran and Hussein (1997) the court agreed that it would be wrong for a defendant to be prevented from lying by being presented with the whole of the evidence against him prior to interview.

[redacted] v Mason (1987) covers disclosing or withholding information, the process must be justifiable and conducted in the full knowledge of the likely consequences. These consequences could affect not only any subsequent interview but also potentially the whole investigation and any subsequent trial.

Article 6 Human Rights Act deals with the right of an individual facing criminal charge to have a fair and public hearing

Advance disclosure of documentation prior to interviews under caution gives any potential suspect the [redacted]pportunity to interfere with the interviewing of other witnesses who may have information beneficial to the case.

Furthermore the suspect does not have the opportunity to respond to questioning in an uncontaminated way. They may well respond with answers that they think the police wish to hear. This is unfair to the individual concerned.

Finally early disclosure of material can lead to a suspect fabricating a defence or alibi.

Signed : Code A

Signature witnessed by : _____

MG

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

The Police have an over riding responsibility to conduct an effective and ethical investigation and a have a legal and moral duty to be scrupulously fair to suspects. In addition the police carry an additional responsibility to representing the interests of the victims of crime and society in general. Therefore to provide a guilty suspect with the ability to fabricate a defence around police evidence does not serve those wider interests.

As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case.

I understand that there is a voluntary agreement in place between Dr BARTON and the Fareham and Gosport Healthcare Trust of November 2002, the following is a quotation from an e mail message to the investigation from the trust in respect of that matter.

'Dr BARTON has undertaken not to prescribe benzodiazepines or opiate analgesics from the 1st October 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.

Dr Barton will not accept any house visits if there is a possible need for such drugs to be prescribed.

Problems may arise with her work for Health-call as a prescription may be required for a 14 day supply of benzodiazepines for bereavement.

Dr BARTON also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patient's notes.

Signed Code A Signature witnessed by : _____

MG11T

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of: STEVEN ALEC WATTS

During a 13month periods from April 2003 Dr BARTON had written a total of 20 prescriptions all for 2mg diazepam to relatives of deceased and had not prescribed any diamorphine, morphine or other controlled drug.'

[redacted] have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim order committee during September 2002.

Arthur CUNNINGHAM - this has been assessed as a category three case and is being investigated accordingly.

Robert WILSON - again a category three case.

Gladys RICHARDS.- Assessed as a category two case by the clinical team, this assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004.

[redacted] Alice WILKIE. – No further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points;

1. There is no admissible evidence at this time of criminal culpability in respect of any individual.
2. The information adduced by the investigation thus far, and the findings of the experts lead me to have concerns that are such that, in my judgment the continuing investigation and the high level of resources being applied to it are justified.

Signed Code A

Signature witnessed by : _____

MG

HAMPSHIRE CONSTABULARY

RESTRICTED – For Police and Prosecution Only

WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

Code A

Code A S.A.WATTS.

Signature witnessed by : _____

Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Tel: 01329 233447
Fax: 01329 234984

Direct Line: Code A
Direct Fax:

Mr Paul Hylton
Assistant Registrar
General Medical Council
2nd Floor, Regents Place
350 Euston Road
London
NW1 3JN

25th November 04

Dear Mr Hylton

RE: Dr Jane Barton

I have met with Dr Barton on three occasions since October 2002 in order to examine the prescribing data supplied by the Prescription Pricing Authority (PPA). At our last meeting, we looked at the data for benzodiazepine and opiate prescribing from October 2002 until August 2004. The PPA records prescribing data according to the named GP on the bottom of the prescription form NOT the GP signing the form. Consequently, a number of prescriptions were attributed to Dr Barton, which had been initiated by another partner. Dr Barton has agreed to take certain actions, following our last meeting, the details of which are included in the report.

I am enclosing copies of the PPA data, together with graphs and the reports of our meetings. If I can be of any further help, please contact me.

Yours sincerely

Code A

Hazel Bagshaw
Pharmaceutical Adviser

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton Oct 2002 - March 20

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Diazepam_Tab 5mg	2	60.0	£2.29
October 2002	Diazepam_Tab 5mg	1	28.0	£0.55
October 2002	Diazepam_Tab 5mg	1	56.0	£1.07
October 2002	Diazepam_Tab 2mg	2	60.0	£2.11
October 2002	Diazepam_Tab 2mg	1	28.0	£0.51
October 2002	Diazepam_Tab 5mg	1	30.0	£0.59
October 2002	Temazepam_Tab 10mg	1	56.0	£1.65
October 2002	Lorazepam_Tab 1mg	1	28.0	£1.16
October 2002	Diazepam_Oral Soln 2mg/5ml S/F	1	200.0	£2.64
October 2002	Diazepam_Tab 10mg	1	60.0	£1.65
October 2002	Nitrazepam_Tab 5mg	1	60.0	£1.61
October 2002	Nitrazepam_Tab 5mg	1	56.0	£1.51
October 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Diazepam_Tab 5mg	1	28.0	£0.55
December 2002	Diazepam_Tab 5mg	1	60.0	£1.15
December 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Temazepam_Tab 20mg	1	30.0	£1.50
January 2003	Diazepam_Tab 2mg	2	28.0	£1.02
January 2003	Diazepam_Tab 2mg	1	56.0	£0.98
January 2003	Temazepam_Tab 20mg	1	28.0	£1.41
February 2003	Diazepam_Tab 2mg	3	28.0	£1.52
February 2003	Temazepam_Tab 10mg	1	56.0	£1.62
March 2003	Diazepam_Tab 5mg	1	6.0	£0.14
March 2003	Diazepam_Tab 5mg	2	28.0	£1.11
		30		***£31.13***

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton 2003-4

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
May 2003	Diazepam_Tab 2mg	1	28.0	£0.51
May 2003	Diazepam_Tab 10mg	1	60.0	£1.65
June 2003	Diazepam_Tab 2mg	1	28.0	£0.51
June 2003	Diazepam_Tab 2mg	1	6.0	£0.13
June 2003	Temazepam_Oral Soln 10mg/5ml S/F	1	100.0	£3.01
June 2003	Diazepam_Tab 5mg	2	28.0	£1.11
July 2003	Diazepam_Tab 2mg	1	28.0	£0.51
July 2003	Diazepam_Tab 10mg	1	60.0	£1.65
September 2003	Chlordiazepox HCl_Cap 5mg	1	52.0	£1.96
October 2003	Diazepam_Tab 2mg	1	28.0	£0.51
October 2003	Diazepam_Tab 2mg	1	10.0	£0.20
October 2003	Diazepam_Tab 5mg	1	10.0	£0.22
November 2003	Diazepam_Tab 2mg	1	21.0	£0.39
November 2003	Diazepam_Tab 2mg	1	28.0	£0.51
November 2003	Diazepam_Tab 5mg	1	60.0	£1.15
December 2003	Diazepam_Tab 2mg	1	28.0	£0.51
February 2004	Diazepam_Tab 2mg	2	28.0	£1.02
February 2004	Diazepam_Tab 5mg	1	56.0	£1.08
		20		*£16.63*

Based on the Selections:

1st Quarter 2003/2004,
2nd Quarter 2003/2004,
3rd Quarter 2003/2004,
4th Quarter 2003/2004
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton April - August 200

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Diazepam_Tab 2mg	1	28.0	£0.51
April 2004	Lorazepam_Tab 1mg	1	28.0	£1.16
May 2004	Diazepam_Tab 2mg	1	60.0	£1.06
May 2004	Nitrazepam_Tab 5mg	1	56.0	£1.53
June 2004	Diazepam_Tab 2mg	1	60.0	£1.06
June 2004	Diazepam_Tab 2mg	1	28.0	£0.51
June 2004	Diazepam_Tab 5mg	3	14.0	£0.88
July 2004	Diazepam_Tab 5mg	2	14.0	£0.59
July 2004	Temazepam_Tab 10mg	1	56.0	£1.75
August 2004	Diazepam_Tab 2mg	1	28.0	£0.51
		13		*£9.56*

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

Prescribing Report Opiates Dr Barton Oct 2002 - March 2003

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
October 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
October 2002	Tramadol HCl_Cap 50mg	1	30.0	£2.76
October 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£8.52
October 2002	Tramadol HCl_Cap 50mg	1	90.0	£8.22
November 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
November 2002	Codeine Phos_Tab 30mg	1	60.0	£2.82
December 2002	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.43
December 2002	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.64
December 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
December 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
December 2002	Tramadol HCl_Cap 50mg	1	100.0	£9.36
January 2003	Codeine Phos_Tab 30mg	1	60.0	£2.82
January 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
January 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
January 2003	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
January 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.74
February 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
February 2003	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.63
February 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
February 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.93
March 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
March 2003	Tramadol HCl_Tab 100mg M/R	2	60.0	£32.88
March 2003	Tramadol HCl_Cap 50mg	2	60.0	£11.26
March 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.58
March 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.43
		29		*£200.48*

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,

NHS

Prescription Pricing Authority

Prescribing Report Opiates Dr Barton 2003-4

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
April 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.42
May 2003	Codeine Phos_Tab 30mg	2	60.0	£5.65
May 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
May 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
May 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
June 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
June 2003	Mst Continus_Tab 10mg	1	120.0	£10.96
June 2003	Mst Continus_Tab 60mg	1	60.0	£25.63
June 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£3.20
June 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.68
June 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
July 2003	Codeine Phos_Tab 30mg	1	240.0	£11.19
July 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
July 2003	Codeine Phos_Tab 30mg	2	60.0	£5.44
July 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.93
July 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
August 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
August 2003	Dihydrocodeine Tart_Tab 30mg	1	40.0	£1.97
September 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
September 2003	Morph Sulph_Tab 15mg M/R	1	42.0	£6.75
September 2003	Zydol_Cap 50mg	1	60.0	£9.14
September 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.74
September 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
September 2003	Codeine Phos_Tab 30mg	2	60.0	£5.42
October 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.14
October 2003	Meptazinol HCl_Tab 200mg	1	60.0	£10.72
October 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.37
October 2003	Codeine Phos_Tab 30mg	1	60.0	£2.84
November 2003	Tramadol HCl_Cap 100mg M/R	1	28.0	£6.95
November 2003	Tramadol HCl_Cap 50mg	1	84.0	£7.87
November 2003	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.79
December 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
December 2003	Codeine Phos_Tab 30mg	2	60.0	£5.46
January 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
January 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
February 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
February 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
February 2004	Dihydrocodeine Tart_Tab 30mg	1	180.0	£5.77
February 2004	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.76
March 2004	Codeine Phos_Tab 30mg	1	60.0	£2.62
March 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.38
March 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90

52 £340.81

Based on the Selections:

Financial 2003/2004
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

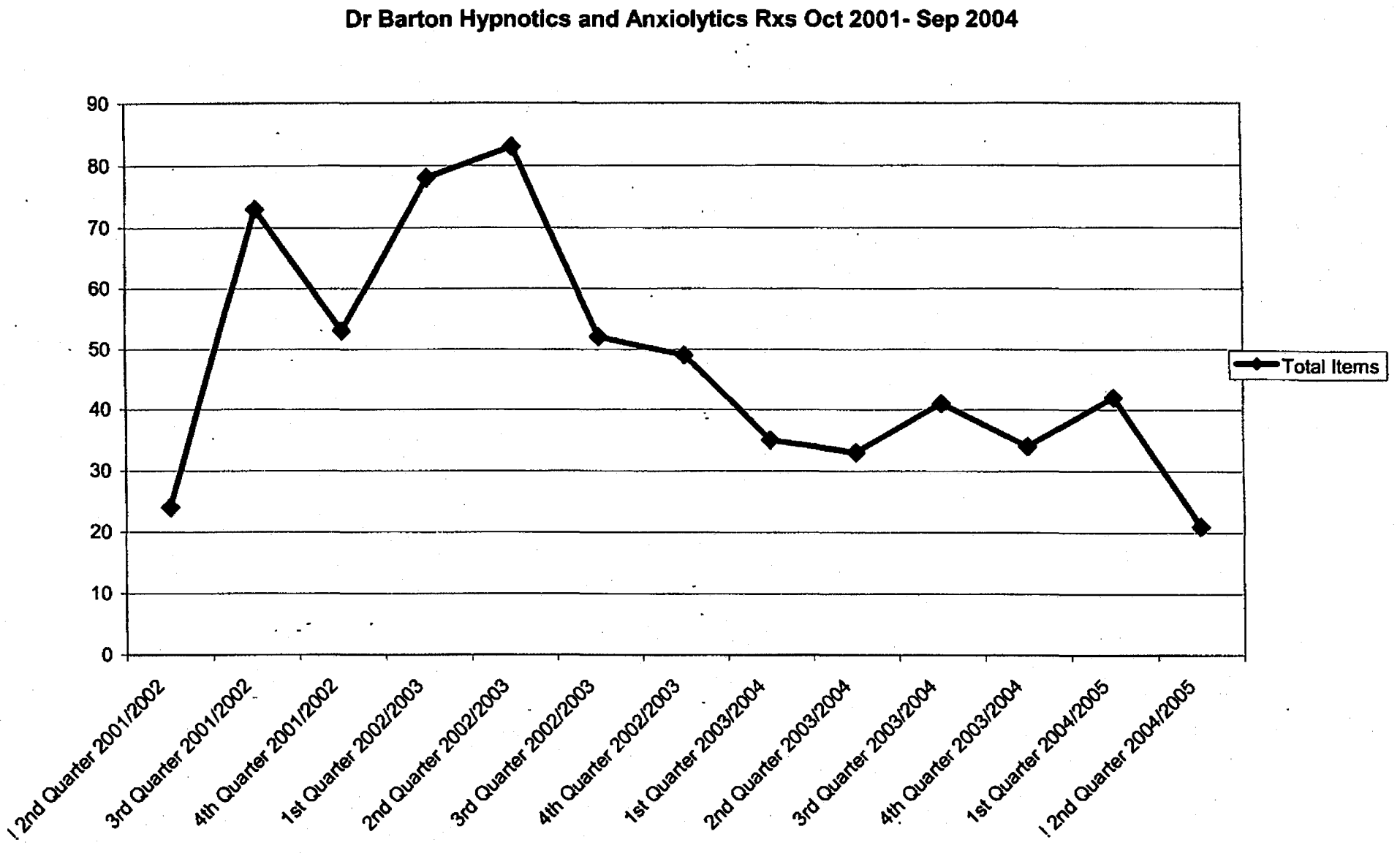
Prescribing Report Opiates Dr Barton April - August 2004

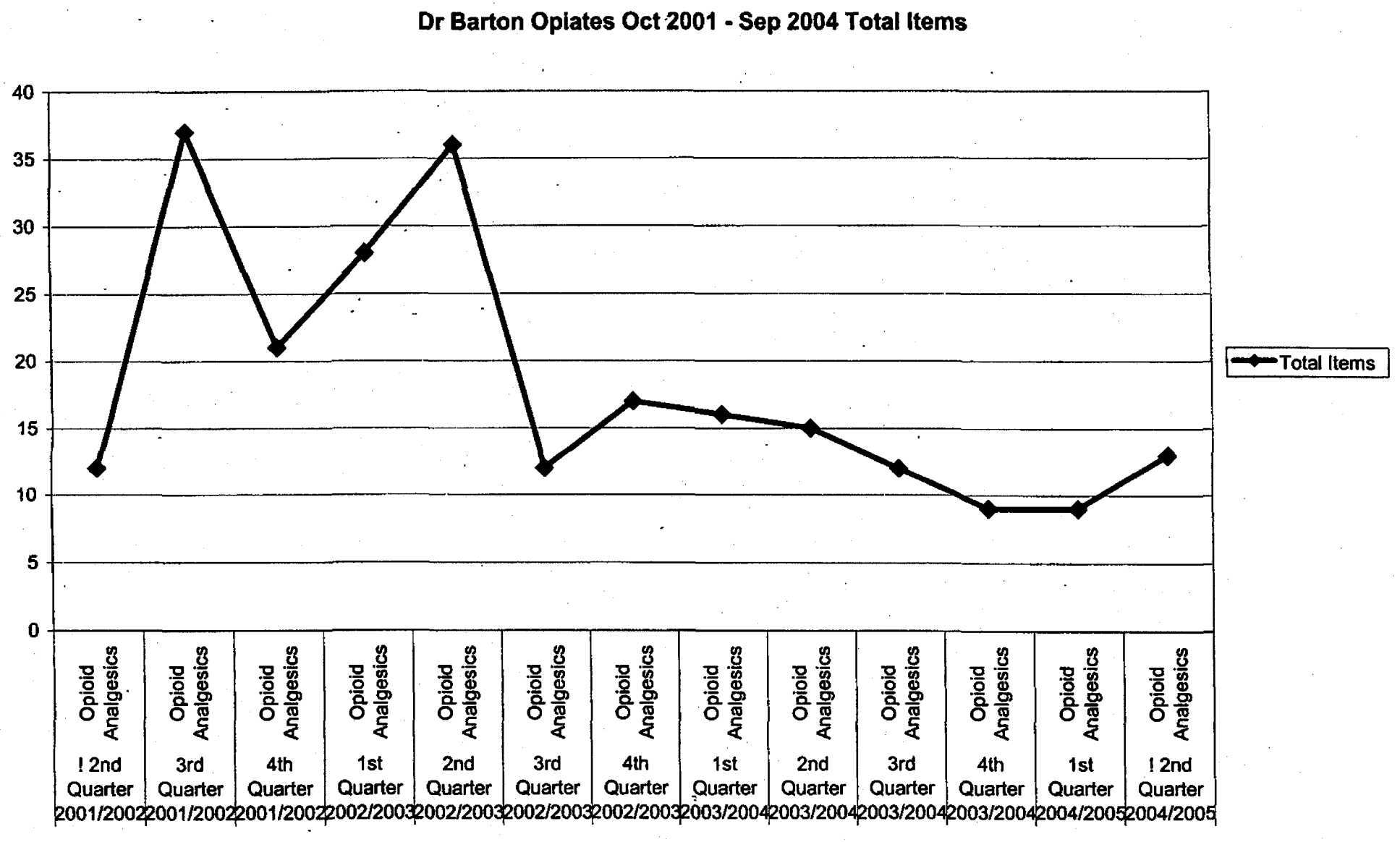
Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.13
April 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
April 2004	Tramadol HCl_Cap 50mg	2	150.0	£28.07
May 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
June 2004	Tramadol HCl_Tab 100mg M/R	2	60.0	£33.02
June 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
July 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
July 2004	Tramadol HCl_Tab 100mg M/R	3	60.0	£49.49
July 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.89
July 2004	Tramadol HCl_Cap 50mg	2	100.0	£18.71
August 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
August 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
August 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.12
August 2004	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.86
August 2004	Tramadol HCl_Cap 50mg	1	150.0	£13.67
		22		*£221.38*

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.


Dr Barton Hypnotics and Anxiolytics Rxs Oct 2001- Sep 2004
90
80
70
60
50
40
30
20
10
0
Total Items
2nd Quarter 2001/2002
3rd Quarter 2001/2002
4th Quarter 2001/2002
1st Quarter 2002/2003
2nd Quarter 2002/2003
3rd Quarter 2002/2003
4th Quarter 2002/2003
1st Quarter 2003/2004
2nd Quarter 2003/2004
3rd Quarter 2003/2004
4th Quarter 2003/2004
1st Quarter 2004/2005
2nd Quarter 2004/2005


Dr Barton Oplates Oct 2001 - Sep 2004 Total Items
40
35
30
25
20
15
10
5
0
Total Items
Opioid Analgesics ! 2nd Quarter 2001/2002
Opioid Analgesics 3rd Quarter 2001/2002
Opioid Analgesics 4th Quarter 2001/2002
Opioid Analgesics 1st Quarter 2002/2003
Opioid Analgesics 2nd Quarter 2002/2003
Opioid Analgesics 3rd Quarter 2002/2003
Opioid Analgesics 4th Quarter 2002/2003
Opioid Analgesics 1st Quarter 2003/2004
Opioid Analgesics 2nd Quarter 2003/2004
Opioid Analgesics 3rd Quarter 2003/2004
Opioid Analgesics 4th Quarter 2003/2004
Opioid Analgesics 1st Quarter 2004/2005
Opioid Analgesics ! 2nd Quarter 2004/2005

From:- Mrs R Hoare

Code A

F.A.O.:- Mr Paul Hylton
CCP Section, GM Council,
2nd Floor, Regents Place,
350 Euston Road, London.
NW1 3JN

Subject Reference №: PCH/2000/2047
Mrs Margaret Jane Queree Deceased

Dear Sir

We as a Family(Six of Mothers Children, living around the U/K) apologise for the delay in a reply to you letter dated 5th October 2004, the contents plus the Hampshire Police letter on our Mothers **'Treatment'**, their Decision/Verdict(Catt 2) on the Medical **'Reasons'** leading up to her subsequent failure of Health.

We have highlighted 2 Words-***Treatment***, and ***Reasons***.

Treatment

On release from PHA Queen Alexandria Hospital, she was in good spirits, and had her Family around her with daily visits, as stated by Hants Pol/Medical Panel, "Gosport War Memorial Hospital for **'Rehabilitation'**"(Short TERM stay, not TERMINAL), from her arrival in July, NO member of GWMH Staff suggested that Mothers 'Health', would deteriorate and her Condition become 'Terminal' .

Reasons

We as a Family fully understand the difficulties that Nursing Staff and Doctors face and 'Decisions' they take on a daily basis, and these 'Decisions' are also taken by Hospital administrators, eg, 'Supply and Demand of BEDS', was there a 'Admin Regime' to overcome the 'Problem of Bed blocking'. ? , or are we being 'Facetious' in even suggesting this. Please Advise.

Yours Sincerely-Dated 18th October 2004

Messr's: Rita Hoare, John, Margaret Shepherd, Anthony, Peter Queree and Philip Queree (Deceased)

Copies to: Alexander Harris(solicitors), David Williams(Det/Supt, H Pol).

Your reference:
Our reference: BFEH/4002044-0131-0
Document number: 80651946_1.doc

Code A

MILLS & REEVE

Urgent
Peter Swain
General Medical Council
Regent's Place
350 Euston Road
LONDON
NW1 3JN

14 October 2004

For the attention of Peter Swain

Dear Peter

Dr Jane Barton

I am enclosing the files that we have received so far from you as promised.

Once again I really do regret that I am not able to deal with this for you. If you find that the medical records have been dispatched to me, let me know and I will make inquiries this end but we have had a look round the post room this morning and we are pretty sure they haven't come in.

Kind regards,

Yours sincerely

Code A

Fiona Hawker
Partner

Mills & Reeve
54 Hagley Road
Edgbaston
Birmingham
B16 8PE

Tel: +44(0)121 454 4000
Fax: +44(0)121 456 3631
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info@mills-reeve.com

Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Tel: 01329 233447
Fax: 01329 234984

Direct Line; Code A
Direct Fax:

Mr Paul Hylton
Assistant Registrar
General Medical Council
2nd Floor, Regents Place
350 Euston Road
London
NW1 3JN

25th November 04

Dear Mr Hylton

RE: Dr Jane Barton

I have met with Dr Barton on three occasions since October 2002 in order to examine the prescribing data supplied by the Prescription Pricing Authority (PPA). At our last meeting, we looked at the data for benzodiazepine and opiate prescribing from October 2002 until August 2004. The PPA records prescribing data according to the named GP on the bottom of the prescription form NOT the GP signing the form. Consequently, a number of prescriptions were attributed to Dr Barton, which had been initiated by another partner. Code A has agreed to take certain actions, following our last meeting, the details of which are included in the report.

I am enclosing copies of the PPA data, together with graphs and the reports of our meetings. If I can be of any further help, please contact me.

Yours sincerely

Code A

Hazel Bagshaw
Pharmaceutical Adviser

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton Oct 2002 - March 20

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Diazepam_Tab 5mg	2	60.0	£2.29
October 2002	Diazepam_Tab 5mg	1	28.0	£0.55
October 2002	Diazepam_Tab 5mg	1	56.0	£1.07
October 2002	Diazepam_Tab 2mg	2	60.0	£2.11
October 2002	Diazepam_Tab 2mg	1	28.0	£0.51
October 2002	Diazepam_Tab 5mg	1	30.0	£0.59
October 2002	Temazepam_Tab 10mg	1	56.0	£1.65
October 2002	Lorazepam_Tab 1mg	1	28.0	£1.16
October 2002	Diazepam_Oral Soln 2mg/5ml S/F	1	200.0	£2.64
October 2002	Diazepam_Tab 10mg	1	60.0	£1.65
October 2002	Nitrazepam_Tab 5mg	1	60.0	£1.61
October 2002	Nitrazepam_Tab 5mg	1	56.0	£1.51
October 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Diazepam_Tab 5mg	1	28.0	£0.55
December 2002	Diazepam_Tab 5mg	1	60.0	£1.15
December 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Temazepam_Tab 20mg	1	30.0	£1.50
January 2003	Diazepam_Tab 2mg	2	28.0	£1.02
January 2003	Diazepam_Tab 2mg	1	56.0	£0.98
January 2003	Temazepam_Tab 20mg	1	28.0	£1.41
February 2003	Diazepam_Tab 2mg	3	28.0	£1.52
February 2003	Temazepam_Tab 10mg	1	56.0	£1.62
March 2003	Diazepam_Tab 5mg	1	6.0	£0.14
March 2003	Diazepam_Tab 5mg	2	28.0	£1.11
		30		*£31.13*

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton 2003-4

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
May 2003	Diazepam_Tab 2mg	1	28.0	£0.51
May 2003	Diazepam_Tab 10mg	1	60.0	£1.65
June 2003	Diazepam_Tab 2mg	1	28.0	£0.51
June 2003	Diazepam_Tab 2mg	1	6.0	£0.13
June 2003	Temazepam_Oral Soln 10mg/5ml S/F	1	100.0	£3.01
June 2003	Diazepam_Tab 5mg	2	28.0	£1.11
July 2003	Diazepam_Tab 2mg	1	28.0	£0.51
July 2003	Diazepam_Tab 10mg	1	60.0	£1.65
September 2003	Chlordiazepox HCl_Cap 5mg	1	52.0	£1.96
October 2003	Diazepam_Tab 2mg	1	28.0	£0.51
October 2003	Diazepam_Tab 2mg	1	10.0	£0.20
October 2003	Diazepam_Tab 5mg	1	10.0	£0.22
November 2003	Diazepam_Tab 2mg	1	21.0	£0.39
November 2003	Diazepam_Tab 2mg	1	28.0	£0.51
November 2003	Diazepam_Tab 5mg	1	60.0	£1.15
December 2003	Diazepam_Tab 2mg	1	28.0	£0.51
February 2004	Diazepam_Tab 2mg	2	28.0	£1.02
February 2004	Diazepam_Tab 5mg	1	56.0	£1.08
		20		*£16.63*

Based on the Selections:

1st Quarter 2003/2004,
2nd Quarter 2003/2004,
3rd Quarter 2003/2004,
4th Quarter 2003/2004
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton April - August 200

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Diazepam_Tab 2mg	1	28.0	£0.51
April 2004	Lorazepam_Tab 1mg	1	28.0	£1.16
May 2004	Diazepam_Tab 2mg	1	60.0	£1.06
May 2004	Nitrazepam_Tab 5mg	1	56.0	£1.53
June 2004	Diazepam_Tab 2mg	1	60.0	£1.06
June 2004	Diazepam_Tab 2mg	1	28.0	£0.51
June 2004	Diazepam_Tab 5mg	3	14.0	£0.88
July 2004	Diazepam_Tab 5mg	2	14.0	£0.59
July 2004	Temazepam_Tab 10mg	1	56.0	£1.75
August 2004	Diazepam_Tab 2mg	1	28.0	£0.51
		13		***£9.56***

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

Prescribing Report Opiates Dr Barton Oct 2002 - March 2003

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
October 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
October 2002	Tramadol HCl_Cap 50mg	1	30.0	£2.76
October 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£8.52
October 2002	Tramadol HCl_Cap 50mg	1	90.0	£8.22
November 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
November 2002	Codeine Phos_Tab 30mg	1	60.0	£2.82
December 2002	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.43
December 2002	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.64
December 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
December 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
December 2002	Tramadol HCl_Cap 50mg	1	100.0	£9.36
January 2003	Codeine Phos_Tab 30mg	1	60.0	£2.82
January 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
January 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
January 2003	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
January 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.74
February 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
February 2003	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.63
February 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
February 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.93
March 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
March 2003	Tramadol HCl_Tab 100mg M/R	2	60.0	£32.88
March 2003	Tramadol HCl_Cap 50mg	2	60.0	£11.26
March 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.58
March 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.43
		29		*£200.48*

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,

NHS

Prescription Pricing Authority

Prescribing Report Opiates Dr Barton 2003-4

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
April 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.42
May 2003	Codeine Phos_Tab 30mg	2	60.0	£5.65
May 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
May 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
May 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
June 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
June 2003	Mst Continus_Tab 10mg	1	120.0	£10.96
June 2003	Mst Continus_Tab 60mg	1	60.0	£25.63
June 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£3.20
June 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.68
June 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
July 2003	Codeine Phos_Tab 30mg	1	240.0	£11.19
July 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
July 2003	Codeine Phos_Tab 30mg	2	60.0	£5.44
July 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.93
July 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
August 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
August 2003	Dihydrocodeine Tart_Tab 30mg	1	40.0	£1.97
September 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
September 2003	Morph Sulph_Tab 15mg M/R	1	42.0	£6.75
September 2003	Zydol_Cap 50mg	1	60.0	£9.14
September 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.74
September 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
September 2003	Codeine Phos_Tab 30mg	2	60.0	£5.42
October 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.14
October 2003	Meptazinol HCl_Tab 200mg	1	60.0	£10.72
October 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.37
October 2003	Codeine Phos_Tab 30mg	1	60.0	£2.84
November 2003	Tramadol HCl_Cap 100mg M/R	1	28.0	£6.95
November 2003	Tramadol HCl_Cap 50mg	1	84.0	£7.87
November 2003	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.79
December 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
December 2003	Codeine Phos_Tab 30mg	2	60.0	£5.46
January 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
January 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
February 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
February 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
February 2004	Dihydrocodeine Tart_Tab 30mg	1	180.0	£5.77
February 2004	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.76
March 2004	Codeine Phos_Tab 30mg	1	60.0	£2.62
March 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.38
March 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90

52 *£340.81*

Based on the Selections:

Financial 2003/2004
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

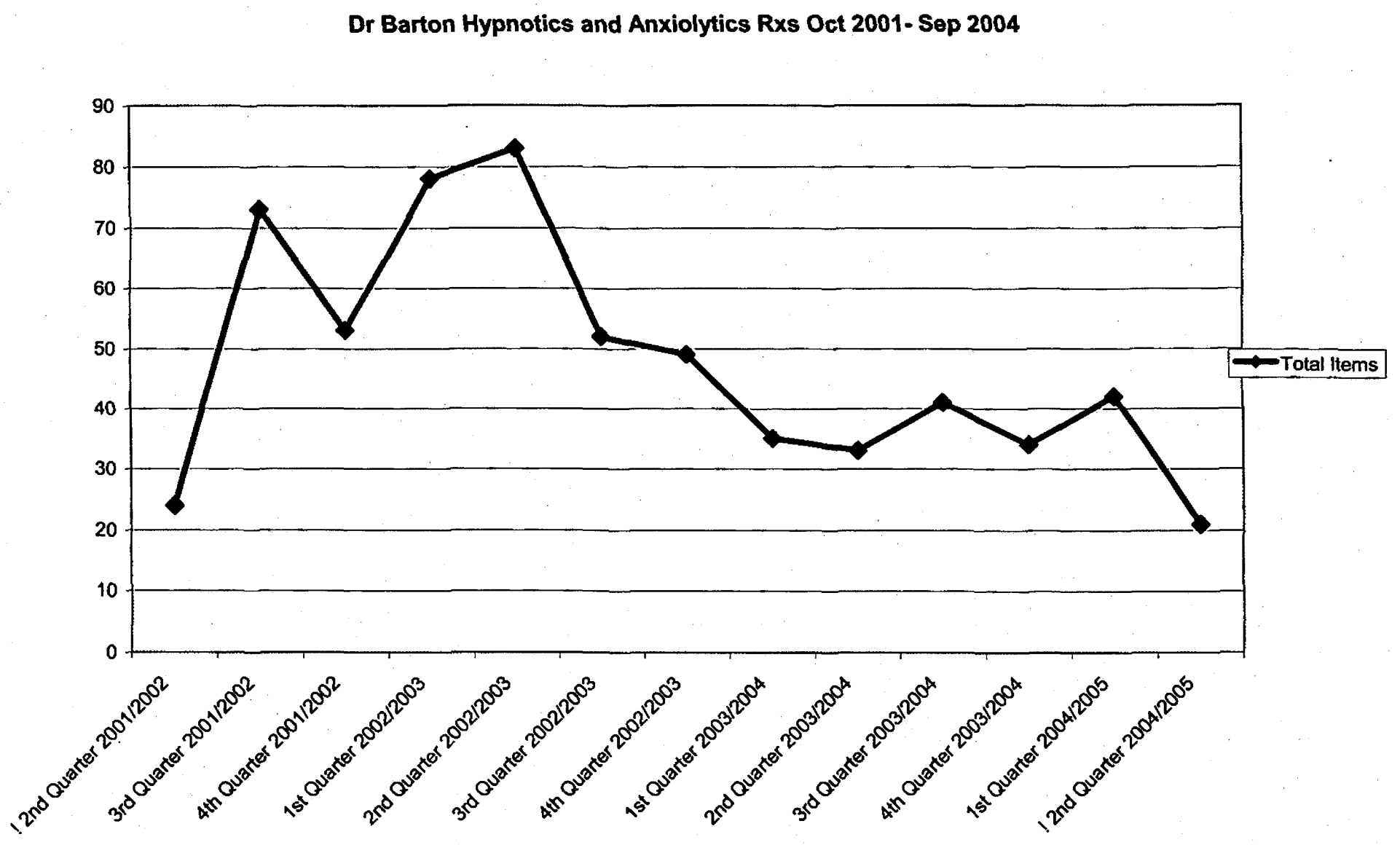
Prescribing Report Opiates Dr Barton April - August 2004

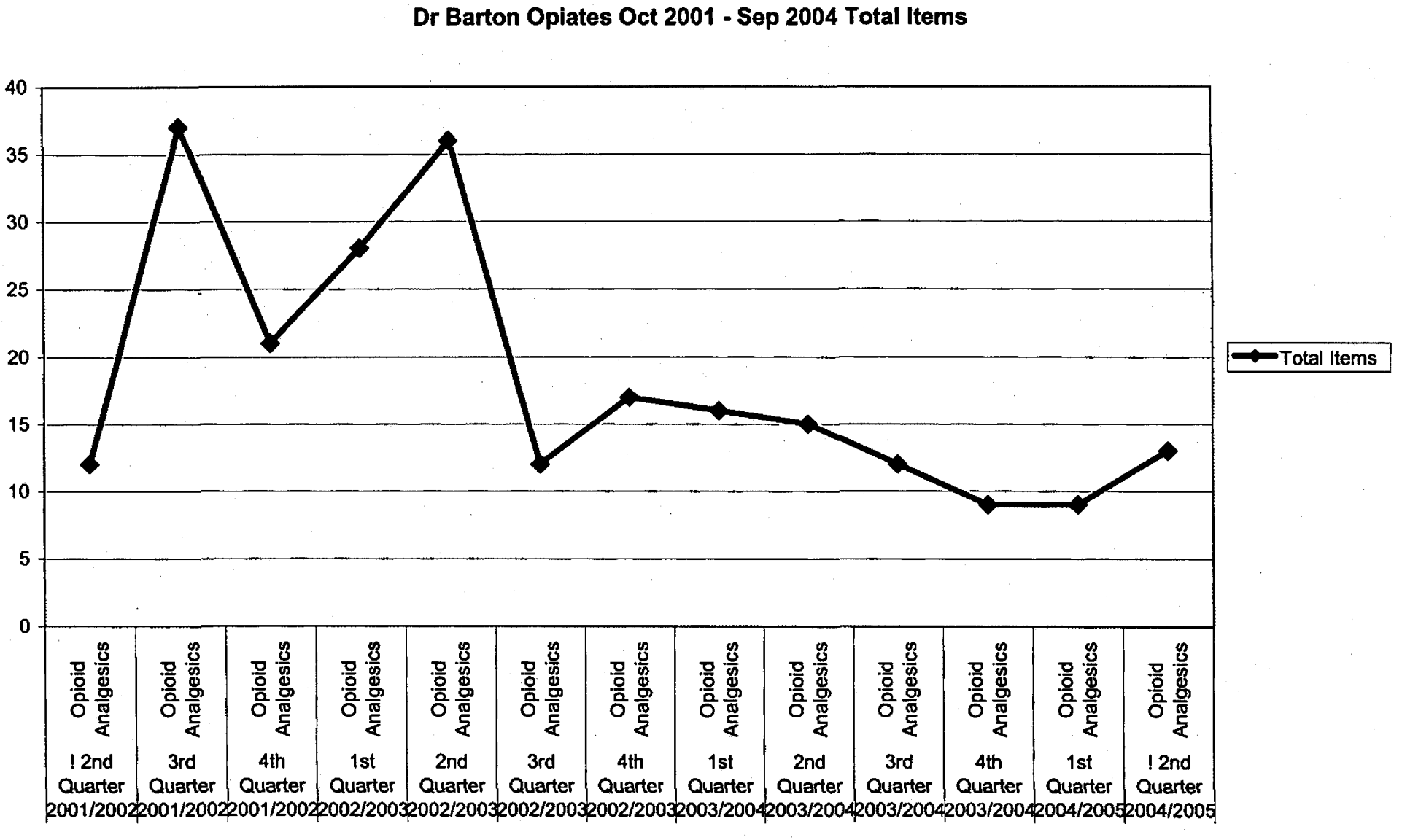
Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.13
April 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
April 2004	Tramadol HCl_Cap 50mg	2	150.0	£28.07
May 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
June 2004	Tramadol HCl_Tab 100mg M/R	2	60.0	£33.02
June 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
July 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
July 2004	Tramadol HCl_Tab 100mg M/R	3	60.0	£49.49
July 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.89
July 2004	Tramadol HCl_Cap 50mg	2	100.0	£18.71
August 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
August 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
August 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.12
August 2004	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.86
August 2004	Tramadol HCl_Cap 50mg	1	150.0	£13.67
		22		*£221.38*

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.


Dr Barton Hypnotics and Anxiolytics Rxs Oct 2001- Sep 2004
90
80
70
60
50
40
30
20
10
0
Total Items
! 2nd Quarter 2001/2002
3rd Quarter 2001/2002
4th Quarter 2001/2002
1st Quarter 2002/2003
2nd Quarter 2002/2003
3rd Quarter 2002/2003
4th Quarter 2002/2003
1st Quarter 2003/2004
2nd Quarter 2003/2004
3rd Quarter 2003/2004
4th Quarter 2003/2004
1st Quarter 2004/2005
! 2nd Quarter 2004/2005


Dr Barton Opiates Oct 2001 - Sep 2004 Total Items
40
35
30
25
20
15
10
5
0
Total Items
Opioid Analgesics
! 2nd Quarter 2001/2002
Opioid Analgesics
3rd Quarter 2001/2002
Opioid Analgesics
4th Quarter 2001/2002
Opioid Analgesics
1st Quarter 2002/2003
Opioid Analgesics
2nd Quarter 2002/2003
Opioid Analgesics
3rd Quarter 2002/2003
Opioid Analgesics
4th Quarter 2002/2003
Opioid Analgesics
1st Quarter 2003/2004
Opioid Analgesics
2nd Quarter 2003/2004
Opioid Analgesics
3rd Quarter 2003/2004
Opioid Analgesics
4th Quarter 2003/2004
Opioid Analgesics
1st Quarter 2004/2005
Opioid Analgesics
! 2nd Quarter 2004/2005

Meetings with Dr J Barton.

The meetings were held to discuss matters raised in the CHI report on Gosport War Memorial Hospital. PACT data was obtained for 2001-2 to establish Dr Barton's prescribing patterns for benzodiazepines and opiates (see attached PPA data and analysis table). PACT catalogue data is also available on file.

Meeting on November 1st 2002.
Dr Barton has undertaken not to prescribe benzodiazepines or opiate analgesics from October 1st 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.
Dr Barton will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health Call as a prescription may be required for a 14-day supply of benzodiazepines for bereavement.
Dr Barton also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patients' notes.
The next meeting will be in 6 months time

Visits to local pharmacies for spot checks on Dr Barton's prescriptions was discussed and deemed to be impractical.

Meeting on June 27th 2003
Data was available from the PPA up to and including April 2003. 12 months data was discussed.
Dr Barton had initiated searches on the practice computer system and the data collected by the practice IT manager for the 4th quarter of 2002-3 was studied. 7 of the 8 diazepam prescriptions had been prescribed by other partners for Dr Barton's patients.
Copies of the breakdown of PACT data from October 2002 to April 2003 for nitrazepam, temazepam, diazepam and opiates were given to Dr Barton. Monthly reports on these drugs will be prepared for Dr Barton.

Hazel Bagshaw
Pharmaceutical Adviser
Fareham and Gosport PCT
05.09.03

Notes from meeting with Dr J Barton

3rd November 2004

Details of the voluntary agreement - from October 2002 as confirmed in an e-mail from Dr Sommerville. It was agreed that this should run until Dr Barton had been before the Conduct Committee. The agreement was for a restriction on the prescribing of opiates and for benzodiazepines to only be prescribed in line with BNF guidance.

The Prescription Pricing Authority data was examined for the period October 2002 until August 2004 (the latest data on the system at the time of the meeting). Dr Barton had made great efforts to transfer patients requiring opiates or benzodiazepines to other partners within the practice. The practice data analyst had produced a list of the prescriptions for diazepam 2mg, which had been issued with Dr Barton's name as the prescriber. Dr Barton had written 5 prescriptions and a reason for the treatment was documented. The remaining prescriptions had been issued during consultations with other partners.

Only 3 of the opiate prescriptions were for controlled drugs in tablet form. Dr Barton will ask the practice data analyst to follow up this matter. The remainder of the prescriptions were for drugs such as codeine phosphate, tramadol and dihydrocodeine tablets or capsules.

Dr Barton will also ask the data analyst to follow up the diazepam 10mg prescriptions.

As far as Dr Barton is concerned, the voluntary agreement is still in place. The agreement for opiates was a restriction on controlled drugs, in particular, for injection.

The PPA data is recorded against the GP name printed in the bottom of the prescription not against the signature. Dr Barton continues to assure me that all patients requiring long-term treatment with opiates or benzodiazepines are asked to see other partners within the practice.

Hazel Bagshaw
Pharmaceutical Adviser
Fareham and Gosport PCT
04.11.04

Please quote our reference when communicating with us about this matter

Our ref: ISPB/sls/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
17 September 2002

Ms Vanessa Carroll
Assistant Registrar
General Medical Council
178 Great Portland Street
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Dear Ms Carroll

Interim Orders Committee - Dr Jane Barton

I write with reference to your letter to my client, Dr Barton, of 13 September 2002.

With reference to the Rule 11 of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000, I would be grateful if you would kindly make available to me all documents in this matter as a matter of urgency. In particular, I would be grateful for sight of any communications between the Council and the Department of Health whether in letter form or notes of telephone communication.

Yours sincerely

Code A

17/09 '02 13:55 FAX Code A THE M D U LEGAL 001

THE MDU

The Medical Defence Union Limited
Legal Department

Facsimile

To:	Ms Vanessa Carroll
Company:	General Medical Council
Fax no:	Code A
From:	Ian Barker
Date sent:	17 September 2002
Time sent:	
No. of sheets inclusive:	2
Re:	**Jane Barton**

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Yours sincerely

Code A

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: MSL/TL/00492-14742/2065792 v1
Your ref: MK/2000/2047

Michael Keegan
Conduct Case Presentation Section
Fitness to Practise Directorate
General Medical Council
178 Great Portland Street
London W1W 5JE

9 October 2002

Dear Michael

Dr Jane Ann Barton

I refer to your letter of 27 September 2002 and our subsequent meeting with Peter Swain where we discussed the additional information which has been forwarded to the GMC by Dr Simon Tanner at Hampshire and Isle of Wight Health Authority.

You have requested my written advice as to whether there is anything in the material received since the last IOC, or any other new facts not previously known to the IOC when they considered the case, which would justify a referral of this matter back to the IOC. I note that the material from Dr Tanner is the only information received since the last IOC.

Having reviewed the documentation, my advice would be that there is nothing within the papers which would justify a referral of this matter back to the IOC once more.

Although there is new material contained within these papers there is nothing in them which would merit a referral of the entire case back to the IOC. These papers relate to general concerns expressed in 1991 about prescribing practices at the Gosport War Memorial Hospital. There are no new criticisms over and above those already contained within the initial IOC papers; in fact the papers note that all staff at the hospital had "***great respect for Dr Barton and did not question her professional judgment***".

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Although it would be open to you to show this new material to the screeners and seek their direction, my firm view would be that the screeners would be misdirecting themselves if, having seen the new papers, they were to refer the matter for further consideration by the IOC.

Yours sincerely

Code A

Matthew Lohn

Partner

Code A

FIELD FISHER WATERHOUSE

THE EUROPEAN LEGAL ALLIANCE

Our ref: JZC/HJA/00492-14742/2145525 v1
Your ref: MK/2000/2047

Mr M Keegan
Conduct Case Presentation Section
General Medical Council
178 Great Portland Street
London W1W 5JE

17 December 2002

Dear Michael

Dr. Jane Barton

Thank you for copies of the letters you have recently sent through to Alexander Harris.

Following our meeting with the Hampshire Constabulary on 20 November 2002 I thought it would be helpful to send you an update.

Attendance Notes

I enclose a copy of the attendance note of the meeting held on 3 October 2002. I noted, on a review of the file, that I had not forwarded the document to you earlier. You may wish to add this to your file for information.

In addition, I enclose a copy of the meeting note taken after the meeting with Hampshire Constabulary last month. I have forwarded a copy of the note to Nigel Niven together with a request that he advises me of any changes he wishes incorporated into the document. Should any amendments be made, I shall forward a further copy of the note to you.

Hampshire Constabulary

I recently received the enclosed letter from Nigel Niven which formally requests that the GMC's enquiries and proceedings are stayed pending the outcome of the criminal investigation. As Nigel suggested at the meeting, our hearing date of April 2003 should be vacated as the police investigation is likely to be lengthy; indeed it appears that following the meetings with the CPS a decision has been

taken to enlarge the parameters of the investigation. If the expansion involves the hundreds of patients who were certified dead by Dr. Barton and treated by her during their stay at Gosport War Memorial Hospital, the investigation could take, as we were warned, some years. When I next speak with Nigel Niven on the telephone I will attempt to get some indication of the degree to which the enquiries have been enlarged.

I should be grateful if you could provide me with instructions to write to Hampshire Constabulary to advise them formally that the GMC proceedings will be stayed pending the outcome of the police investigation. Currently I have acknowledged Nigel's letter and indicated that we are seeking your formal response.

Commission for Health Improvement

At the meeting you will recall that Nigel provided with specific permission to contact CHI in order to examine their documents and the statements they had obtained during their Inquiry. The permission was granted on the basis that we would not contact any of the individuals but were merely assessing the documents and the material held by CHI.

Following the meeting and prior to my holiday last week, I wrote to Julie Miller at CHI requesting a number of documents and asking for inspection facilities in respect of the witness statements and other material held by CHI. I have received a response from Ms Miller who has indicated her willingness to cooperate with the GMC's enquiries. Unfortunately, it has not been possible to find a two-day slot in which my, John Offord's and Julie Miller's diaries are all free until 14-15 January 2003. Given, however, the fact that we will be unable to hold the hearing in April 2003, I do not consider that it is of concern that we must wait until mid-January before visiting CHI. I hoe that you agree.

In light of the fact that it has not been possible to arrange an appointment with CHI prior to the New Year, I wonder whether it would be beneficial for us to postpone the meeting tentatively arranged for 8 January 2002 to 22 January 2002. This would allow John and I to update to as to the documents and information we obtained from our visit to CHI. Are you free on this date?

I look forward to hearing from you.

Kindest regards,

Code A

Judith Chrystie

Code A

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Our ref: ISPB/TOC/0005940/Legal
Your ref: ACE/HJ/FPD/2000/2047
16 September 2002

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Mr Adam Elliott
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: 0207-915-7406

Dear Mr Elliott

Dr *Jane Barton*

I write further to our telephone conversations today to assist in clarifying Dr Barton's position. As I indicated in my previous letter to you, Dr Barton will not be practicing during the currency of her sickness certificate – that being for 3 weeks from today's date. To clarify, Dr Barton will not be practicing in any way over this period, be it NHS or private practice, given that ill-health.

Dr Barton is happy to provide the assurance to you that if her position changes in this regard within the 3 week period, though there is no anticipation that it will do so, she will first notify the Council before resuming practice.

I hope this is of assistance, and once again please do not hesitate to contact me if I can assist further.

Yours sincerely

Code A

Copy No 4
GMC

A Review of Deaths of Patients

at

Gosport War Memorial Hospital

Final version: October 2003

Contents

Acknowledgements

The staff of the records department of Gosport War Memorial Hospital have provided considerable assistance in identifying and obtaining documents for the review, and I am grateful to them for their assistance. I also thank Peter Goldblatt of National Statistics and Stephen Price of Hospital Episode Statistics, and Professor Code A of the Department of Epidemiology and Public Health, University of Leicester, for advice and for undertaking the analysis of the relationship between numbers of deaths and periods of leave. I also acknowledge the assistance of Paul Sinfield, research associate, in management of the databases required for the review, and Ms Vicki Cluley for assistance in preparation of the manuscript.

Richard Baker

Clinical Governance Research and Development Unit

Department of Health Sciences

University of Leicester

Summary

This report presents the findings of an audit of care at Gosport War Memorial Hospital that was commissioned by the Chief Medical Officer. Concerns about the care of patients in Gosport hospital were first raised in 1998, and a police investigation is continuing.

The audit has drawn on documentary evidence that has included:

1. A random sample of 81 clinical records of patients who died in Gosport hospital between 1988 and 2000
2. The counterfoils of medical certificates of the cause of death (MCCDs) retained at Gosport hospital relating to deaths in the hospital 1987-2001
3. The admissions books of Dryad ward at Gosport, 1993-2001
4. Surviving controlled drugs registers at Gosport hospital
5. MCCDs completed by a sample of general practitioners in Gosport.

On the basis of these sources of evidence, I have concluded that a practice of almost routine use of opiates before death had been followed in the care of patients of the Department of Medicine for Elderly People at Gosport hospital, and the attitude underlying this approach may be described in the words found in many clinical records – 'please make comfortable'. It has not been possible to identify the origin of this practice, since evidence of it is found from as early as 1988. The practice almost certainly had shortened the lives of some patients, and it cannot be ruled out that a small number of these would otherwise have been eventually discharged from hospital alive.

The practice was disclosed in several key findings.

- Opiates had been administered to virtually all patients who died under the care of the Department of Medicine for Elderly People at Gosport, and most had received diamorphine by syringe driver.
- Opiates were administered to patients with all types of conditions, including cancer, bronchopneumonia, dementia, and strokes.
- Opiates were often prescribed before they were needed – in many cases on the day of admission, although they were not administered until several days or weeks later.
- In many records, evidence of a careful assessment before use of opiates was absent, and the stepped approach to management of pain in palliative care had not been followed.

In addition to these findings, two other matters also gave rise to concern. The amount of information recorded in the clinical notes was often poor, and recent fractures that had contributed to deaths, most commonly fractured hips, had not been reported on MCCDs.

Most patients admitted to Gosport under the care of the Department of Medicine for Elderly People had severe clinical problems, and many had been transferred from acute hospitals after prolonged in-patient stays. Some had been admitted for rehabilitation, but many were believed to be unlikely to improve sufficiently for discharge to a nursing home. Consequently, a relatively high number of deaths among those admitted would have been expected. The types of patients (case mix) admitted to Gosport varied during the period of interest (1988-2000), and it was not possible to identify an adequate source of data about numbers of deaths in similar hospitals that admitted similar types of patients in the same time periods to enable a reliable estimate of excess deaths to be calculated. Nevertheless, the findings tend

to indicate that the finding of a statistical excess of deaths among patients admitted to Gosport would be unlikely.

In undertaking the audit, I have drawn on documentary evidence only. There has been no opportunity for relatives or staff involved in the care of patients in Gosport to give information or comment on the findings. Dr Barton in particular has not been invited to give a first hand account of care at Gosport or comment on the findings of the review. It is possible, therefore, that my conclusions would be altered in the light of information from Dr Barton or other individuals. However, such information would be more appropriately considered in a different type of inquiry, for example that being undertaken by the police, rather than in the context of an audit.

Recommendations

In view of the findings of the audit, I submit the following recommendations:

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.
4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to

suspect that some patients at the end of life do not receive adequate analgesia.

5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

Chapter One: Introduction

This report describes a review of the deaths of older patients at Gosport War Memorial Hospital. The review was commissioned by the Chief Medical Officer because concerns had been raised about the care of some elderly patients who had died in the hospital, and is particularly concerned with the deaths of elderly patients under the care of the Department of Medicine for Elderly People.

Gosport War Memorial Hospital is a 113-bed local hospital situated on the Gosport peninsula. It was part of Portsmouth Health Care NHS Trust from April 1994 until April 2002, when the services at the hospital were transferred to the local primary care trusts (Fareham and Gosport PCT, and East Hampshire PCT). Gosport itself is a relatively isolated community at the end of a peninsula with some areas of high deprivation. It is reported to be under-provided with nursing homes

Concerns about deaths at the hospital were raised in September 1998, when police commenced investigations into an allegation that a patient had been unlawfully killed on Daedalus ward. In March 1999, the Crown Prosecution Service (CPS) decided that there was insufficient evidence to prosecute. In 2001, a further police investigation took place, and again the CPS decided that there was insufficient evidence to proceed. In January 2000 an NHS Independent Review Panel found that whilst drug doses were high, they were appropriate in the circumstances.

A complaint was made to the Health Service Commissioner against Portsmouth Healthcare NHS Trust about the death of a patient who had undergone an operation on a broken hip at another hospital and had been transferred in October 1998 to Gosport War Memorial Hospital 1998. The patient had died of bronchopneumonia in

December 1998, and the complaint was that the patient had received excessive doses of morphine, had not received reasonable medical and nursing care, and had been allowed to become dehydrated. The Commissioner undertook an investigation, at the conclusion of which he accepted professional advice that medical management had been appropriate and that the patient's nursing needs had been systematically assessed and met. The pain relief was judged to have been appropriate and necessary for the patient's comfort and the commissioner did not uphold the complaint.

In March 2001, 11 families raised further concerns with the police about the care and deaths of relatives in 1998, and four of these deaths were referred for an expert opinion. In August 2001, the police shared their concerns with the Commission for Health Improvement (CHI), and CHI then began an investigation.

The CHI Review (2001-2002)

The terms of reference of the review are shown in Box 1.1., and indicate that the aim of the review was to investigate care since 1998 rather than to undertake an investigation into care at the hospital leading up to the complaint first raised in 1998. During the review, CHI studied documents held by the trust, received views from samples of patients, relatives and friends, conducted a five-day site visit during which 59 staff from all groups involved in the care of elderly patients were interviewed, undertook an independent review of the notes of a sample of patients who had died on three wards (Daedalus, Dryad and Sultan) between August 2001 and January 2002, and interviewed relevant agencies, including those representing patients and relatives. On concluding its review, CHI did commend some features of services at Gosport, including leadership in Portsmouth Healthcare NHS Trust, the

standard of nursing care on Daedalus, Dryad and Sultan wards, and the trust's clinical governance framework. However, CHI also reported several concerns (Box 1.2.).

Box 1.1. Terms of reference of the CHI review (CHI, 2002).

The investigation will look at whether, since 1998, there has been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within services for older people (inpatient, continuing and rehabilitative care) at Gosport War Memorial Hospital.

i) staffing and accountability arrangements, including out of hours

ii) the guidelines and practices in place at the trust to ensure good quality care and effective performance management

iii) arrangements for the prescription, administration, review and recording of drugs

iv) communication and collaboration between the trust and patients, their relatives and carers and with partner organisations

v) arrangements to support patients and their relatives and carers towards the end of the patient's life

vi) supervision and training arrangements in place to enable staff to provide effective care.

In addition, CHI will examine how lessons to improve patient care have been learnt across the trust from patient complaints.

The investigation will also look at the adequacy of the trust's clinical governance arrangements to support inpatient continuing and rehabilitation care for older people.

Box 1.2. CHI's key concerns

- There was lack of clarity amongst all groups of staff and stakeholders about the focus of care for older people and therefore the aim of the care provided. This confusion had been communicated to patients and relatives, which had led to expectations of rehabilitation which had not been fulfilled.
- CHI has serious concerns regarding the quantity, combination, lack of review and anticipatory prescribing of medicines prescribed to older people on Dryad and Daedalus wards in 1998. A protocol existed in 1998 for palliative care prescribing referred to as the 'Wessex guidelines', this was inappropriately applied to patients admitted for rehabilitation.
- Though CHI is unable to determine whether these levels of prescribing contributed to the deaths of any patients, it is clear that had adequate checking mechanisms existed in the trust, this level of prescribing would have been questioned.
- CHI welcomes the introduction and adherence to policies regarding the prescription, administration, review and recording of medicines. Although the palliative care Wessex guidelines refer to non-physical symptoms of pain, the trust's policies do not include methods of non-verbal pain assessment and rely on the patient articulating when they are in pain.
- Relatives speaking to CHI had some serious concerns about the care their relatives received on Daedalus and Dryad wards between 1998 and 2001. The instances of concern expressed to CHI were at their highest in 1998. Fewer concerns were expressed regarding the quality of care received on Sultan ward.

- Portsmouth Healthcare NHS Trust did not have any systems in place to monitor and appraise the performance of clinical assistants. There were no arrangements in place for the adequate supervision of the clinical assistant working on Daedalus and Dryad wards.
- The police investigation, the review of the Health Care Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake a review of prescribing practices. The trust should have responded earlier to concerns expressed around levels of sedation, which it was aware of in late 1998.
- Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

CHI did undertake an independent review of anonymised medical and nursing notes of a random sample of patients who had died on Daedalus, Dryad and Sultan wards between August 2001 and January 2002. It should be noted that this was a period in which the clinical assistant no longer worked at the hospital, and in particular excludes deaths during the period 1998-1999, when concerns first arose. The case note review confirmed that the admission criteria for Dryad and Daedalus wards were being adhered to. CHI also investigated the amount of diamorphine, haloperidol and midazolam used on Daedalus and Dryad wards between 1997/1998 and 2000/01. These data indicated a decline in use of diamorphine and haloperidol on both wards after 1998/1999, with a relatively less marked decline in the use of midazolam in the later years.

Staff concerns about the use of diamorphine, 1991-2

Staffs concern about the use of diamorphine was brought to the attention of the branch convenor of the Royal College of Nursing (RCN) in April 1991, the convenor being told that the problem had been present for the past two years. At a specially convened meeting in July 1991, nursing staff of Redclyffe Annexe raised their concerns about the use of diamorphine with the patient care manager of Gosport Hospital. Among the points made at that meeting were that not all patients who had been given diamorphine had pain, no other forms of analgesia had been considered, the drug regime was not always tailored to each patient's individual needs, and that deaths were sometimes hastened unnecessarily. Discussions took place between nursing and medical staff, the patient care manager and the RCN convenor over the ensuring months, with the result that a plan for the use of diamorphine appears to have been agreed.

The role of the clinical assistant, Dr Barton

The concerns, police investigations and GMC referral have focussed on the role of the clinical assistant involved, Dr Jane Barton. Dr Barton is a general practitioner based in a practice in Gosport. She was employed for five sessions a week as a clinical assistant in the Department of Medicine for Elderly People from 1st May 1988 until her resignation on 5th July 2000. In this post, Dr Barton was accountable to the consultant physician in geriatric medicine, and responsible for arranging cover for annual leave and sickness absence with her practice partners. The post was subject to the terms and conditions of hospital, medical and dental staff.

When Dr Barton began work at the hospital, she had responsibility for patients in Redclyffe Annexe. This unit is isolated from the main parts of the hospital, and had

approximately 20 beds classified as continuing care. Until 1993/4, there were also two wards (referred to as the male and female wards) at the main hospital site, having a total of approximately 37 beds (Box 1.3.). Nineteen of these were designated for use by patients under the care of their GP, and seven designated as GP day surgery beds. Dr Barton was responsible for the care of patients in the remaining 11 beds. (The precise number of beds on the female ward is uncertain since the information is based on the memories of staff. It is believed to have been 20 or 21.) The total number of beds under the supervision of Dr Barton was therefore 31 until 1993/4.

From 1993/4, Dr Barton appears to have ceased responsibility for Redclyffe Annexe, and taken on responsibility for Dryad and Daedalus wards in the new hospital building, the male and female wards being closed. This gives a total of 44 beds under Dr Barton's care, with a mix of continuing care and rehabilitation. CHI was critical of arrangements for supervising the practice of the clinical assistant, and found no evidence of any formal lines of communication regarding policy development, guidelines and workload. Some of the staff interviewed had indicated that the clinical assistant worked in excess of the five contracted sessions. The CHI review notes that in 1998, there was a fortnightly consultant ward round on Daedalus ward. Ward rounds were also scheduled fortnightly on Dryad ward, although they occurred less frequently.

Box 1.3 Reported bed use at the hospital

1980-1993:

Northcott house, 11-12 continuing care beds

Redclyffe Annexe 20 continuing care beds

Male ward - 17 beds (9 continuing care, 8 GP beds)

Female ward – 20 beds (2 continuing care, 7 GP day surgery, 11 GP beds)

Total beds 1980-1993=69

From 1994:

Redclyffe Annexe was still used;

Sultan ward – 24 GP beds

Dryad ward – 20 continuing care beds

Daedalus – 24 beds in total (8 slow stream stroke from April 1994. 16 continuing care [24 prior to April 1994]); from 2000, the Daedalus beds were used for intermediate care, comprising 8 fast stream stroke, 8 slow stream stroke, 8 general rehabilitation.

Other investigations

Several other investigations have been, or are being, undertaken into the events at Gosport War Memorial Hospital. Hampshire Constabulary are continuing an intensive investigation, and I am grateful to them for their agreement that the review requested by the Chief Medical Officer should be completed. A referral to the General Medical Council (GMC) has also been made. However, the review described in this report is an independent clinical review or audit. I have sought to come to an

independent view based on an analysis of clinical information from surviving documentary evidence (for example, clinical records, drug registers, medical certificates of the cause of death, and ward registers). The review does not consider statements from witnesses, and does not involve a detailed forensic inquiry into particular deaths, since these aspects are the proper responsibility of the police and other agencies.

Aims of the review

The aims of the review were:

1) To identify any excess mortality or clusters of deaths among patients who were on Daedalus and Dryad wards 1988-2000 and to identify initial evidence to explain any excess or clusters.

2) To determine whether the numbers of deaths among Dr Barton's general practice patients was higher than would have been expected.

Palliative and terminal care

Some understanding of current practice and policies on the care of dying patients is required in order to enable judgements to be made about the appropriateness of care given to patients who died in Gosport War Memorial Hospital. This section outlines relevant features of this aspect of care.

The World Health Organisation (WHO) defines palliative care as 'the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families' (O'Neill and Fallon, 1997). Palliative care for people with advanced cancer is now widely available. However, people with other chronic progressive

conditions may also need palliative care when other treatment ceases to be of benefit. Such conditions include advanced respiratory, cardiac or neurological disease (O'Brien et al, 1998). Some of the patients who died on Daedalus and Dryad wards had dementia, and in recent years, it has been increasingly recognised that palliative care also has a role to play in advanced (or 'end stage') dementia. Since a basic awareness of the care of the people with advanced dementia is required in order to interpret the findings of this review, an outline of selected key issues follow.

In advanced dementia, death occurs as a consequence of the many secondary impairments that arise, including progressive immobility, reduced ability for self-care, poor nutrition and reduced intake of fluids, infections related to immobility, skin breakdown, and general debilitation (Shuster, 2000). Although patients dying from dementia have symptoms and health care needs comparable with cancer (McCarthy et al, 1997), patients on long-stay wards who are dying at the end stage of dementia do not always received appropriate palliative care.

In a study undertaken in a long-stay psychogeriatric unit in England, patients with end stage dementia were found to have many symptoms, including pain, dyspnoea and pyrexia for which no palliative treatment was given. Instead, there was widespread use of parenteral antibiotics and infrequent use of analgesia in the last few days of life (Lloyd-Williams 1996). In a follow-up to this study, guidelines on palliative care in end stage dementia were developed, and an increase in the use of analgesics including opiates occurred (Lloyd-Williams and Payne, 2002). The data collected after the implementation of the guidelines related to the deaths of 27 patients, of whom 13 (48%) were prescribed 4-hourly morphine for the palliation of pain or shortness of breath (caused by pneumonia). Two patients who were unable

to take oral medication were commenced on diamorphine administered by syringe drivers. It should be noted that pneumonia can cause significant symptoms in people with dementia, including shortness of breath and discomfort (Steen et al, 2002). Deficiencies in palliative care of elderly patients with or without dementia are also found in other countries (Fox et al, 1999; Evers et al, 2002; Morrison and Siu, 2000).

Information about a palliative care service for elderly people in the same district as Gosport is pertinent to the review. In 1989, a 12-bedded palliative care ward was opened within the Geriatric Department at Queen Alexandra Hospital, Portsmouth (Severs and Wilkins, 1991). The aim was to improve the care of elderly people at the end of life. In the first year, 128 patients were admitted to the ward, of whom 101 (78.9%) had cancer, 17 had strokes and two had dementia. The service was therefore primarily caring for elderly people with terminal cancer.

Guidelines

Communication between professionals (nurses and doctors), and between professionals and relatives or dying elderly patients is sometimes poor (Costello, 2001), and decisions on whether resuscitation would be appropriate ('do not resuscitate' or DNR orders) may not be fully discussed (Costello, 2002). Wider use of clinical guidelines might assist health professionals overcome these problems and provide palliative care to more of those patients who need it. A growing number of publications offer guidance about palliative care for patients with cancer, but the two clinical guidelines discussed here illustrate current professional opinion about the care of people in the terminal phase of dementia. The first guideline was developed in a long-stay hospital in England (Lloyd-Williams and Payne, 2002), and was

concerned with the palliative care of patients with end stage dementia. It is summarised in Box 1.4.

Box 1.4. Guidelines for the management of patients with end stage dementia (from: Lloyd-Williams and Payne, 2002)

Consider treatable causes of pain (e.g. pressure sores, full bladder); use oral medication when possible, and administer on a regular basis; use co-proxamol initially; if still in pain, consider a non-steroidal anti-inflammatory drug.

When opiates are used, start with a low dose and increase as needed to control pain; always prescribe diamorphine 2.5-10mg for injection on an as required basis so that analgesia can still be given if the oral route is not available.

When converting from oral subcutaneous opiates, remember to divide the total oral dose by three e.g. 60mg oral morphine in 24 hours = 20mg diamorphine in syringe driver.

In the event of agitation, think of full bladder; midazolam 2.5mg-10mg subcutaneously or oral haloperidol or thioridazine may be used.

The most common cause of dyspnoea is bronchopneumonia. There is no evidence that using antibiotics in end stage dementia is helpful or improves patients' comfort or prolongs the quality of life. Oral morphine 5mg 4-hourly can reduce the sensation of breathlessness and improve patient's comfort.

The second guideline mentioned here was developed to help physicians decide whether to forgo curative treatment of pneumonia in patients with dementia resident

in nursing homes, and has been developed by a research group in the Netherlands (Steen et al, 2000). The guidelines were based on a literature review, discussion papers prepared by Dutch medical associations, and consensus procedures with experienced nursing-home physicians and international experts in the fields of nursing-home medicine, ethics and law. The guidelines were subsequently authorized by the Dutch professional organisation of nursing home physicians. The guidelines were presented in the form of a checklist for use by physicians in nursing homes (see Box 1.5.).

Box 1.5. Checklist on decision for starting or not starting a curative treatment of pneumonia in a patient with dementia (Steen et al, 2000).

The key factors to consider are:

1. the expected effect of a curative treatment from the medical perspective
2. the patient's wish: a living will, or the reconstruction of the wish
3. the patient's best interest when the wish of the patient is not clear, or remains unknown.

The checklist considerations:

1. Is an intentionally curative treatment indicated for this patient?
2. How physically and/or psychiatrically burdensome would the total curative treatment – antibiotics and (re)hydration – be for the patient?
3. Is the patient sufficiently mentally competent to indicate their wish, and if so, what treatment does the patient want?
4. What is the purport of the written will?
5. What is the purport of the reconstruction of the patient's will according to the representative(s)?
6. What is the purport of the reconstructed patient's wishes according to the other involved professional carers?
7. Which treatment seems to be in the patient's best interests (not certain, intentionally curative treatment, or palliative treatment)?

An important step in palliative care is the point at which terminal care begins. The factors that lead to the decision to begin terminal care will depend on the stage of the patient's disease. An example of criteria that may be used for initiating terminal care is shown in Box 1.6 (Edmonds and Rogers, 2003).

Box 1.6. Criteria for starting an integrated care pathway for patients dying in hospital (from Edmonds and Rogers, 2003)

Patients who have a known diagnosis and have deteriorated despite appropriate medical intervention. The multiprofessional team have agreed the patient is dying and at least two of the following apply:

The patient:

1. is bedbound
2. is only able to take sips of fluids
3. has impaired concentration
4. is semi-comatose
5. is no longer able to take tablets

General Medical Council Guidance

In 2002, the general Medical Council (GMC) (GMC, 2002) issued guidance on withholding life-prolonging treatment. Much of this guidance is not directly relevant to an assessment of the care of patients at Gosport, but the guidance does state guiding principles dealing with respect for human life and patients' best interests. These make clear what is expected of doctors in the UK, and are relevant to judgements that may be made about the care of people under the care of the Department of Medicine for Elderly People at Gosport Hospital. The relevant section of the guidance is quoted in full in Box 1.7.

Box 1.7 Respect for Human Life and Best Interests (GMC, 2002)

Doctors have an ethical obligation to show respect for human life; protect the health of their patients; and to make their patients' best interests their first concern. This means offering those treatments where the possible benefits outweigh any burdens or risks associated with the treatment, and avoiding those treatments where there is no benefit to the patient.

Benefits and burdens for the patient are not always limited to purely medical consideration, and doctors should be careful, particularly when dealing with patients who cannot make decisions for themselves, to take account of all the other factors relevant to the circumstances of the particular patient. It may be very difficult to arrive at a view about the preferences of patients, who cannot decide for themselves, and doctors must not simply substitute their own values or those of the people consulted.

Prolonging life will usually be in the best interests of a patient, provided that the treatment is not considered to be excessively burdensome or disproportionate in relation to the expected benefits. Not continuing or not starting a potentially life-prolonging treatment is in the best interests of a patient when it would provide no net benefit to the patient. In cases of acute critical illness where the outcome of treatment is unclear, as for some patients who require intensive care, survival from the acute crisis would be regarded as being in the patient's best interests.

End of natural life

Life has a natural end, and doctors and others caring for a patient need to recognise that the point may come in the progression of a patient's condition where death is drawing near. In these circumstances doctors should not strive to prolong the dying

process with no regard to the patient's wishes, where known, or an up to date assessment of the benefits and burdens of treatment or non-treatment.

Notes on selected drugs

1. *Morphine and diamorphine*

Important sections of the review are concerned with the use of selected drugs towards the end of life. Brief notes about relevant drugs are included here for those who may not be familiar with them. The transition from the weaker to the stronger analgesics is usually described in terms of a three step ladder (Twycross et al, 1998), beginning with non-opioid analgesics such as paracetamol (step one), followed by the addition of a weak opioid such as codeine or dextromoramide (step two), the final step being the addition of a strong opioid.

Morphine and diamorphine are both strong opiate analgesics. Although there is a risk of dependence if the drugs are administered repeatedly, the British National Formulary (2001) makes clear that this should not be taken as a reason for not using regular opiates in terminal care. Morphine is the treatment of choice for oral treatment of severe pain in palliative care, and a dose of 5-10mg given every 4 hours is enough to replace a non-opioid analgesic such as paracetamol or a non-opioid and weak opioid used in combination (for example, paracetamol with dihydrocodeine). However, the dose should be increased stepwise according to response. Oramorph is a pharmaceutical company's name for a particular preparation of oral morphine. Modified release preparations suitable for twice daily administration are available as tablets (for example MST Continus), capsules or in suspension.

If the patient becomes unable to swallow, intramuscular morphine may be given, the equivalent dose being half the dose of the oral solution. However, diamorphine is preferred for injection because it is more soluable and can therefore be given in smaller volumes. The equivalent intramuscular or subcutaneous dose of diamorphine is one third the oral dose of morphine (Twycross et al, 1998). Thus, if a patient has been receiving 10mg of morphine oral solution every 4 hours (a total of 50 mg in each 24 hours), the equivalent dose of diamorphine administered subcutaneously by syringe driver would be approximately 17 mg in 24 hours.

Agitation, confusion and myoclonic jerks occur as a consequence of opiate toxicity. These features may be interpreted as un-controlled pain, leading to the administration of more opiate medication. The consequences are increased sedation, dehydration and further toxicity (O'Neill and Fallon, 1997).

2. *Fentanyl*

Fentanyl (Durogesic) is a strong opioid analgesic that can be absorbed through the skin, and is therefore administered by self-adhesive patches applied to the skin. The patch releases a defined dose per hour over a period of 72 hours, after which the patch should be replaced.

3. *Haloperidol*

Haloperidol is given in syringe drivers to control nausea and vomiting, in doses of 2.5 to 10mg in 24 hours. It is an antipsychotic, but has little sedative effect.

4. *Hyoscine hydrobromide*

Hyoscine hydrobromide is used to control respiratory secretions and is given by syringe driver in doses of 0.6 to 2.4 mg per 24 hours. Drowsiness is a side-effect

5. *Midazolam*

Midazolam (Hypnovel) is a benzodiazepine sedative and is suitable for the very restless patient, in doses of 20 to 100 mg in 24 hours. Drowsiness is a side-effect, and haloperidol is an alternative if symptoms are not controlled by doses of 30mg or less per 24 hours (Twycross et al, 1998)

The Wessex Guidelines

Local guidelines on palliative care were available to health professionals in Gosport. They were published by the Wessex Specialist Palliative Care Unit, and were referred to as the "Wessex Guidelines". The edition of the guidelines current in 1998 recommended assessment of pain, including the site, severity, duration, timing, and aggravating and relieving factors. The use of a body diagram and the patient's own words were recommended as part of the assessment. Depending on the findings of the assessment, analgesics if appropriate were advised, in accordance with the three steps in the WHO analgesic ladder (step one non-opioids, step 2 weak opioids, step 3 strong opioids). The guidelines included advice about the choice of opiate analgesics, and selection of dose, the recommendations being in accordance with the notes and drugs discussed above. The guidelines noted that the use of nebulised opioids was not supports by scientific evidence and might induce bronchospasm. The guidelines address all aspects of clinical management in palliative care, in addition to use of medication.

An Overview of The Report

The review is presented in the following six Chapters. Chapter Two reports an investigation of a random sample of clinical records of patients who died between 1988 and 2000. The review of records was undertaken following review of five records of patients whose deaths were being investigated by the police, and sought to describe clinical practice in the Department of Medicine for Elderly People at Gosport hospital.

In Chapter Three, an analysis of the numbers of deaths in Gosport hospital 1988-2000 is presented, the data being based on counterfoils of medical certificates of the cause of death completed by doctors at the hospital. The data are used to describe the certified causes of death, to identify clusters of deaths, and the features of patients whose deaths had been certified by Dr Barton. The Chapter also outlines the difficulties encountered in use of Hospital Episode Statistics to explore patterns of deaths in Gosport hospital.

Chapter Four presents the findings of a review of information obtained from admissions books from Dryad ward. The admissions books contain information about the duration of admission, whether patients had died or were discharged from the ward, the place patients were admitted from, and some indication of the reason for admission.

An investigation of information contained in retained controlled drugs registers is reported in Chapter Five. Data in the registers indicate which patients received opiate medication, how much medication they received, and the wards on which patients were staying. The information was related to information from the

counterfoils of medical certificates of the cause of death to investigate the proportions of people who died who had received an opiate.

Chapter Six presents information obtained from medical certificates of the cause of death completed by Dr Barton and a comparison sample of general practitioners. This analysis was undertaken to determine whether the numbers of deaths among patients in general practice was as expected. Finally, Chapter Seven presents the conclusions and a small number of recommendations.

Ethics approval

Approval for access to data from Hospital Episodes Statistics and National Statistics was obtained from the ethics committees of these organisations. The methods of the audit were discussed with the Chair of the Isle of Wight, Portsmouth and SE Hants Local Research Ethics Committee, and it was confirmed that it was not a research study that required approval. The audit has been undertaken in accordance with the guidance of the GMC on confidentiality. In the Chapters that follow, care has been taken to exclude any material that might lead to the identification of individual patients.

Much of this review is focused on the work of Dr Barton. This should not be taken as meaning that Dr Barton was the origin of approach followed at Gosport hospital, or that her clinical practice was the key problem that has given rise to the concerns expressed by relatives. Since Dr Barton issued most of the medical certificates of cause of death for patients of the Department of Medicine for Elderly People, made most of the entries in the clinical records, and was responsible for most of the prescribing, she has served as a means of identifying patients and care that should be included in the review. However, it should be recalled that she was a member of a

clinical team, and the review has not investigated the process of decision making in the clinical team. The audit relied on documentary evidence about care of patients at Gosport, and did not involve consideration of statements from individuals. Therefore, conclusions about the actions of individuals should not be reached since they have not had the opportunity of presenting their own side of the story.

References

British National Formulary (2001). Edition 41. London: British Medical Association, Royal Pharmaceutical Society of Great Britain.

CHI (2002). Portsmouth Healthcare NHS Trust at Gosport War Memorial Hospital. Commission for Health Improvement. The Stationery Office

Costello J (2001). Nursing older dying patients: findings from an ethnographic study of death and dying in elderly care wards. J Advanced Nursing 35:59-68.

Costello J (2002). Do not resuscitate orders and older patients: findings from an ethnographic study of hospital wards for older people. J Advanced Nursing 39:491-9.

Edmonds P, Rogers A (2003). 'If only someone had told me ....' A review of the care of patients dying in hospital. Clinical Medicine 3:149-52.

Evers MM, Purohit D, Perl D, Khan K, Marin DB (2002). Palliative and aggressive end-of-life care for patients with dementia. Psychiatric Services 53:609-13.

Fox PL, Raina P, Jadad AR (1999). Prevalence and treatment of pain in older adults in nursing homes and other long-term care institutions: a systematic review. Canadian Med Ass J 160:329-33.

GMC (2002). Withholding and Withdrawing Life-Prolonging Treatment: Good Practice in Decision-Making. London: General Medical Council.

Lloyd-Williams M (1996). An audit of palliative care in dementia. Eur J Cancer Care 5:53-5

Lloyd-Willliams M, Payne S (2002). Can multidisciplinary guidelines improve palliation of symptoms in the terminal phase of dementia? Int J Palliative Nursing 8:370-5.

McCarthy M, Addington-Hall J, Altmann D (1997). The experience of dying with dementia: a retrospective study. Int J Geriatr Psychiatr 12:404-9.

Morrison RS, Siu AL (2000). Survival in end-stage dementia following acute illness. JAMA 284:47-52.

O'Brien T, Welsh J, Dunn FG (1998). Non-malignant conditions. ABC of palliative care. BMJ 316:286-9.

O'Neill B, Fallon M (1997). Principles of palliative care and pain control. ABC of palliative care. BMJ 315:801-4.

Severs MP, Wilkins PSW (1991). A hospital palliative care ward for elderly people. Age and Ageing 20:361-4.

Shuster JL (2000). Palliative care for advanced dementia. Clinics in Geriatric Medicine 16:373-86.

Steen JT van der, Graas T de, Ooms ME, (2000). When should physicians forgo curative treatment of pneumonia in patients with dementia? West J Med 173:274-7.

Steen T van der, Ooms ME, Wal G van der, Ribbe MW (2002). Pneumonia: the demented patient's best friend? Discomfort after starting of withholding antibiotic treatment. J Am Geriatr Soc 50:1681-8.

Twycross R, Wilcock A, Thorp S (1998). Palliative Care Formulary. Abingdon: Radcliffe Medical Press.

Chapter Two. Review of records

A review of records of cases reported to Hampshire Constabulary

In 1998, the initial police investigation into care of patients at Gosport War Memorial Hospital was prompted by the death of one patient that was reported to the police by the family of the deceased as a potential case of unlawful killing. In the months that followed, other families who had become aware of concerns about care at the hospital also contacted the police. From the cases notified to them, the police had, by December 2002, identified five cases that shared certain features that indicated the need for detailed investigation. The police permitted me to review the clinical records of these cases.

The aim of the review of these records was to identify those features recorded in the records that might give rise to concern about the care patients had received and the cause of death. The police had invited a small number of clinical experts to review the records, but I did not consult the reports of these experts in order to ensure that an independent opinion was reached. The records available included all those made by medical and nursing staff at Gosport War Memorial Hospital, drug charts, X rays and investigation reports, records made by staff in acute hospitals in the case of those patients who had been transferred to Gosport from another hospital, and correspondence from patients' general practitioners. The features identified from the five sets of records were:

1. *All were frail, with major clinical problems.* All five had been admitted to Gosport War Memorial Hospital from other services, for example from acute hospital following surgery for a fractured hip, or from a day hospital. All were

dependent on nursing care and had more than one health condition, including for example Alzheimer's disease, Parkinson's disease, or cancer. Their continuing problems included pressure sores, mobility, confusion and incontinence.

2. *In some cases, active treatment had been planned.* Some, although not all of the five patients had been admitted to Gosport to enable active treatment to be arranged, for example rehabilitation after a fractured hip, or aggressive treatment to heal a sacral ulcer. It should be noted, however, that in one case admission was for palliative care, and in another the prognosis had been noted as poor prior to transfer from an acute hospital.
3. *Oramorph was written on the drug chart on admission.* In four of the five cases, Oramorph was prescribed although not necessarily administered on the day of admission.
4. *Diamorphine was administered by syringe driver in all cases.* Diamorphine was commenced when a patient had pain not otherwise controlled, was noted to be agitated, or had deteriorated in some way. Diamorphine was usually administered with hyoscine and midazolam.
5. *Doses of opiates were unexceptional.* Patients were not given extremely high doses of diamorphine or Oramorph, although it should be noted that they were all frail and elderly, and diamorphine was administered along with midazolam.
6. *The records did not contain full explanations for the treatment decisions.* The medical records were generally rather brief, although the amount of detail varied between doctors. Consultants tended to make more detailed notes. The reason for selecting morphine rather than a non-opiate analgesic was not recorded, even though in some cases other analgesics had not been used. Likewise, the decision to initiate subcutaneous diamorphine by syringe

driver or the reasons for not investigating the potential causes of new symptoms such as pain or agitation were often not fully described.

7. *Remarks in the records suggested a conservative rather than active attitude towards clinical management.* Two of the five records included the instruction by a doctor to nursing staff: 'Please make comfortable'; three records included: 'I am happy for nursing staff to confirm death', written by Dr Barton in all cases on the day of admission.

Review of a random sample of records

Having identified features of cases that the police had been investigating, a review of a random sample of records of patients who had died in Gosport War Memorial Hospital was undertaken. The aims of the review were to (a) determine whether other cases shared these features, and (b) describe the pattern of care of patients who died in the hospital. The review concentrated on patients who had been under the care of Dr Barton, since the medical certificates of cause of death (MCCD) of most patients who had died on Daedalus and Dryad wards had been issued by Dr Barton. Most MCCDs issued by Dr Barton would have been for patients who have been under the care of the Department of Medicine for Elderly People.

Method

Patients whose deaths had been certified by Dr Barton between 1987 and 2002 were identified by National Statistics. From 1993 onwards, information about deaths has been stored on a computer system by National Statistics, and those certified by Dr Barton were readily identified. However, prior to 1993 information was stored on paper only, and a hand search of files containing information about deaths notified in districts local to Gosport was required. The information held on computer or paper

systems consists of details recorded by the certifying doctor on the MCCD, and associated information provided to the registrar of births, marriages and deaths by the informant, who is usually a relative of the deceased. In this report, the summaries of the information from these two sources combined are referred to as death notifications. In addition to the name of the deceased, date of death, and certified cause of death, the information available includes the name of the doctor who issued the MCCD, and the place of death.

The sample of records selected for review was taken from the notifications provided by National Statistics. The review sampled cases from 1988 until 2000, from the beginning of Dr Barton's work at the hospital until she left her post of clinical assistant. A 10% sample of the 833 deaths certified by Dr Barton during this period was selected using the random sampling procedure in the Statistical Package for the Social Sciences (SPSS), the principal statistics software employed in this review.

The hospital records of all deceased patients had been retained by Portsmouth Healthcare NHS Trust for all years during which Dr Barton worked at Gosport, although records of patients who died in 1995 or before had been stored on microfiche. The record department of Gosport War Memorial Hospital was asked to provide all the sampled records, and once these had been retrieved, the review was undertaken. The information extracted from each record is shown in Table 2.1. The notes recorded by both doctors and nurses were reviewed, and drug charts were also inspected. In addition, in each case my own observations on the patient's care were recorded, and the cause of death as certified by Dr Barton was noted. Causes of death were grouped into six categories, according to the first cause of death noted on the MCCD. Thus, the category 'cancer' included all deaths in which a type of cancer was given as the first cause of death. Heart conditions included myocardial

infarction, heart failure, ischaemic heart disease, and other heart disorders. Stroke included both cerebral thrombosis and cerebral haemorrhage. Some certificates gave bronchopneumonia as the sole cause of death, and these were placed in a category distinct from deaths certified as due to bronchopneumonia associated with other conditions that included cancer, dementia, or other disorders. The 'other' category included dementia, old age, renal disease, progressive neurological conditions and other medical conditions not included in the five other categories.

Table 2.1. Information extracted from the clinical records

	Information collected from records
1	Age and gender
2	Date of admission
3	Past medical history
4	History of the final illness
5	Administration of opiate medication

Results

The sample consisted of 85 patients. The records of four were held by the police and therefore were excluded from this review. All the remaining 81 records were reviewed. The numbers of records in each year are shown in Table 2.2. The mean age of patients in the sample was 84.5 years (95% confidence interval 82.8-86.1), and in the group not sampled 82.7 years (95% confidence interval 82.2-83.3). The proportion of females was slightly higher in the sample than in the group not in the sample (Table 2.3), although this did not reach statistical significance (Chi Sq 3.26, df 1, p 0.07). There was no difference between the groups of patients included in and excluded from the sample with respect to the numbers of patients certified as dying from different categories of illness (Chi Sq 3.02, df 5, p 0.70) (Table 2.4).

Table 2.2. Numbers of deaths in Gosport War Memorial Hospital certified by Dr Barton in total, and numbers in sample, 1988-2000.

Year	Number of patients in sample	Number of deaths certified by Dr Barton
1988	2	19
1989	4	30
1990	3	38
1991	6	31
1992	2	32
1993	10	94
1994	8	104
1995	7	80
1996	8	84
1997	11	86
1998	7	107
1999	12	92
2000	1	34
Total	81	833

Table 2.3. Numbers (%) of males and females in the sample compared to those not in the sample the (the Table does not include the four cases excluded from the sample).

Gender	Not in sample	In sample	Total
male	337 (45.1)	28 (34.6)	365 (44.0)
female	411 (54.9)	53 (65.4)	464 (56.0)
total	748	81	829

Table 2.4. Numbers (%) of deaths due to different categories of disease, in those patients included in and excluded from the sample.

Category of disease	Not in sample	In sample	Total
Cancer	44 (5.9)	5 (6.2)	49 (5.9)
Heart	85 (11.4)	7 (8.6)	92 (11.1)
Stroke	122 (16.3)	13 (16.0)	135 (16.3)
bronchopneumonia + other conditions	331 (44.3)	33 (40.7)	364 (43.9)
bronchopneumonia only	139 (18.6)	21 (25.9)	160 (19.3)
Other	27 (3.6)	2 (2.5)	29 (3.5)
total	748	81	829

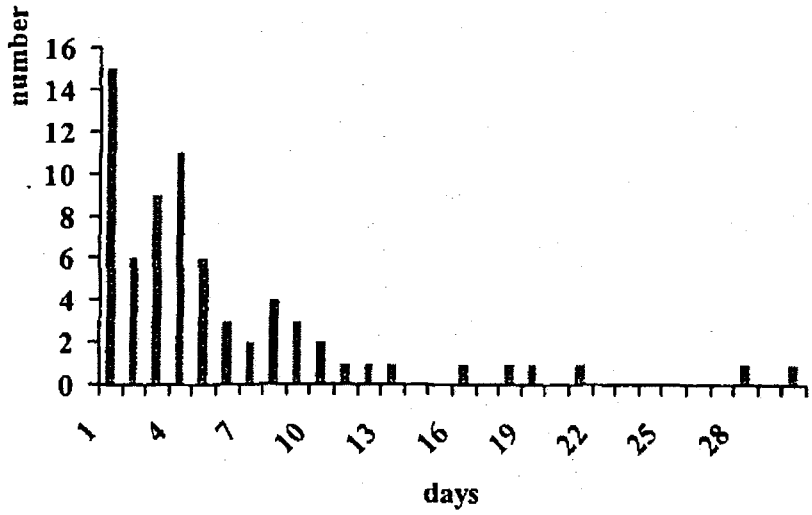
The patients in the sample were almost all elderly; all except two were aged 70 or over (one was aged 69 and one 60). Twenty-one (25.9%) were aged 90 or above (one was aged 100). Typically, patients had been transferred to Gosport following admission to an acute hospital for a major illness, the transfer to Gosport being arranged because the patient would have required more support than could have been provided in a nursing home. In some cases, the aim of transfer to Gosport was rehabilitation, for example, following a stroke or fractured hip. In others, the aim was long term care, as in patients with lasting disabilities following major strokes, or with terminal cancer. Many patients also had other comorbid conditions contributing to the development of dependence on nursing care, including advanced dementia and cardiovascular disease.

Table 2.5. Numbers (%) of patients who received opiate medication before death

	N	%
None	5	6.2
Diamorphine only	21	25.9
Oramorph and diamorphine	38	46.9
Other oral opiates and diamorphine	13	16.0
Other opiates, no diamorphine	4	4.9
Total	81	100.0

Most patients had received an opiate before death (Table 2.5). The most common pattern was initial use of Oramorph, followed by diamorphine subcutaneously. When used in a syringe driver in this way, diamorphine was invariably accompanied by other drugs. In 1988, diamorphine was used in combination with atropine, but in subsequent years it was combined with hyoscine and midazolam. In one case, the duration of opiate medication could not be determined from the records. The other 76 who received opiates were administered the drugs for a median of four days (range 1 – 120 days, inter-quartile range 7 days) (see Figure 2.1).

Figure 2.1. Duration of administration of opiate medication (chart excludes 2 patients at 42 days, 3 at 90 days and 1 at 120 days).



The pattern of use of opiates in these patients generally involved the administration of an oral opiate for pain or distress from whatever cause, followed by the use of subcutaneous diamorphine when the patient became unable to swallow oral medication. This process was usually triggered by a deterioration in health. An example taken from the medical records is as follows:

'further deterioration. Uncomfortable coughing, to have a tiny dose of oramorph regularly JAB' (JAB are Dr Barton's initials) (Case 1210).

Oramorph would also be commenced by other doctors, for example:

Oedema worse, relative feels patient has had enough. Oramorph started. (Signature not clear) (Case 1209).

If the patient deteriorated further, subcutaneous diamorphine would be used, for example:

'Further deterioration in general condition. In pain, confused and frightened. sc analgesia commenced. JAB' (Case 1139).

or:

'patient has deteriorated over weekend, pain relief is a problem. I suggest starts sc analgesia and please make comfortable. I am happy for nursing staff to confirm death. JAB' (Case 708).

The initial dose of diamorphine varied from 5 mg to 80 mg in 24 hours, doses below 20 mg being administered intramuscularly, and doses of 20 mg or more being administered subcutaneously by syringe driver. Of the 60 patients in whom the starting dose of diamorphine could be established, the most common dose was 40mg (50.8%), followed by 20 mg (31.7%) (Table 2.6). Of the 19 who received 20 mg diamorphine in 24 hrs, the dose of oral morphine being administered before

diamorphine was commenced could be identified in seven. The mean total daily dose of oral morphine in these cases was 27.1 mg. Of the 31 who received a starting dose of diamorphine of 40 mg in 24 hours, the daily dose of oral morphine before changing to subcutaneous diamorphine could also be established in seven cases, and the mean morphine dose in these was 44.3 mg. It is generally recommended that to obtain an equivalent level of pain relief, the dose of diamorphine on transfer from oral morphine should be one third of the total daily oral dose (see Chapter One). If this guidance is followed, a starting dose of subcutaneous diamorphine of 20 mg would equate to a daily dose of oral morphine of 60 mg, and a 40 mg dose of diamorphine would equate to a 120 mg dose of oral morphine in 24 hours.

Table 2. 6. Numbers (%) of patients receiving different starting doses of diamorphine

Diamorphine (mg)	N	%
5	1	1.7
10	2	3.3
15	1	1.7
20	19	31.7
30	2	3.3
40	31	50.8
60	1	1.7
80	3	5.0
Total	60	

The use of opiates was not confined to patients with cancer. Only two (15.4%) patients who were certified as having died from strokes did not receive an opiate, and only three (9.1%) of those who were certified as dying from bronchopneumonia associated with other conditions did not receive an opiate (Table 2.7).

Table 2.7. The certified causes of deaths of patients and the numbers (%) who received an opiate.

	Opiates					Total
	none	*diamorphine only*	*oramorph then diamorphine*	*other opiates then diamorphine*	*other opiates*	
cancer	0	1 (20.0)	3 (60.0)	0	1 (20.0)	5
heart	0	2 (28.6)	2 (28.6)	2 (28.6)	1 14.3)	7
stroke	2 (15.4)	3 (23.1)	8 (61.5)	0	0	13
bronchopneumonia with other conditions	3 (9.1)	10 (30.3)	15 (45.5)	5 (15.2)	0	33
bronchopneumonia alone	0	5 (23.8)	9 (42.9)	5 (23.8)	2 (9.5)	21
other conditions	0	0	1 (50.0)	1 (50.0)		2
Total	5 (6.2)	21 (25.9)	38 (46.9)	13 (16.0)	4 (4.9)	81

Typically, a deterioration in a patient's condition would not be investigated in depth. In many cases this would have been appropriate, since the advanced state of illness and impossibility of further curative or rehabilitative treatment had been well established. However, in some cases, the resort to opiate medication might have been, but was not, preceded by some investigation, or trial of analgesics other than opiates. The degree of assessment of pain recommended in the 'Wessex guidelines' was not usually evident in the records, and body maps to highlight areas of pain were not used. For example:

– *'frightened agitated appears in pain suggest transdermal analgesia despite no obvious clinical justification!! Dr Lord to countersign. I am happy for nursing staff to confirm death. JAB'* (Case 785).

In 18 (22.2%) cases the drug chart could not be reviewed because a copy had not been stored on microfiche. Nonetheless, in these cases it was possible to describe the use of opiate medication from entries in the medical and nursing records. Drug charts were almost always completed by Dr Barton. It was notable that in many cases, prescriptions for opiate medication had been entered by Dr Barton on drug charts on the day of the patient's admission, although the medication was not administered until some days or even weeks later. For example, in the case of a patient who had abdominal obstruction and had been admitted to Gosport from an acute hospital, diamorphine was entered onto the drug chart on the day of admission, but not administered until 16 days later (Case 597). Prescriptions for diamorphine typically indicated a range of dose, to enable adjustment without a new prescription being written. In the example just mentioned, the indicated dose was 20-80 milligrams subcutaneously in 24 hours, to be administered with hyoscine and midazolam. It was not unusual for entries in the records by Dr Barton on the day of admission to include the statement '*I am happy for nursing staff to confirm death JAB*' (e.g. Case 530).

The proportion of patients who received an opiate before death did not vary significantly from year to year (Table 2.8). Of the nine deaths that occurred between 1988 and 1990, seven had received an opiate, and it therefore appears that the almost routine use of opiates before death had been established at Gosport hospital long before the initial complaint in 1998.

Table 2.8. Numbers (%) of patients who received an opiate before death, 1988-2000 (Chi Sq 50.0, p not significant).

year	Opiates					Total
	none	*diamorphine*	*oramorph plus diamorphine*	*other plus diamorphine*	*other only*	
1988	1 (50.0)			1 (50.0)		2
1989	1 (25.0)	3 (75.0)				4
1990		2 (66.7)		1 (33.3)		3
1991	1 (20.0)	1 (20.0)	1 (20.0)	2 (40.0)		5
1992			1 (50.0)	1 (50.0)		2
1993		4 (36.4)	3 (27.3)	3 (27.3)	1 (9.1)	11
1994	1 (12.5)	3 (37.5)	4 (50.0)			8
1995		2 (28.6)	5 (71.4)			7
1996		1 (12.5)	6 (75.0)		1 (12.5)	8
1997	1 (9.1)	2 (18.2)	6 (54.5)	2 (18.2)		11
1998		1 (14.3)	3 (42.9)	2 (28.6)	1 (14.3)	7
1999		2 (16.7)	8 (66.7)	1 (8.3)	1 (8.3)	12
2000			1 (100.0)			1
	5 (6.2)	21 (25.9)	38 (46.9)	13 (16.0)	4 (4.9)	81

The medical records were often limited. In 32 (39.5%) of the cases reviewed, the records were judged to be too brief to enable an adequate assessment of care to be made. In particular, they did not always contain information about the decision to initiate opiate medication.

In the review, it was possible to relate information contained in the records to the information reported on death certificates. In 42 (51.9%) cases, the information on certificates was judged to be an incomplete statement of factors contributing to

death. In 16 of these, a recent fracture that had contributed to the patient's condition had not been reported on the death certificate. These included patients who had suffered a fractured hip and undergone operative fixation or partial hip replacement in an acute hospital prior to transfer to Gosport. Indeed, a fracture had not been mentioned on any of the death certificates in the sample. Typically, death in these cases was reported as being caused by bronchopneumonia.

Forty-eight records contained sufficient details to enable a judgement to be made about the appropriateness of care. In 32 (66.7%) of these, care was judged to have been appropriate. There were some concerns about the decision to start opiate medication in the remaining 16 (33.3%). The indications for starting the drugs were either not clearly stated, or if pain was mentioned it had not been investigated, and neither remedial treatment or alternative analgesia had been attempted. For example, the following was written in one set of records in Dr Barton's handwriting: *'marked deterioration over last 24 hrs. Persistent cough relieved by nebulised diamorphine in N/saline. .... Sc analgesia is now appropriate + neb if required'* (Case 587). No investigation of the cough was described nor treatment other than nebulised diamorphine.

Discussion

A number of qualifications about the review of records should be acknowledged. The information was obtained from the records only, and because of the pressure of routine care in a hospital ward, clinicians may often fail to record extensive details about patient care. In some cases, the drug charts that recorded prescribing and administration of opiate medication were not available because they had not been copied onto microfiche. More complete records, or information obtained through interviews of clinical staff or relatives, might have explained some of the findings

that, on the evidence of the records alone, gave rise to some concern. The sample included only patients whose deaths had been certified by Dr Barton. However, the records contained entries from other doctors, and demonstrated that they had made some treatment decisions.

The record review was undertaken to identify broad patterns of care, and therefore included a relatively large number of cases, albeit a sample from over 800 cases. An intensive, prolonged and in depth review of a small number of cases might have reached, in those cases, different conclusions. Nevertheless, despite these reservations, the review does raise questions about the care provided to patients at Gosport War Memorial Hospital.

Features of care

The first aim of the review was to determine whether features associated with the care of patients whose deaths were being investigated by the police could also be found in the sample.

1. All patients were severely ill, having major disabling, or progressive conditions, or illnesses that were unlikely to substantially improve. They were heavily dependent on nursing care, and many had been intensively investigated and treated in acute hospitals before transfer to Gosport.
2. The precise reasons for admission were not always clear from the records, but some patients had certainly been admitted for rehabilitation. The majority of patients, however, had major clinical problems.
3. 93.8% of patients received an opiate, and almost half received Oramorph (Table 2.5). Opiate medication was frequently prescribed on the day of admission, although there was no immediate indication for their use, and they

were sometimes not administered until after several days or weeks. There was little evidence of use of weak or moderate analgesics before resort to oral morphine, opiate medication being used when patients suffered a deterioration in their condition. Further investigation or active treatment were often not undertaken, and alternative analgesics were generally not used first. If pain was a feature of a patient's deterioration, a detailed assessment of the reasons for pain was not usually recorded.

4. Diamorphine was administered to 72 (88.9%) patients, almost always by syringe driver and accompanied with other drugs with sedative properties, most commonly midazolam and hyoscine. Diamorphine was used in all categories of condition (Table 2.7). In those patients in whom the dose of oral morphine could be established, the starting dose of diamorphine tended to be higher than would have been expected. The two potential explanations are that oral opiates were not being administered at sufficient doses to control pain, or that the doses of diamorphine were greater than required.
5. In most cases, opiates were not used for prolonged periods, 47 (61.8%) patients dying within five days of starting treatment.
6. The records were generally brief. On occasions, details were either not recorded, or no entries were made when the patient had been assessed by a doctor, although the consultation was mentioned in the nursing records. The reasons for starting opiate medication were often not adequately recorded, and in 39.5% of cases it was not possible to assess the appropriateness of care.
7. The conservative attitude to treatment identified in the records of the cases being investigated by the police was also evident in the records of the sample. The quotations included above serve to illustrate this finding. The

initial medical assessment of a patient on admission was often concluded with the phrase 'Please make comfortable'.

8. In the case of patients whose deaths had been preceded by a bone fracture (most commonly the hip), Dr Barton did not note the fracture on the medical certificate of cause of death. The Office of National Statistics (ONS) encourages the practice of voluntary referral to the coroner by the certifying doctor of deaths due to accidents (whenever the accident occurred) (Devis and Rooney, 1999). It is conceivable that the local coroner would have undertaken at least some investigation into a number of the deaths that had followed fractures.

The pattern of care

The review included records of patients who died from 1988 to 2000. The findings reveal a distinct pattern dating from 1988. Indeed, the almost routine use of opiates before death appears to date from at least as early 1988, but it is conceivable that this practice was in use before this, and before Dr Barton was appointed as clinical assistant.

The patients admitted to Gosport War Memorial Hospital under the care of the Department of Medicine for Elderly People were old and frail. They had major illnesses and were heavily dependent on nursing care. In managing these patients, the culture at Gosport throughout the period appeared, from the records, to have been conservative with regard to treatment and modest with regard to expectations of improving patient health. It may be summed up in Dr Barton's own words, frequently written in the records: 'Please make comfortable'. This approach may have been entirely correct for many of the severely ill and dependent patients

admitted to Gosport. However, it is possible that in some patients, a more active clinical approach would have extended life.

Opiates were used extensively, and often without recourse to other analgesics, detailed assessment of the cause of pain, agitation or deterioration, or active treatment. The doses of diamorphine appear to have been higher than prior doses of oral morphine would have suggested were required, and most patients died within a few days of starting opiates. These observations might be interpreted as indicating that management of patients with terminal illnesses, in placing so much emphasis on the comfort of the patient, were in advance of those followed elsewhere in the health service. However, they might also be interpreted as indicative of a conservative approach to treatment, and even a premature resort to opiates that in some cases may have shortened life.

The lack of detail recorded in the notes about medical decisions, and contrast between the detailed notes written by the consultants and the short entries of other doctors – sometimes written within a few hours of each other – suggests that the level of supervision and teamwork was poor. The failure of the records to provide a coherent description of a patient's illness and care, the often disjointed nature of entries by different doctors, and the lack of detail about some decisions may have been a consequence of inadequate discussion between members of the clinical team on patient management.

The completion of medical certificates of cause of death was inadequate. In particular, the pattern of not reporting recent fractures was not appropriate.

References

Devis T, Rooney C (1999). Death certification and the epidemiologist. *Health Statistics Quarterly*, Spring, 21-33.

Chapter Three: Deaths at Gosport War Memorial Hospital, 1987-2000: A review of Medical Certificates of Cause of Death (MCCDs) counterfoils

Introduction

Medical certificates of cause of death are supplied in books, each book containing 50 certificates. Each certificate is attached to a counterfoil from which it is detached when it is issued. At Gosport, only one book of MCCDs was in use at any one time, the book being held in an office close to the mortuary. It was hospital policy that MCCDs should be issued from the centrally held book, and the books of counterfoils have been retained for a number of years. Consequently, the counterfoils are likely to represent a reasonably complete record of deaths for which an MCCD was issued, although deaths that were referred to the coroner would have been excluded. This chapter describes the findings from review of these counterfoils.

The counterfoils record selected information that is also entered on the MCCD itself, including the deceased's name, date of death, the place of death, and the cause of death. From early 1988, the counterfoils of the books of certificates in use at Gosport also required the certifying doctor to state the deceased's age.

Method

Information from all the available counterfoils was entered into a database. The specific data items are shown in Table 3.1.

Table 3.1. Information obtained from the MCCD counterfoils.

1	Name
2	Gender
3	Age
4	Date of death
5	Certified cause(s) of death
6	Doctor completing the certificate
7	Place of death

The counterfoils were completed in the certifying doctors handwriting. Dr Barton had a distinctive signature almost invariably written with black ink. Consequently, deaths she had certified could be readily and confidently identified. However, the signatures of the other doctors were generally less distinctive, and consequently it was not possible to reliably identify other doctors. The other doctors would have included general practitioners who had cared for patients admitted to general practitioner beds, and doctors attending patients of the Department of Medicine for Elderly People when Dr Barton was not on duty.

Results

1. Numbers of deaths

The numbers of certificates issued each year by Doctor Barton and other doctors are shown in Table 3.2.

Table 3.2. Numbers (%) of MCCD counterfoils each year, 1987-2000, completed by Dr Barton or other doctors at Gosport.

Year	Other docs	Dr Barton	Total
1987	105 (98.1)	2 (1.9)	107
1988	85 (74.6)	29 (25.4)	114
1989	71 (69.6)	31 (30.4)	102
1990	72 (65.5)	38 (34.5)	110
1991	59 (65.6)	31 (34.4)	90
1992	68 (68.0)	32 (32.0)	100
1993	57 (36.5)	99 (63.5)	156
1994	56 (34.6)	106 (65.4)	162
1995	74 (47.7)	81 (52.3)	155
1996	100 (54.3)	84 (45.7)	184
1997	106 (55.2)	86 (44.8)	192
1998	107 (50.0)	107 (50.0)	214
1999	71 (43.6)	92 (56.4)	163
2000	81 (70.4)	34 (29.6)	115
2001	103 (98.1)	2 (1.9)	105
Total	1214 (58.7)	854 (41.3)	2069

Between 1987 and 2001, Dr Barton completed 854 MCCDs, 41.3% of all those issued at the hospital. The numbers issued by Dr Barton rose from 1988, when she issued 25% of all those issued in the year, to 1994 when she issued 64% of the total. There was a rise in the total numbers coincident with the rise in proportion issued by Dr Barton, and it was not until 2000 when the total number returned to the levels typical of the years 1987-1992. Dr Barton issued two MCCDs in 2001 for patients

who had died in general practitioner beds, the year after the termination of her clinical assistant post.

2. Age and gender of deceased patients

The mean age of Dr Barton's deceased patients was 82.8 years, but for the other doctors the mean was 78.8 (t 9.31, df 1807, p<0.001). The difference in age is probably explained by the admission criteria for the different hospital wards. The gender of the deceased could be identified in 2033 (98.3%) of the 2069 cases, and among Dr Barton's patients 478 (56.8%) were female, in comparison with 623 (52.3%) among the other doctors (Chi Square 3.95, df 1, p 0.047).

3. Certified cause of death

The cause of death, grouped into the six categories as defined in Chapter Two, given by Dr Barton and other doctors are shown in Table 3.3.

Table 3.3: Numbers (%) of deaths certified as due to groups of conditions by Dr Barton and the other doctors (Chi Sq 507.9, df 5, p <0.001).

	Other docs	Dr Barton	
cancer	424 (38.6)	49 (5.8)	473
heart conditions	165 (15.0)	100 (11.8)	265
stroke	106 (9.7)	139 (16.4)	245
bronchopneumonia + other conditions	235 (21.4)	367 (43.3)	602
bronchopneumonia alone	21 (1.9)	162 (19.1)	183
other condition	147 (13.4)	31 (3.7)	178
total	1098	848	1946

Dr Barton's patients were less likely to have been certified as dying primarily because of cancer or heart conditions, but more likely to have died from bronchopneumonia with or without other conditions, or from strokes. Case mix will explain at least some of these differences. Thus, local general practitioners appear to have admitted patients with cancer to Gosport Hospital for terminal care, but Dr Barton was responsible for the care of other groups, including people with Alzheimer's disease or other forms of dementia, and those recovering from strokes or in need of rehabilitation for other reasons.

4. Deceased seen after death, and post-mortems

Dr Barton was more likely to have reported personally seeing the deceased after death (98.6% vs 86.9%, Chi Sq 89.3, df 2, $p<0.001$). Dr Barton reported that in 99.4% of deaths, no post mortem or referral to the coroner occurred; the proportion for the other doctors was 98.4%. These cases will not have included all cases reported to the coroner, since no MCCD would have been issued by the doctor in those cases that the coroner chose to investigate. In such cases, a certificate would be issued by the coroner at the conclusion of the coronial investigation. Therefore, the deaths indicated as referred to the coroner on the counterfoils are likely to include only those in which a discussion took place with the coroner or coroner's officer, and that concluded that an MCCD should be issued by the doctor.

5. Day, calendar quarter and week of death

The date of death was used to identify the day of week of death. In the case of both Dr Barton's patients and the patients whose deaths were certified by other doctors, the pattern was as expected, with approximately equal proportions of deaths occurring on each day of the week (Table 3. 4). A marginally greater proportion of Dr Barton's patients died during the winter (October to March), a factor that might be explained by seasonal factors influencing the types of conditions with which patients

were admitted, or because Dr Barton was more likely to take vacations between April and September (Table 3.5). Table 3.6 shows the distribution of deaths during the year when the certified cause of death was given as bronchopneumonia only. Dr Barton issued a greater number of certificates giving this cause of death, although the temporal distribution was no different to that of the other doctors.

Table 3.4. Numbers (%) of patients certified as dying on each day of the week (Chi Sq 5.1, df 6, not significant).

	doctor		total
	other doctors	Dr Barton	
1	174 (15.7)	113 (13.3)	287
2	147 (13.2)	111 (13.0)	258
3	154 (13.9)	122 (14.3)	276
4	151 (13.6)	137 (16.1)	288
5	139 (12.5)	117 (13.7)	256
6	176 (15.9)	132 (15.5)	308
7	169 (15.2)	119 (14.0)	288
	1110	851	1961

Table 3.5. Numbers (%) of patients certified as dying in each calendar quarter (Chi Sq 11.2, df 3, p < 0.01)

quarter	doctor		total
	Other doctors	Dr Barton	
Jan-Mar	269 (24.1)	235 (27.6)	504
Apr-Jun	288 (25.8)	199 (23.4)	487
Jul-Sep	294 (26.3)	182 (21.4)	476
Oct-Dec	266 (23.8)	236 (27.7)	502
	1117	852	1969

Table 3.6. Numbers (%) of deaths in different quarters certified as due to bronchopneumonia alone (Chi Sq 0.67, df 3, not significant).

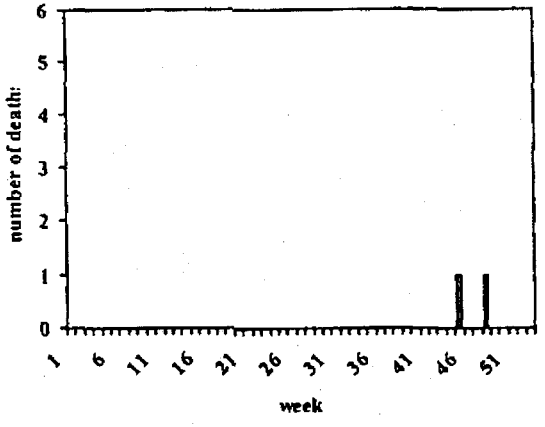
quarter	Doctor		total
	other doctors	Dr Barton	
Jan-Mar	7 (31.8)	51 (31.5)	58
Apr-Jun	6 (27.3)	33 (20.4)	39
Jul-Sep	3 (13.6)	28 (17.3)	31
Oct-Dec	6 (27.3)	50 (30.9)	56
	22	162	184

The distribution of deaths according to week of the year may also be used to identify clusters of deaths, and variations in the numbers of deaths at different times. Table 3.7 shows the mean number of deaths per week certified by Dr Barton from 1988 until July 2000, when she ceased employment at Gosport hospital. The findings demonstrate the increase in the numbers of deaths from 1993, the year in which Dryad and Daedalus wards were opened.

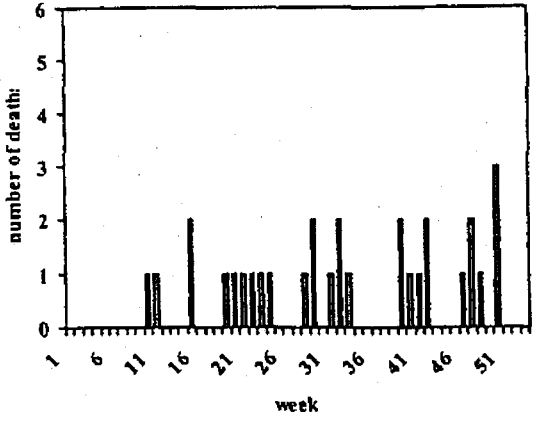
Table 3.7. Mean and standard deviation (SD) of numbers of deaths certified by Dr Barton per week, 1988- 2000.

year	minimum	maximum	number	mean	SD
1988	0	3	29	.53	.77
1989	0	2	31	.58	.69
1990	0	5	38	.72	.97
1991	0	3	31	.58	.89
1992	0	2	32	.60	.77
1993	0	5	99	1.87	1.43
1994	0	6	105	1.98	1.63
1995	0	6	81	1.53	1.31
1996	0	5	84	1.58	1.18
1997	0	6	86	1.62	1.40
1998	0	6	107	2.02	1.57
1999	0	6	92	1.74	1.32
2000	0	4	34	1.31	1.19

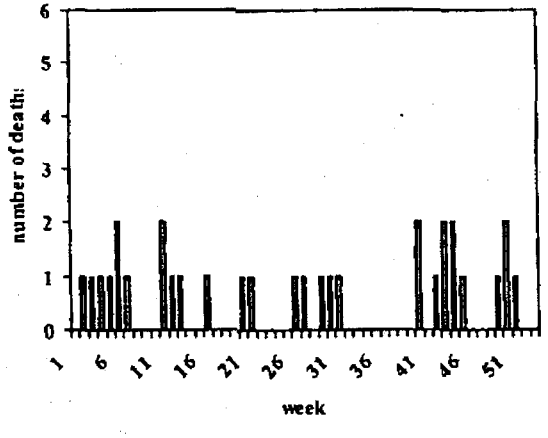
The Figures 3.1 to 3.15 in the following pages show the numbers of deaths certified each week from 1987 to 2001. They demonstrate the rise in the numbers of deaths from 1993 onwards, and suggest a decline in numbers may have occurred during 2000, although Dr Barton worked only until July in that year. The two deaths in 1987 would presumably have been for patients in general practitioner beds under the care of Dr Barton or one of her partners in her general practice. Other than the rise in numbers of deaths from 1993, the Figures do not indicate any clear clusters of deaths or patterns of concern.



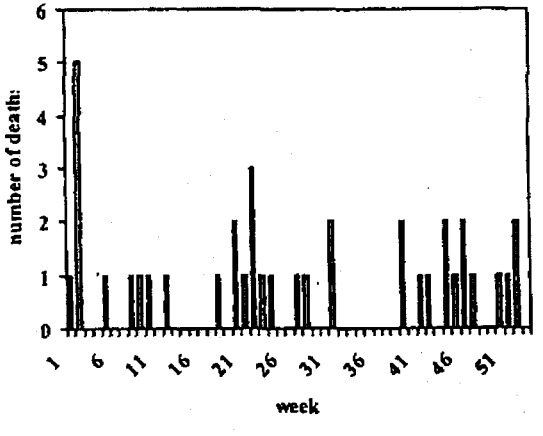
3.1. Deaths in 1987



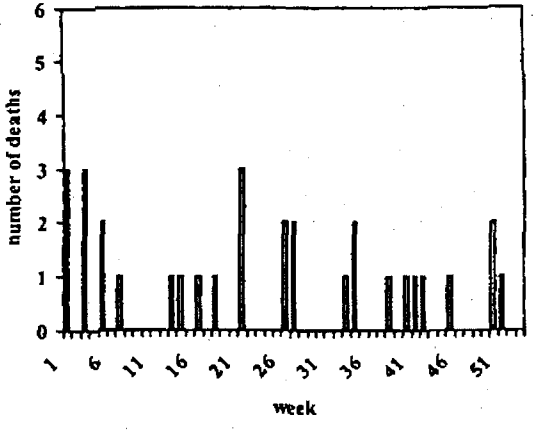
3.2. Deaths in 1988



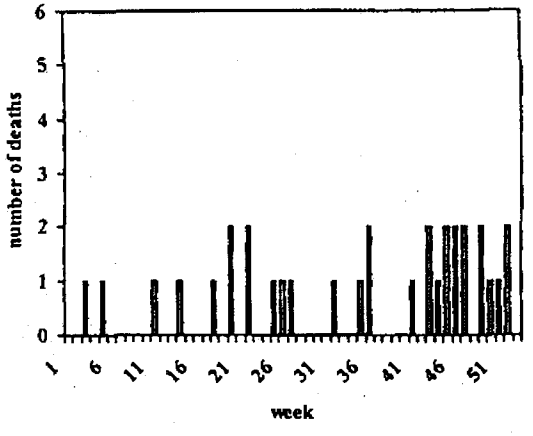
3.3. Deaths in 1989



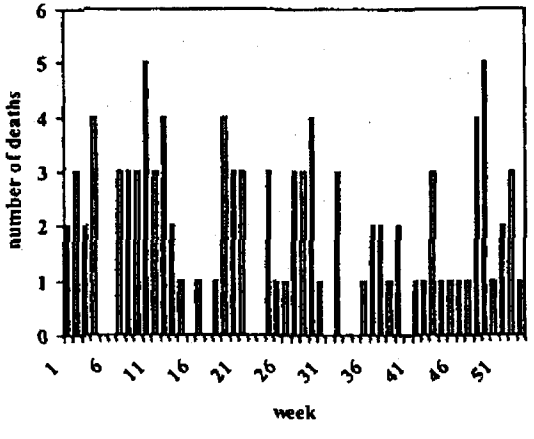
3.4. Deaths in 1990



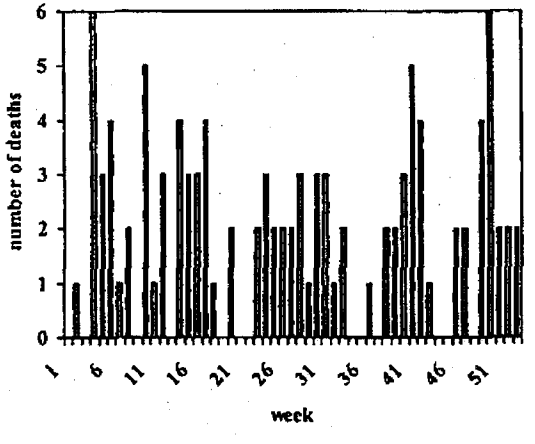
3.5. Deaths in 1991



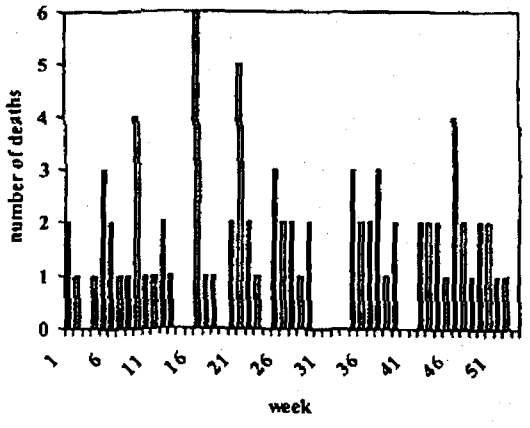
3.6. Deaths in 1992



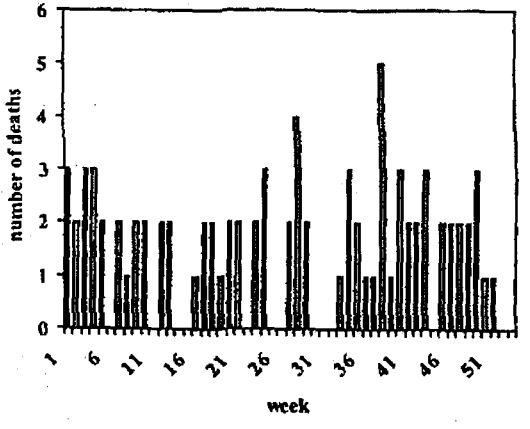
3.7. Deaths in 1993



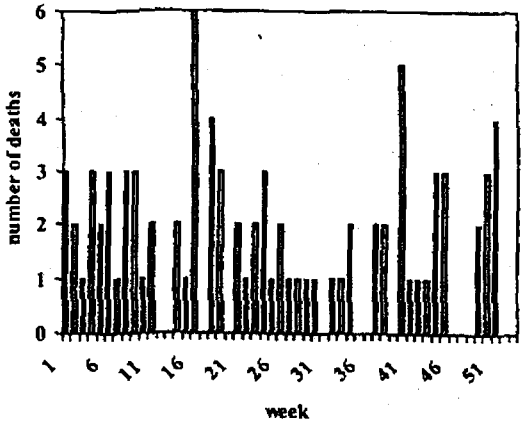
3.8. Deaths in 1994



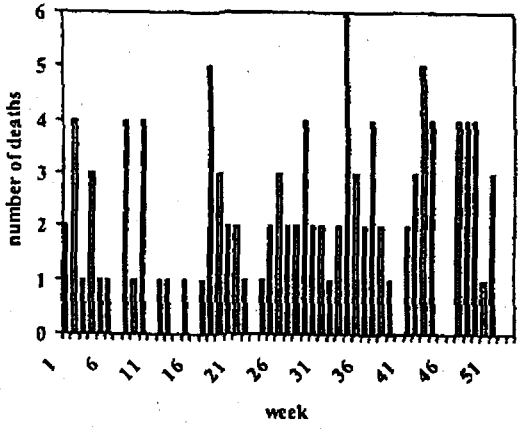
3.9. Deaths in 1995



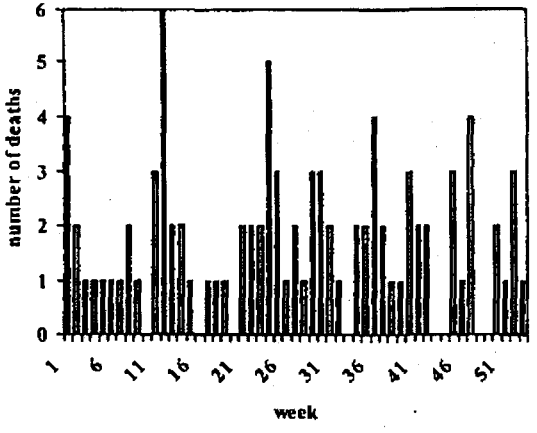
3.10. Deaths in 1996



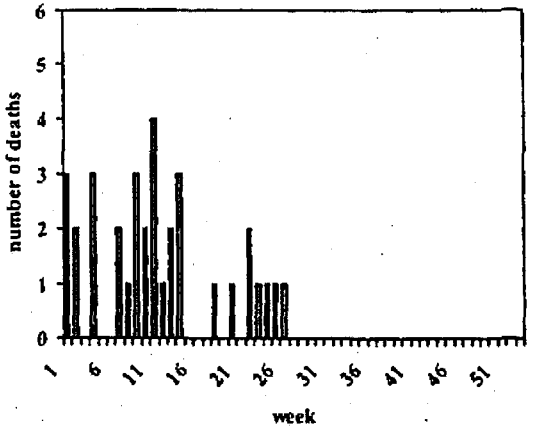
3.11. Deaths in 1997



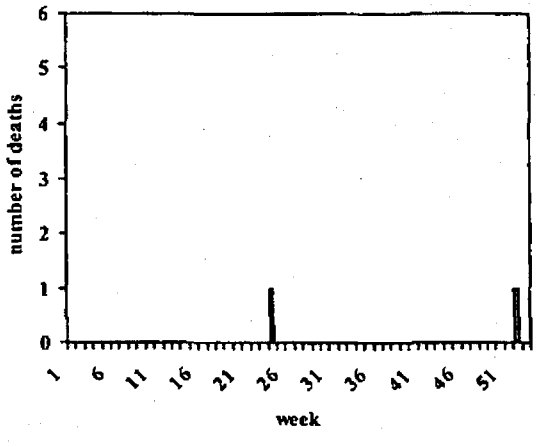
3.12. Deaths in 1998



3.13. Deaths in 1999



3.14. Deaths in 2000



3.15. Deaths in 2001

6. Patients on Dr Barton's wards

In some cases, doctors other than Dr Barton issued MCCDs for patients who died on wards specifically served by Dr Barton in her role as clinical assistant in the Department of Medicine for Elderly People. These wards were Redclyffe Annexe, and Dryad and Daedalus wards. Dr Barton also cared for some patients in the male and female wards, but these wards were not exclusive to patients of the Department. The completion of MCCDs by other doctors for patients in Redclyffe Annexe, or Dryad and Daedalus wards, could occur principally when Dr Barton was on leave or not on duty. Therefore, the case mix of these patients would tend to be similar to those whose deaths were certified by Dr Barton.

Tables 3.8 and 3.9 show respectively the certificates issued by the other doctors at the hospital and Dr Barton for deaths on different wards. These data reflect the fact that Dr Barton ceased responsibility for patients in Redclyffe Annexe and took on the new Dryad and Daedalus wards 1993/4.

Table 3.8. Deaths certified by doctors other than Dr Barton on wards at Gosport (Mulberry is a 40 bed assessment unit).

year	place of death								
	Gosport (ward not stated)	*Redclyffe*	*male ward*	*female ward*	*Daedalus ward*	*Dryad ward*	*Sultan ward*	*Mulberry*	*tota*
1987	66	9	9	11					95
1988	61	3	13	5					82
1989	52	3	3	10					68
1990	52	2	9	9					72
1991	37	1	10	11					59
1992	35	1	16	15					67
1993	34	2	3	6	3		8		56
1994	15	5			2		33		55
1995	12				12	5	35	10	74
1996	28	7			10	6	37	11	99
1997	10	3			8	7	45	33	100
1998	23	5			12	11	35	18	93
1999	12	7			6	9	27	10	71
2000	20	5			13	12	22	9	81
2001	59	8			1	4	25	6	103
	523	61	63	67	67	54	267	97	1175

Table 3.9. Deaths certified by Dr Barton on different wards at Gosport.

year	place of death							Total
	Gosport (ward not stated)	*Redclyffe*	*male ward*	*female ward*	*Daedalus ward*	*Dryad ward*	*Sultan ward*	
1987	1	1						2
1988	2	6	11	1				20
1989	1	19	8	1				29
1990		23	13	2				38
1991		18	11	2				31
1992		23	8	1				32
1993		51	7	6	35			99
1994		58	1		42		4	105
1995	1	4			42	33	1	81
1996					48	32	3	83
1997					39	47		86
1998					51	51	5	107
1999					42	49	1	92
2000					15	17	2	34
2001						1	1	2
	5	203	59	13	314	230	17	841

The mean age of patients who died on each ward was different (Table 3.10). Patients in Redclyffe, Daedalus and Dryad wards tended to be older than those in the other wards. Greater proportions of patients who died in Redclyffe, Daedalus and Dryad wards were female than those who died in Sultan ward (Table 3.11).

Table 3.10. Mean age (years) of patients who died in different wards. (N=1799, p <0.005)

Ward	number	mean age	95 % confidence intervals
Gosport hospital, ward not specified	427	78.4	77.4 – 79.4
Redclyffe	250	82.8	81.8 – 83.7
Male ward	109	78.1	76.4 – 79.9
Female ward	68	80.3	77.7 – 82.8
Daedalus	381	82.5	81.8 – 83.2
Dryad	284	83.7	82.9 – 84.5
Sultan	280	77.0	75.6 – 78.4

Table 3.11. Numbers (%) of males and females who died in wards in Gosport hospital.

ward	gender		total
	male	*female*	
Gosport, ward not stated	244 (47.8)	266 (52.2)	510
Redclyffe	68 (26.2)	192 (73.8)	260
male ward	115 (96.6)	4 (3.4)	119
female ward		78 (100.0)	78
Daedalus ward	173 (46.1)	202 (53.9)	375
Dryad Ward	135 (47.7)	148 (52.3)	283
Sultan Ward	142 (51.1)	136 (48.9)	278
total	877 (46.1)	1026 (53.9)	1903

7. Certified cause of death

The certified cause of death could be determined from 2052 (99.2%) of the 2069 counterfoils available. Table 3.12 shows, for all deaths regardless of place of death in Gosport Hospital, the numbers of deaths certified as primarily due to one of six groups of conditions. Dr Barton was more likely to give bronchopneumonia or stroke as the cause of death (Chi sq 529.6, df 5, P< 0.001). A potential explanation is case mix – patients with dementia or stroke would have been admitted to Redclyffe, Dryad and Daedalus wards. Another possibility is excess use of sedative medication, leading to development of bronchopneumonia.

Table 3.12. Cause of death in groups, according to whether Dr Barton or other doctors signed the certificate.

Cause of death	Other doctors	Barton	total
cancer	460 (38.3)	50 (5.9)	510
heart	172 (14.3)	100 (11.8)	272
stroke	112 (9.3)	139 (16.4)	251
bronchopneumonia plus another	263 (21.9)	368 (43.3)	631
bronchopneumonia only	22 (1.8)	162 (19.1)	184
other	173 (14.4)	31 (3.6)	204
	1202	850	2052

It was possible to identify from the counterfoils 946 patients who had died in Daedalus, Dryad and Sultan wards. The admission criteria for these wards were different, and this is reflected in the differences in the certified causes of death among patients who died in these wards (Table 3.13). Since Dr Barton was responsible for patients in Daedalus and Dryad wards, and general practitioners were responsible for patients in Sultan ward, it is possible that the differences observed in the certified causes of deaths between these doctors would be at least partly explained by the different characteristics of the patients they cared for.

Table 3.13. Numbers (%) of deaths certified as due to different causes on Daedalus, Dryad and Sultan wards (Chi Sq 344.8, df 10, p<0.005).

	ward			total
	Daedalus ward	*Dryad ward*	*Sultan ward*	
cancer	21 (5.5)	24 (8.5)	158 (56.0)	203
heart	51 (13.4)	37 (13.0)	36 (12.8)	124
stroke	95 (25.0)	29 (10.2)	10 (3.5)	134
bronchopneumonia plus another	135 (35.5)	103 (36.3)	44 (15.6)	282
bronchopneumonia only	56 (14.7)	65 (22.9)	13 (4.6)	134
other	22 (5.8)	26 (9.2)	21 (7.4)	68
	380	284	282	946

There were also variations in the certified causes of death according to the gender of patients, cancer being less frequently given as the cause of death among males, and bronchopneumonia alone more frequently among females (Table 3.14). However, this difference was not apparent when the analysis was confined to patients whose deaths had been certified by doctors other than Dr Barton (Table 3.15).

Table 3.14. Numbers (%) of male and female patients certified as dying due to certain causes (Chi Sq 19.8, df 5, p<0.001)

cause of death	gender		total
	male	*female*	
cancer	244 (28.0)	241 (23.6)	485
heart	114 (13.1)	137 (13.4)	251
stroke	104 (12.0)	129 (12.6)	233
bronchopneumonia plus another	278 (32.0)	305 (29.9)	583
bronchopneumonia only	57 (6.6)	124 (12.1)	181
other	73 (8.4)	85 (8.3)	158
	870 (100.0)	1021 (54.0)	1891

Table 3.15. Numbers (%) of male and female patients certified by doctors other than Dr Barton as dying due to certain causes (Chi 3.9, df 5, not significant).

cause of death	gender		total
	male	*female*	
cancer	218 (42.7)	219 (39.5)	437
heart	66 (12.9)	91 (16.4)	157
stroke	44 (8.6)	53 (9.5)	97
bronchopneumonia plus another	113 (22.2)	112 (20.2)	225
bronchopneumonia only	9 (1.8)	12 (2.2)	21
other	60 (11.8)	68 (12.3)	128
	510 (100.0)	555 (100.0)	1065

A comparison between certificates issued by Dr Barton and the other doctors restricted to selected wards would reduce the likelihood that case mix would explain any observed differences. From 1987, 745 MCCDs were issued by Dr Barton and 166 by other doctors for patients in Redclyffe Annexe and Daedalus and Dryad wards. The mean age of the patients was similar (Dr Barton 83.0, the other doctors 82.5, not significantly different), as would be expected if the case mix had been the same. Among Dr Barton's patients, 439 (59.5%) were females, and among the patients of the other doctors 103 (57.2%) were females (difference not statistically significant). However, the other doctors gave bronchopneumonia alone as the cause of death in only 3% of cases, but among Dr Barton's patients the proportion was 20% (Chi Square 88.3, df 5, p 0.000) (Table 3.16).

Table 3.16. Causes of death among patients of Redclyffe Annexe, Daedalus and Dryad Wards, 1987-2001, comparing those certified by Dr Barton and other doctors.

cause of death	**ward**					
	Redclyffe		Daedalus ward		Dryad ward	
	other	*Dr Barton*	*other*	*Dr Barton*	*other*	*Dr Barton*
cancer	3 (5.9)	2 (1.0)	6 (9.2)	14 (4.5)	5 (10.0)	18 (7.9)
heart	7 (13.7)	12 (5.9)	11 (16.9)	40 (12.7)	6 (12.0)	31 (13.5)
stroke	8 (15.7)	23 (11.4)	18 (27.7)	77 (24.5)	4 (8.0)	25 (10.9)
bronchopneumonia plus another	23 (45.1)	125 (61.9)	17 (26.2)	118 (37.6)	19 (38.0)	84 (36.7)
bronchopneumonia only		36 (17.8)	1 (1.5)	55 (17.5)	4 (8.00)	58 (25.3)
other	10 (19.6)	4 (2.0)	12 (18.5)	10 (3.2)	12 (24.0)	13 (5.7)
	51	202	65	314	50	229

8. Hospital Episode Statistics

To determine whether there were a greater number of deaths than would have been expected among patients admitted to Gosport under the care of the Department of Medicine for Elderly People, a method is required for estimating the numbers of deaths that would have been expected. Since Gosport hospital is a community hospital, a comparison with other community hospitals would be a logical approach.

Information on admitted patient care delivered by NHS hospitals from 1989 is provided by Hospital Episode Statistics (HES), and HES were requested to provide information for this review. HES employs a coding system, each patient episode being assigned a series of codes that indicate the hospital in which care was provided, the type of speciality concerned, and the diagnosis. The codes are entered into a database in each NHS hospital, and the information is then collated at a national level by the Department of Health.

In order to identify those patients who were cared for in the Department of Medicine for Elderly People in Daedalus and Dryad wards at Gosport, specific codes indicating the speciality, hospital and ward would have been desirable. However, HES at a national level records information by hospital trust, but not necessarily by local hospital or specific ward. Thus, the national data do not allow the ready identification of patients who were cared for in the two wards at Gosport that are the focus of this review. Episode statistics that identified the ward were, however, available at Gosport hospital, but only relating to the years 1998 onwards. Consequently, data about most of the years of interest were not available.

Even if complete data for all the years of interest had been available, the difficulties would not have been resolved. The reason for employing HES data is to enable comparisons between the mortality rates in Gosport hospital with those of similar community hospitals elsewhere who were caring for similar groups of patients over the same period. The level of detail in the central HES data does not, however, permit the identification of a satisfactory group of comparable community hospitals and similar group of patients. For example, even when HES codes are selected that identify patients who have been transferred between hospitals following initial admission because of a stroke, the mortality rate (approximately 30%) is substantially lower than that in Gosport (see Table 4.3). An uncritical acceptance of this finding would lead to the conclusion that patients admitted to Gosport were more likely to die than if they had been admitted elsewhere, whereas in fact the patients who were admitted to Gosport were more severely ill than those in the best comparison group yet identified from the central HES data. The collection of episode statistics directly from a sample of community hospitals would ensure that more detailed information would be obtained. However, since a comparison would only be possible from 1998, and it would be impossible to eliminate the effects of case-mix among patients admitted to different hospitals, it would be impossible to place much confidence on the findings of such a comparison. Consequently, an analysis using HES data has not been undertaken in this review.

Discussion

Two points about the use of counterfoils as a source of data should be discussed first.

1) identification of all deaths

In this analysis of deaths identified from the counterfoils of MCCDs stored at Gosport hospital, some deaths may not be included, for example deaths referred to the coroner; in a few cases the doctor may not have issued the certificate from the Gosport hospital certificate book. However, a comparison with the numbers of certificates for deaths at the hospital completed by Dr Barton and certificates identified by National Statistics shows the number to be virtually identical (Tables 3.1 and 6.1), and therefore the data from counterfoils are likely to be sufficiently complete to permit conclusions to be drawn.

2) completion of counterfoils

The writing of some doctors was difficult to read, and the signatures of many could not be interpreted. However, the counterfoils completed by Dr Barton were easily identified. She had bold and confident handwriting, and used distinctive black ink. Also, occasional counterfoils were not fully completed, although this problem was uncommon and will not have influenced the findings of the analysis. Although Dr Barton usually specified the ward in which patients had died, other doctors often gave less detail and usually only indicated Gosport hospital as the place of death. However, this lack of detail is unlikely to have been systematic, and therefore it is possible to be reasonably confident in the findings of the comparison between deaths in different wards.

Findings

The analysis has identified the following concerns:

1. In her role as clinical assistant in the Department of Medicine for Elderly People, Dr Barton issued a large number of MCCDs between 1987 and 2000. Between 1988 and 1992, the numbers were between 29 and 38 per year, but from 1993 the numbers increased to between 81 and 107 per year, falling to 34 in 2000, the year in which Dr Barton left the hospital in July. Dryad and Daedalus wards

opened in 1993-4, a factor that is likely to explain the increase in numbers of deaths in these years owing to differences in the types of patients admitted to these wards. Patients in Redclyffe Annexe commonly suffered from dementia, but those admitted to Dryad and Daedalus had a wider range of severe clinical problems.

2. The proportion of deaths certified by either Dr Barton or other doctors occurring on each day of the week was more or less the same. In comparison with other doctors, Dr Barton issued a lower proportion of MCCDs during the summer months, but this finding is likely to be explained by annual leave being taken during the summer months.
3. The case mix of patients is likely to explain most of the observed differences between MCCDs issued by Dr Barton and those issued by other doctors. For example, patients under her care tended to be older than patients whose deaths were certified by other doctors.
4. It is notable that the patients admitted to Sultan ward, under the care of their general practitioners, were more likely to have been certified as dying due to cancer. They were also younger than patients who had died in Daedalus and Dryad wards.
5. The effect of case mix is probably reduced in an analysis that compared deaths in Redclyffe Annexe, Daedalus and Dryad wards that had been certified by Dr Barton or by other doctors. In this analysis, the mean age and proportion who were female was similar. However, Dr Barton gave bronchopneumonia alone as the cause of death significantly more frequently than the other doctors. The review of records (Chapter Two) highlighted that patients who had been certified as having died of bronchopneumonia had had other significant conditions, including recent fractures of the hip. Furthermore, a high proportion of these patients had received opiates before death. Consequently, although case mix

almost certainly explains much of the difference between patients in the Department of Medicine for Elderly People managed by Dr Barton and those under the care of other general practitioners, concerns about the use of opiates and the possible contribution they may have made to the deaths of some patients cannot be ruled out.

Chapter Four: Admissions to Dryad Ward

Introduction

The admissions book for Dryad ward has been retained by the hospital, and contained information about all admissions from 1993, the year of first opening of the ward. The information recorded in the book included dates of admission and discharge (or death), the time of day of deaths, some indication of the reasons for admission, and the place the patient had been admitted from. This information was studied in order to identify the characteristics of patients admitted to Dryad ward, and aspects of the care they had received.

It should be noted that Daedalus ward did not have a similar book, although a day-book appears to have been employed. This did not contain information helpful to this review.

Methods

There had been a total of 715 admissions from the opening of the ward in 1993 until the end of 2001. The admissions book recorded the date of admission and the date of discharge or death, and it was therefore possible to calculate the length of admission. Table 4.1 shows the mean length of admissions by year of admission, for the 676 (94.5%) admissions in which the admission and discharge date could be identified. There was some variation between years, with admissions during 1998 having the shortest mean length.

Table 4.1. Mean length (days) of stay on Dryad ward, days, 1993-2001.

year	number of admissions	mean (days)	95% CI for mean		minimum	maximum
			Lower	Upper		
1993	37	148.6	87.6	209.5	4	652
1994	68	41.7	24.7	58.7	1	326
1995	52	88.8	41.9	135.6	1	856
1996	43	56.0	33.6	78.3	1	345
1997	67	33.9	19.3	48.6	1	365
1998	103	36.0	28.1	43.9	0	195
1999	131	42.5	32.4	52.6	0	406
2000	90	65.8	47.4	84.2	1	487
2001	85	67.5	48.5	86.6	4	409
Total	676	57.1	50.0	64.1	0	856

The mean age of patients on admission to Dryad ward is shown in Table 4.2, according to year of admission, for the 708 (99.0%) cases in which the patient's age could be identified. There was no significant difference between years. The admissions book did not record the gender of patients, but gender could be inferred from the names of 712 (99.5%) of the 715 cases. Of these 414 (58.1%) were female.

Table 4.2. Mean age (yrs) at admission to Dryad ward, 1993-2001.

year	number of admissions	mean (yrs)	95% CI for mean		minimum	maximum
			Lower	Upper		
1993	38	82.1	79.7	84.4	66.0	97.0
1994	75	83.7	82.0	85.3	64.4	100.0
1995	56	82.6	80.6	84.5	66.9	99.0
1996	45	83.0	81.0	84.9	69.8	95.2
1997	71	81.8	79.9	83.8	66.3	98.0
1998	105	83.2	81.7	84.6	67.1	100.0
1999	133	83.6	82.3	84.8	65.0	98.2
2000	89	82.7	81.2	84.2	67.0	100.0
2001	96	80.9	79.2	82.6	61.0	100.0
Total	708	82.7	82.1	83.21	61.0	100.0

The Dryad ward admissions book recorded whether the patient died or was discharged. Table 4.4 indicates that the proportion of patients who were discharged

alive was less than 50% until 1999. Between 1993-5, 80% of admitted patients died on the ward.

Table 4.3. Numbers (%) of admissions followed by death or discharge, Dryad ward, 1993-2001.

year	Outcome		Total
	died	discharged	
1993	29 (80.6)	7 (19.4)	36
1994	59 (84.3)	11 (15.7)	70
1995	42 (80.8)	10 (19.2)	52
1996	31 (70.5)	13 (29.5)	44
1997	48 (69.6)	21 (30.4)	69
1998	64 (61.5)	40 (38.5)	104
1999	58 (43.9)	74 (56.1)	132
2000	35 (38.5)	56 (61.5)	91
2001	39 (45.3)	47 (54.7)	86
	405	279	684

The causes of death of patients of Dryad certified by Dr Barton are shown in Table 4.4. These data were taken from the MCCD counterfoils (see Chapter Three).

Table 4.4. Deaths on Dryad ward certified by Dr Barton

Cause of death							Total
	cancer	*heart*	*stroke*	*bronchopneumonia plus another*	*bronchopneumonia only*	*other*	
1995	2	4	2	15	8	1	32
1996	1	3	5	17	5	1	32
1997	2	11	4	23	6	1	47
1998	3	4	6	15	18	5	51
1999	7	6	5	12	15	4	49
2000	3	2	3	2	6	1	17
2001					1		1
	18	30	25	84	59	13	229

The admissions book recorded brief information about the patient's illnesses at the time of admission. On a few occasions, this information included an indication of the reason for admission, for example respite care. Table 4.5 summarizes the findings. Medical/mental problems refer in the Table to either dementia or a mix of medical conditions with the additional problem of confusion or dementia; "post-op" indicates people who have had a recent operation, most commonly surgery following a fractured hip.

Table 4.5. Numbers (%) cases admitted to Dryad ward with different primary problems, 1993-2001.

Year	Diagnostic group							Total
	stroke	*general medical problems*	*medical/ mental problems*	*heart problems*	*Cancer*	*post op*	*respite care/social admission*	
1993	9 (23.7)	19 (50.0)	6 (15.8)	2 (5.3)	2 (5.3)			38
1994	10 (13.5)	31 (41.9)	14 (18.9)	2 (2.7)	3 (4.1)	14 (18.9)		74
1995	7 (12.5)	23 (41.1)	13 (23.2)		7 (12.5)	5 (8.9)	1 (1.8)	56
1996	1 (2.5)	20 (50.0)	10 (25.0)		7 (17.5)	2 (5.0)		40
1997	4 (5.7)	29 (41.4)	16 (22.9)	5 (7.1)	8 (11.4)	8 (11.4)		70
1998	6 (5.8)	42 (40.4)	11 (10.6)	3 (2.9)	9 (8.7)	23 (22.1)	10 (9.6)	104
1999	10 (7.6)	47 (35.9)	10 (7.6)	6 (4.6)	11 (8.4)	38 (29.0)	9 (6.9)	131
2000	8 (9.0)	38 (42.7)	8 (9.0)	2 (2.2)	10 (11.2)	20 (22.5)	3 (3.4)	89
2001	11 (12.4)	30 (33.7)	16 (18.0)	1 (1.1)	8 (9.0)	9 (10.1)	14 (15.7)	89
Total	66	279	104	21	65	119	37	691

General medical problems were the commonest reason for admission in all years, but the proportion of admissions for other problems varied. Stroke was a relatively common reason for admission in 1993, and dementia with or without other medical problems was also relatively common until 1998. The proportion of patients who had been admitted following surgery increased from 1998, as did admissions for respite care.

The admissions book also recorded information about the source of admission. This information is summarised in Table 4.6. Dolphin Day Hospital is the day hospital based in Gosport War Memorial Hospital.

Table 4.6. Sources of admission to Dryad ward, 1993-2001.

year	home	rest/nursing home	acute hospital	Sultan ward	another ward at Gosport	Dolphin day hospital	
1993	4 (10.5)	2 (5.3)	23 (60.5)	8 (21.1)	1 (2.6)		38
1994	8 (10.7)	2 (2.7)	56 (74.7)	8 (10.7)	1 (1.3)		75
1995	6 (10.9)	2 (3.6)	42 (76.4)	3 (5.5)	1 (1.8)	1 (1.8)	55
1996	2 (4.4)	4 (8.9)	36 (80.0)	2 (4.4)	1 (2.2)		45
1997	3 (4.2)		56 (78.9)	7 (9.9)	3 (4.2)	2 (2.8)	71
1998	13 (12.4)		82 (78.1)	4 (3.8)	5 (4.8)	1 (1.0)	105
1999	19 (14.4)	2 (1.5)	103 (78.0)	1 (0.8)	4 (3.0)	3 (2.3)	132
2000	8 (8.8)	1 (1.1)	76 (83.5)	1 (1.1)	4 (4.4)	1 (1.1)	91
2001	23 (24.5)	2 (2.1)	49 (52.1)	8 (8.5)	12 (12.8)		94
Total	86	15	523	42	32	8	706

Most patients admitted to Dryad ward had been transferred from acute hospitals. Only in 2001 did the proportion of admissions directly from home approach 25%, a finding that is likely to be partly explained by the increase in admissions for respite care (Table 4.5).

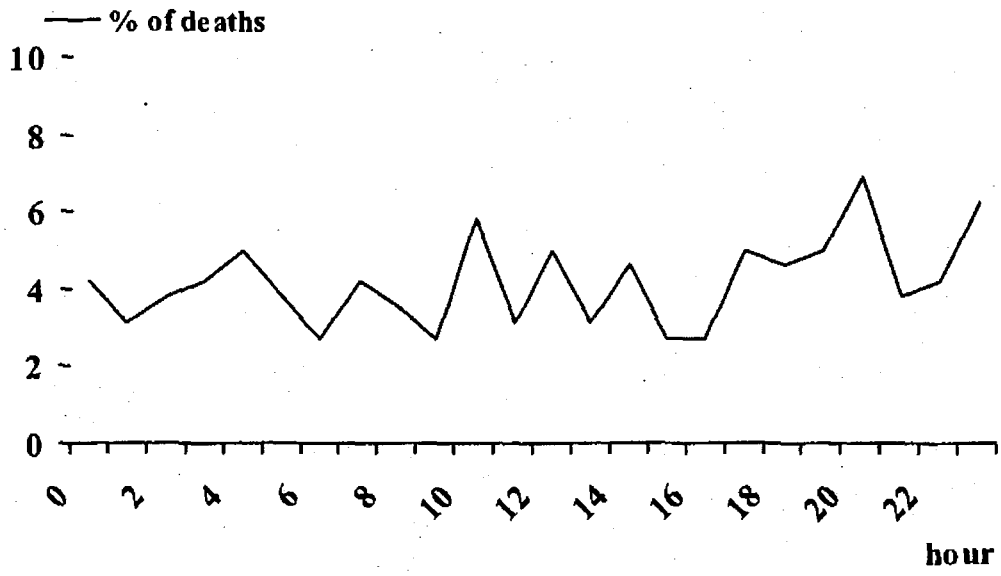
The time of death had been recorded in the admissions book in 260 cases (64.2% of the 405 deaths on the ward). Deaths are reasonably equally distributed among hours of the day (Table 4.7 and Figure 4.1).

Table 4.7. Time of death (data recorded in only cases only).

hour	year of admission									total
	1993	*1994*	*1995*	*1996*	*1997*	*1998*	*1999*	*2000*	*2001*	
0	1 (5.0)	4 (11.4)		1 (5.9)	1 (3.3)			4 (15.4)		11 (4.2)
1	1 (5.0)	2 (5.7)	2 (6.7)	1 (5.9)		1 (2.3)			1 (4.3)	8 (3.1)
2	1 (5.0)	1 (2.9)	3 (10.0)		1 (3.3)	2 (4.5)	1 (2.9)	1 (3.8)		10 (3.8)
3	1 (5.0)	1 (2.9)			1 (3.3)	2 (4.5)	5 (14.3)	1 (3.8)		11 (4.2)
4		3 (8.6)	2 (6.7)		2 (6.7)	1 (2.3)	3 (8.6)	1 (3.8)	1 (4.3)	13 (5.0)
5	1 (5.0)		1 (3.3)	1 (5.9)	2 (6.7)	2 (4.5)		2 (7.7)	1 (4.3)	10 (3.8)
6			1 (3.3)		2 (6.7)	3 (6.8)			1 (4.3)	7 (2.7)
7	1 (5.0)	2 (5.7)	2 (6.7)	1 (5.9)	3 (10.0)		1 (2.9)	1 (3.8)		11 (4.2)
8		2 (5.7)	1 (3.3)	2 (11.8)	1 (3.3)				3 (13.0)	9 (3.5)
9	1 (5.0)				1 (3.3)	3 (6.8)	1 (2.9)		1 (4.3)	7 (2.7)
10	1 (5.0)	3 (8.6)	1 (3.3)		2 (6.7)	5 (11.4)	2 (2.7)		1 (4.3)	15 (5.8)
11	2 (10.0)		1 (3.3)	1 (5.9)	1 (3.3)	1 (2.3)	1 (2.9)		1 (4.3)	8 (3.1)
12			2 (6.7)	2 (11.8)	4 (13.3)	2 (4.5)		2 (7.7)	1 (4.3)	13 (5.0)
13		3 (8.6)		2 (11.8)	1 (3.3)	2 (4.5)				8 (3.1)
14	2 (10.0)	1 (2.9)			1 (3.3)	3 (6.8)	1 (2.9)	3 (11.5)	1 (4.3)	12 (4.6)
15		1 (2.9)	1 (3.3)		2 (6.7)		2 (5.7)	1 (3.8)		7 (2.7)
16						1 (2.3)	2 (5.7)	2 (7.7)	2 (8.7)	7 (2.7)
17	1 (5.0)	1 (2.9)	2 (6.7)	1 (5.9)	1 (3.3)	2 (4.5)	2 (5.7)	1 (3.8)	2 (8.7)	13 (5.0)
18		2 (5.7)	2 (6.7)	2 (11.8)		1 (2.3)	3 (8.6)	2 (7.7)		12 (4.6)
19	4 (20.0)	1 (2.9)	2 (6.7)	1 (5.9)		1 (2.3)	3 (8.6)		1 (4.3)	13 (5.0)
20	1 (5.0)	2 (5.7)	3 (10.0)	2 (11.8)		1 (2.3)	3 (8.6)	3 (11.5)	3 (13.0)	18 (6.9)
21		1 (2.9)			2 (6.7)	3 (6.8)	2 (5.7)		2 (8.7)	10 (3.8)
22	1 (5.0)	2 (5.7)	2 (6.7)		1 (3.3)	3 (6.8)	1 (2.9)	1 (3.8)		11 (4.2)
23	1 (5.0)	3 (8.6)	2 (6.7)		1 (3.3)	5 (11.4)	2 (5.7)	1 (3.8)	1 (4.3)	16 (6.2)

Total	20	35	30	17	30	44	35	26	23	260

Figure 4.1. The percentage of deaths on Dryad ward, 1993-2001, in each hour of the day (n=260).



Discussion

Some qualifications about the admissions book as a source of date must be noted. There were occasional errors in the book, for example the admissions of some patients had not been entered on the day of admission, and some information was occasionally missing, for example the source of admission. Nevertheless, the book was generally complete, and can be assumed to represent a reasonable description of admissions throughout the period.

The information from the admissions book reveals a changing pattern of cases being admitted to Dryad ward. Most patients were admitted from acute hospitals and with general medical problems, dementia or after surgery. However, from 1998, the proportion with dementia decreased, and there were increases in the proportions of admissions that were for respite care or following surgery. These changes in case

mix are important when interpreting changes in mortality. The proportions of admissions that ended in death declined from 1997. However, the annual number of admissions increased, and consequently the total numbers of deaths did not decrease until 2000. It is not possible to describe in detail the changes in case mix of patients admitted to Daedalus and Sultan wards, but it is almost certain that changes did occur. There may also have been changes in case mix in the period 1988 – 1993 with respect to admissions to Redclyffe Annexe, and the male and female wards. If follows that any comparisons in mortality rates between those in the wards of the Department of Medicine for Elderly People at Gosport or between Gosport and other community hospitals must be interpreted with considerable caution.

More or less similar proportions of patients died in each hour, as would normally be expected. The finding of a predictable distribution of deaths throughout the hours of the day serves to reduce concern about the possibility of sudden death following the *administration of lethal drug doses.*

Chapter Five: Prescribing of opiate drugs

Introduction

Many of the concerns about deaths at Gosport War Memorial Hospital relate to the use of opiates. The misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 1985 stipulate that registers are kept of the administration of opiate drugs such as diamorphine, morphine and fentanyl. Registers must be bound, and entries must be in chronological order. This Chapter describes an investigation of the information contained in the controlled drug registers retained at Gosport Hospital.

Method

The surviving controlled drugs registers used at the hospital were obtained and reviewed. The relevant registers that were still available are shown in Table 5.1. No data were available from the male ward. Comparisons between wards were possible for some years, although the data were not always complete.

The controlled drug registers contained a record of every dose of opiate drug administered to each patient. It was possible to identify the first and last doses of each drug administered, and the quantity of drug in each dose.

Table 5.1. The periods for which controlled drug registers from different wards were available.

Ward	Dryad	Daedalus	Sultan	Redclyffe	Female ward	Male ward
Period covered by registers	25.6.95 – 5.3.02	6.10.96 – 14.8.02	13.7.94 – 31.10.01	27.2.93 – 28.10.95	30.8.87 – 8.9.94	No register available

Results

1. Numbers of patients who died who received opiates

Information was available from both the MCCD counterfoils (see Chapter Three) and the controlled drug registers, and it was possible to identify those who had received opiates during their final illness by matching counterfoils and register entries. The years 1997-2000 were selected, since the controlled drug register data from Dryad, Daedalus and Sultan were complete for this period. Table 5.2 shows the numbers and proportions of cases given an opiate before death, according to whether the MCCD was signed by Dr Barton or another doctor. A greater proportion of patients of Dr Barton received an opiate (Chi Square = 30.1; df 1, p <0.001).

Table 5.2. Numbers (%) of patients dying 1997-2000 who were prescribed at least one dose of an opiate before death.

Doctor signing MCCD	Opiate prescribed		Total
	yes	*no*	
Dr Barton	211 (74.0%)	74 (26.0%)	285
Another doctor	146 (51.8%)	136 (48.2%)	282
Total	357 (63.0%)	210 (37.0%)	567

Dr Barton was more likely to prescribe an opiate to patients who were certified as dying from bronchopneumonia with other conditions, bronchopneumonia alone, or other conditions (Table 5.3). In the Table, all the certified causes of death have been grouped into the six categories employed in Chapters Two and Three.

Table 5.3. The numbers (%) of patients dying 1997-2000 from groups of conditions who had been prescribed an opiate by Dr Barton or other doctors.

Cause of death	doctor	opiate		total	Sig (df 1)
		yes	*no*		
Cancer	Barton	15 (68.2%)	7 (31.8%)	22	0.2
	Another	78 (80.4%	19 (19.6%)	97	
Heart	Barton	26 (59.1%)	18 (40.9%)	44	0.58
	Another	11 (36.7%)	19 (63.3%)	30	
Stroke	Barton	37 (69.8%)	16 (30.2%)	53	0.19
	Another	16 (55.2%)	13 (44.8%)	29	
bronchopneumonia with other conditions	Barton	64 (76.2%)	20 (23.8%)	84	0.001
	Another	27 (37.5%)	45 (62.5%)	72	
bronchopneumonia only	Barton	57 (83.8%)	11 (16.2%)	68	0.01
	Another	3 (42.9%)	4 (57.1%)	7	
other conditions	Barton	12 (85.7%)	2 (14.3%)	14	0.001
	Another	10 (21.7%)	36 (78.3%)	46	

The analysis in Table 5.3 was repeated for all deaths that occurred in Redclyffe Annexe up to and including 1994. Patients in the Annexe were generally the elderly mentally infirm, and Dr Barton was the responsible doctor at the Annexe until approximately 1994 (see Table 3.9). The findings do not indicate differences in use of opiates between Dr Barton and the other doctors, although none of the other doctors gave bronchopneumonia alone as the cause of death in this period. However, a comparison involving deaths in Redclyffe from 1995 indicates leads to different findings. None of the patients whose deaths were certified by other doctors had received an opiate, although all three of those certified by Dr Barton had (Table 5.5). A test of statistical significance has not been performed since the numbers of cases involved was small. However, there does appear to have been a change in the use of opiates at the end of life at about the time Dr Barton ceased to have principal

Table 5.4. The numbers (%) of patients dying 1993-1994 in Redclyffe Annexe from different causes who were prescribed an opiate by Dr Barton or other doctors.

Cause of death	doctor	opiate		total	sig
		Yes	no		
Cancer	Barton	1 (50.0)	1 (50.0)	2	0.17
	Another		3 (100.0)	3	
Heart	Barton	5 (41.7)	7 (58.3)	12	0.24
	Another	1 (16.7)	5 (83.3)	6	
Stroke	Barton	6 (27.3)	16 (72.7)	22	0.93
	Another	1 (25.0)	3 (75.0)	4	
Bronchopneumonia with other conditions	Barton	41 (33.1)	83 (66.9)	124	0.39
	Another	3 (50.0)	3 (50.0)	6	
Bronchopneumonia Only	Barton	23 (65.7)	12 (34.3)	35	-
	Another	-	-	0	
Other conditions	Barton		10 (100.0)	10	-
	Another		3 (100.0)	3	

Table 5.5. Numbers (%) of patients dying from different causes in Redclyffe Annexe, 1995 or later.

Cause of death		opiate		total
		yes	no	
Heart	other		1 (100.0)	1
	Dr Barton		1 (100.0)	1
Stroke	other		4 (100.0)	4
	Dr Barton	1 (100.0)		1
bronchopneumonia plus another	other		17 (100.0)	17
	Dr Barton	1 (100.0)		1
bronchopneumonia only	other			
	Dr Barton	1 (100.0)		1
	Dr Barton	1 (100.0)		1
Other	other		5 (100.0)	5

responsibility for patients in Redclyffe Annexe. One explanation for this finding is that the type of patients being cared for in the Annexe changed at the same time, but an alternative is that the practice of almost routine use of opiates before death was discontinued.

2. Deaths on Dryad ward

Since information was available about admissions to Dryad ward, including some indication of the reason for admission, and whether the patient was discharged alive or had died on the ward, it has been possible to estimate the proportions of patients admitted with different types of illnesses who received opiates, and whether they died. Those patients who received at least one dose of opiate were included in this analysis.

The findings are summarized in Table 5.6. The illness groups are stroke, general medical problems, medical and mental problems, heart problems, cancer, post-operative cases such as fractured neck of femur, and respite care. Thus, of the 17 patients admitted with strokes between March 1995 and August 1998, 10 died, of whom 8 received an opiate. None of those discharged alive had received an opiate. Some patients in all illness groups received an opiate except for those in the respite care group. Of those who were admitted with strokes, 47% received an opiate, the proportion for general medical problems was 71.7%, medical and mental problems 73.2%, heart problems 71.4%, cancer 66.7 %, and post-operative cases 60.9%.

Some qualifications must be made about these data. First, 10 patients had been recorded as receiving an opiate although the admissions book did not record them

as having been admitted. These patients were omitted from the analysis. The most likely explanation is that these patients were on a different ward, the drugs been transferred between wards. Second, no account has been made of the dose, numbers of doses, type of opiate received or administration route. The data will

Table 5.6. Patients on Dryad ward who received an opiate, March 1995 – August 1998, according to illness group and outcome (died or discharged). N=209.

illness group	had an opiate	Outcome		Total
		died	*discharged*	
stroke	No	2 (22.2)	7 (77.8)	9
	yes	8 (100.0)		8
	total	10 (58.8)	7 (41.2)	17
general medical problems	No	7 (26.9)	19 (73.1)	26
	yes	55 (83.3)	11 (16.7)	66
	total	62 (67.4)	30 (32.6)	92
medical/mental problems	No	3 (27.3)	8 (72.7)	11
	yes	29 (96.7)	1 (3.3)	30
	total	32 (78.0)	9 (22.0)	41
heart problems	No		2 (100.0)	2
	yes	5 (100.0)		5
	Total	5 (71.4)	2 (28.6)	7
cancer	No	5 (62.5)	3 (37.5)	8
	yes	16 (100.0)		16
	Total	21(87.5)	3 (12.5)	24
post op	No	3 (33.3)	6 (66.7)	9
	yes	12 (85.7)	2 (14.3)	14
	Total	15	8	23
respite care/ social admission	No		5 (100.0)	5

Total	5 (100.0)	5

therefore include a number of patients who received only one or two doses, although this would be unlikely to change the general conclusion from the table. Third, it is difficult to judge whether individual patients did have a level of pain that justified the use of opiate medication. Without a case by case review, the appropriateness of opiate medication for each patient cannot be determined.

3. Quantities of opiates prescribed per patient

An analysis was undertaken to compare the total amount of opiate prescribed per patient by Dr Barton and other doctors at Gosport. A random sample of patients who had died, and who had been prescribed an opiate, was identified, from those who had died on Dryad, Daedalus or Sultan wards, and for whom complete data from controlled drug registers were available. A total of 46 patients were included, 21 being patients whose deaths had been certified by Dr Barton, and 25 whose deaths had been certified by other doctors. Seventeen patients had died on Dryad ward, nine on Daedalus ward, and 20 on Sultan ward. The amount of opiate prescribed for a patient was calculated by identifying the number of doses, and quantity of drug in each dose, for each drug administered to each patient. Thus, if a patient had been administered subcutaneous diamorphine 20 mgm per day for three days, the total amount would be 60 mgm.

There was no significant difference in the total amount in mgms of diamorphine recorded as administered during the terminal illness, the mean for Dr Barton's patients being 113 mgms (SD 211 mgms) in comparison with 1300 mgms (SD 3354 mgms) for the other doctors (t-test p 0.13). The mean quantity of oramorph for Dr

Barton's patients was 276 mgms (SD 276 mgms) and for the other doctors 169 mgms (SD 168 mgms) (t-test p 0.6). None of Dr Barton's patients in the sample had received morphine sulphate tables, although seven in the comparison group had. One patient of Dr Barton had received fentanyl, and one patient of the other doctors had received methadone.

Some caution is needed in drawing definitive conclusions from this analysis since it did not involve review of the clinical records, and the sample was small. Nevertheless, the findings do not suggest that Dr Barton's patients had received opiates for prolonged periods.

Discussion

The findings of the review of prescribing of controlled drugs indicate that patients in Gosport Hospital whose deaths were certified by Dr Barton were more likely to have been prescribed an opiate (most commonly diamorphine or oramorph). The excess was most evident among patients who were certified as dying from bronchopneumonia with or without other conditions, or from some other condition that was not cancer or cerebro- or cardio-vascular disease. This finding is a cause for concern, since the use of opiates for pain relief in terminal care is more common in conditions in which pain would be expected, in particular cancer. Furthermore, a high proportion of the initial cases referred to the police by concerned relatives had been certified as dying due to bronchopneumonia. It does appear that the practice of almost routine use of opiates before death in Redclyffe Annexe changed when Dr Barton ceased principal responsibility for patients in the Annexe. This may have been a consequence of a change in the practice followed by the doctors who took

over from Dr Barton, or a change in the mix of patients who were admitted to the Annexe.

The finding that the quantities of opiate prescribed, in the analysis of a random sub-sample, did not indicate that Dr Barton had prescribed opiates over prolonged periods is reassuring. However, this finding does not eliminate the possibility that some patients were given opiates unnecessarily. Therefore, the findings of the analyses reported here are consistent with a practice of prescribing opiates to an inappropriately wide group of older patients.

Chapter Six: Analysis of medical certificates of cause of death (MCCDs)

Introduction

This Chapter presents the findings of an analysis of numbers of deaths in general practice certified by Dr Barton. The aim was to determine whether there were greater numbers of deaths than would have been expected, and therefore reasons for concern about the care of patients in general practice. Although most of the review is concerned with deaths in Gosport hospital, it was necessary to be certain that there were no reasons for concern about deaths in the community.

Methods

The data relate to the deaths certified by Dr Barton and a sample of general practitioners chosen because they were caring for similar groups of patients in Gosport at the same time as Dr Barton. There were nine general practices in Gosport, one of which was the practice of Dr Barton and her partners (referred to as the index practice). Levels of deprivation were classified into four levels. In the index practice 6.9% of registered patients were classified in one of the four levels (0.4% in the highest level of deprivation), but in the first control practice 8.4% (2.5% in the highest level) and in the second control practice 7.9% (0.5% in the highest level) were classified in one the deprivation levels. Thus, the comparison practices had a marginally higher proportion of deprived patients. In the index practice, 15.6% of patients were aged 65 years or over; in the first control practice 11.3% and in the second control practice 18.3% of patients were aged 65 years or over. Consequently, the analysis took account of the differences in the age of patients

between practices, but did not account for deprivation since the differences were small.

The MCCDs were identified by National Statistics (see Chapter Two). Deaths from 1993 onwards certified by any of the general practitioners of the three practices were identified using the computer database maintained by National Statistics. Deaths prior to 1993 have not been stored on computer, and therefore a hand search was required of the notifications in the death register of files completed in the registration districts serving the Gosport area (Gosport, Fareham 1, and Havant). The data from these sources had been provided by registrars from the death certificates completed by the general practitioners and additional information provided by the person reporting the death to the registrar (the informant). In this review, information from each death notification was entered into a database for analysis.

The deaths certified by the general practitioners included those that had occurred at home, in nursing homes, or in hospitals, in particular Gosport War Memorial Hospital.

Results

Table 6.1 presents information about the numbers of deaths certified by the sample of GPs who were partners in one of the three practices included in this analysis. The figures for Dr Barton are similar to those identified from certificate counterfoils held at the hospital (see Table 3.2).

Table 6.1. Annual number of deaths, 1987-2002.

year	certifying doctor																						tota
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Dr B	
1987	8	20	7					6	10	11	13			2	15	12	3	9	11		17	2	14
1988	4	8	4					10	12	10	11				5	8	5	5	6	1	15	28	13
1989	4	11	10					20	9	13	14				6	9	8	8	5	2	9	39	16
1990	20	11	7	5				8	17	13	17				10	13	1	4	4			41	17
1991	16	20	13	9				7	5	12	11				11	10	7	5				37	16
1992	5	10	8	18				9	10	8	13				9	10	3	5				36	14
1993	8	10	13	7	3			8	9	7	11	1			5							97	17
1994	4	8	5	9	4			12	4	5	12				9							106	17
1995	7	12	8	9	2			8	10	18	9	13	9		6							81	19
1996	15	9	11	11	7			10	5	9	5	11	9									86	18
1997	7	6	3	10	5	1		19	13	5	9	6	8									92	18
1998	5	9	7	10	5	8		2	13	9	15	12	14									108	21
1999	7	9	4	10	4	12	8	2	9	13	9	1	7									94	18
2000	3	5	5	7	5	11	4		7	6	13	7										35	1[illegible]
2001	7	17	9	1	1	13	2	1	5	4	6	8	1									5	[illegible]
2002	9	8	4	9	5	8	5	7	5	5	5	10											8
	129	173	118	115	41	53	19	129	143	148	173	69	48	2	76	62	27	36	26	3	41	887	251

Deaths in Gosport hospital

Dr Barton's partners provided cover at Gosport hospital during her absences (due to vacations and other reasons). Figures 3.1 to 3.15 reveal periods of one or more weeks in which Dr Barton did not issue a certificate for a patient who had died in Gosport hospital, and one explanation for these weeks is that she was on vacation. A comparison of death certification rates by her partners, relating to patients on Daedalus and Dryad wards during those periods of absence, with certification rates by Dr Barton on the same wards when she was present would be of particular interest. A high death rate when Dr Barton was present and a lower rate when she was on leave would raise questions about the impact of her clinical practice on mortality rates.

However, some difficulties of interpretation might remain since mortality during her absences could in part reflect effects of her practice when present, possibly leading to attenuation of observable differences. Also, the delay of the admission of

seriously ill patients until Dr Barton's return may serve as an explanation for differences in deaths rates between normal and holiday periods. Unfortunately, it has proved impossible to obtain information about the doctors' rota for Daedalus and Dryad wards and the analysis reported below differs from a straightforward comparison in two respects:

a) Since individual wards cannot be consistently identified from the place of death details on the certificates, the analysis relates to deaths from all wards at Gosport certified by Dr Barton or her partners. These include deaths of patients in Sultan ward who would have been under the care of their general practitioner as well as deaths in Dryad and Daedalus wards, under the care of the Department of Medicine for Elderly People.

b) Since records of Dr Barton's rota are no longer available, an indirect method of inferring (some of) these periods of absence has been used, as described below, but the validity of this method cannot be verified directly.

Absence of Dr Barton has been inferred from prolonged periods between consecutive deaths certified by her. Such periods could of course occur by chance even when Dr Barton is present. A variety of period lengths has been investigated. The principal results below are based on periods of at least 14 consecutive days, since use of shorter periods are more prone to error, such as uncertainty over the exact start and end dates.

Rates of certification by Dr Barton, except during those periods in which there was at least 14 days between successive certifications by her, were compared with rates of certification by the seven other practice partners in those same 14+ day periods. Incidence ratios (and 95% confidence intervals) were: 1.67 (0.88-3.59) in 1998, 3.78 (1.91-8.52) in 1999, and 1.25 (0.49-4.11) in 2000. If the three 1998-2000 years were considered together, the incidence ratio was 2.24 (1.47-3.55).

In interpreting these ratios, it is helpful to consider the magnitude and direction of possible biases. End-estimate bias in the 14-day intervals is unlikely to exceed 15% (two end days in 14 days); they could operate in either direction (that is increasing or decreasing the true estimate). If Dr Barton had been absent for periods shorter than 14 days, this will lead to under estimation of her rates. If the 14+ day periods are chance occurrences not corresponding to her absence, her rates will be overestimated, by up to 30%. If, as noted earlier, Dr Barton's practice while present impacted on her partners' certification rates during her absence, the incidence ratio might be reduced.

Taking these factors into account, it is difficult to draw secure conclusions. The incidence ratio in 1999 was markedly raised, and this finding may point to a method for exploring further any potential impact of Dr Barton's clinical practice on mortality rates. It has not been possible to obtain reliable information about holiday periods in this review, but this may be possible in the continuing police investigation, in which case the pilot analysis included here should be repeated using valid holiday data.

Deaths at home or in nursing or residential homes

Table 6.2 presents information relating to deaths at home, or in residential or nursing homes, certified by the same group of GPs. Since Dr Barton was required to care for patients in Gosport War Memorial Hospital, she may be expected to have undertaken a reduced workload in the general practice. The findings indicate that Dr Barton issued fewer certificates than most of the other GPs, although some (probably part-timers, or doctors leaving general practice between 1993-5) issued fewer. This finding is reassuring, since it reduces concern about care given to patients in the community. It is notable that Dr Barton issued no certificates in 2002.

Table 6.2. Annual number of deaths at home or in residential/nursing homes certified by GPs, 1987-2002.

year	certifying doctor																						total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	Dr B	
1987	4	13	7					4	6	7	10			2	10	9	3	5	4		10	2	96
1988	1	6	2					9	10	6	8				3	5	4	5	6	1	10	9	85
1989	3	7	7					20	6	5	11				5	6	8	6	3	2	9	9	107
1990	12	6	5	3				7	15	9	11				7	7	1	4	3			3	93
1991	15	15	10	7				7	4	9	9				10	5	7	4				5	107
1992	2	6	6	10				7	8	5	11				6	6	2	4				4	77
1993	5	7	10	5	1			6	7	5	8	1			5							3	63
1994	1	5	4	7	4			9	3	3	10				5							2	53
1995	4	9	6	7	2			8	6	8	7	10	2		3							1	73
1996	10	5	6	8	5			7	3	3	4	6	1									2	60
1997	5	1	1	10	1			15	9	2	6	3	3									6	62
1998	5	7	6	9	1	6		1	8	4	6	9	4									1	67
1999	6	6	3	7	4	10	7		5	4	6	1	5									2	66
2000	2	3	4	4	4	11	2		5	5	7	6										1	54
2001	6	13	8	1	1	11	2	1	2	3	5	7	1									3	64
2002	9	7	3	7	1	7	5	3	4	4	4	7											61
	90	116	88	85	24	45	16	104	101	82	123	50	16	2	54	38	25	28	16	3	29	53	1188

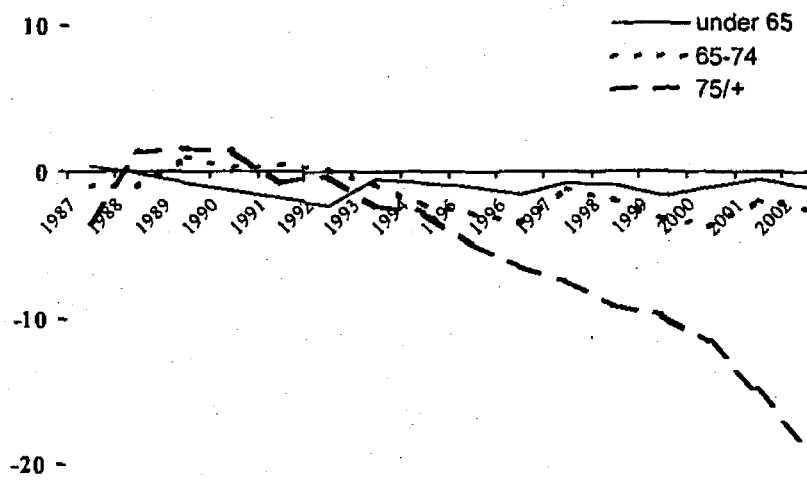
Although Table 6.2 provides some reassurance, a more detailed analysis is required that takes into account the numbers of patients registered with the included general practices. This additional information would enable calculation of the rate of deaths in the three practices, and provide a more meaningful comparison between Dr Barton and other doctors. Information about the numbers of patients registered with each general practitioner was obtained from the Hampshire and Isle of Wight Practitioners and Patient Services. Although the Agency was able to supply information from 1987 onwards about the numbers of patients in three age bands (0-64 years, 65-74 year, and 75 years and over), details on the numbers who were male and female were available only from 1996.

The number of patients registered with a general practitioner is not necessarily an accurate reflection of the number of patients the doctor directly cares for. Within a general practice, some doctors may undertake work outside the practice (as did Dr Barton) and therefore not care for so many patients in the practice. A doctor may

choose to work part-time for other reasons. Therefore, the numbers of patients registered with the doctor were not used in estimating mortality rates. Since detailed information about the work patterns of the general practitioners in the comparison practices was not available, the numbers of patients cared for by each general practitioner was taken to be an equal share of the total practice list size. For example, using this method, in a practice of five doctors and with a total of 10,000 registered patients, the numbers cared for by a single doctor would be assumed to be 2000.

Deaths among males and females combined up to 1995 are shown in Table 6.3 to 6.5, and deaths among males and females separately from 1996 to 2002 are shown in Tables 6.6 to 6.10. Each Table displays the numbers of deaths certified by doctors in the comparison practice, the numbers certified in Dr Barton's practice (the index practice), and the numbers certified by Dr Barton. The Tables also show the numbers of patients registered with the comparison and index practices, and the estimated number under the care of Dr Barton. These data are used to calculate the number of certificates that would have been expected to have been certified by Dr Barton based on the comparison practices, and the difference between the expected number and the number she did in fact certify. In all but two of the Tables, the total of the difference between the numbers expected and observed is less than zero. The cumulative difference between the expected and observed numbers of deaths in the three age bands is displayed in Figure 6.1.

Figure 6.1. The cumulative difference between the observed and expected numbers of MCCDs issued by Dr Barton, 1987-2002. (Deaths occurring at home, or in residential or nursing homes).



By 2002, the total difference between the observed and expected certificates issued by Dr Barton was –0.99 for patients aged 0-64, -2.54 for those aged 65 to 74, and -18.53 for those aged 75 and over. These figures provide further reassurance about the care given to patients in general practice.

Table 6.3. Deaths and death rates/1000 patients under the age of 65 1987-1995 (males and females).

year	Patients in control practices	Deaths in control practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected deaths	Observed – expected, Dr Barton
1987	15376	5	8644	10	.33	1.16	1729	1	.57	.43
1988	15457	5	8569	7	.32	.82	1714	0	.55	-.55
1989	15673	5	8665	3	.32	.35	1733	0	.55	-.55
1990	15490	5	8634	7	.32	.81	1727	0	.55	-.55
1991	13192	4	8644	5	.30	.58	1729	0	.52	-.52
1992	13009	4	8578	2	.31	.23	1716	0	.53	-.53
1993	12933	2	8535	4	.15	.47	1707	2	.26	1.74
1994	13055	1	10819	2	.08	.18	1803	0	.14	-.14
1995	13244	2	10745	4	.15	.37	1791	0	.27	-.27
Total observed - expected										-.94

Table 6.4. Deaths and death rates/1000 patients age 65 - 74 1987-1995 (males and females).

year	Patients in control practices	Deaths in control practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1987	1271	8	783	6	6.29	7.66	157	0	.98	-.98
1988	1315	8	788	9	6.08	11.42	158	1	.96	0.04
1989	1326	8	788	8	6.03	10.15	158	3	.95	2.05
1990	1331	7	785	7	5.25	8.92	157	0	.82	-.82
1991	1176	14	800	6	11.90	7.50	160	2	1.90	0.10
1992	1144	9	805	6	7.87	7.45	161	1	1.27	-.27
1993	1145	7	779	6	6.11	7.70	156	0	.95	-.95
1994	1157	9	986	2	7.78	2.03	164	0	1.28	-1.28
1995	1147	5	993	8	4.36	8.06	166	0	.72	-.72
Total observed - expected										-2.83

Table 6.5. Deaths and death rates/1000 patients age 75 and above 1987 – 1995 (males and females).

year	Patients in control practices	Deaths in control practices	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1987	1231	38	688	28	30.86	40.70	138	1	4.26	-3.26
1988	1231	31	687	25	25.18	36.39	137	8	3.45	4.55
1989	1234	52	677	31	42.14	45.79	135	6	5.69	0.31
1990	1227	29	667	38	23.63	56.97	133	3	3.14	-.14
1991	1138	46	640	31	40.42	48.44	128	3	5.17	-2.17
1992	1125	23	616	32	20.44	51.95	123	3	2.51	.49
1993	1087	27	622	19	24.84	30.55	124	1	3.08	-2.08
1994	1091	20	753	19	18.33	25.23	126	2	2.31	-.31
1995	1120	28	771	25	25.00	32.43	129	1	3.23	-2.23
Total observed - expected										-4.84

Table 6.10. Deaths and death rates/1000 patients age 75 and above, 1996-2002 (females).

year	Patients in control practices	Deaths in index practice	Patients in index practice	Deaths in index practice	Rate /1000 in control practices	Rate /1000 in index practice	Dr Barton's list (estimate)	Certified by Dr Barton	Expected, Dr Barton	Observed – expected, Dr Barton
1996	752	25	471	9	33.24	19.11	79	2	2.63	-.63
1997	731	17	494	15	23.26	30.36	82	2	1.91	.09
1998	730	15	511	13	20.55	25.44	85	0	1.75	-1.75
1999	742	14	491	11	18.87	22.40	82	2	1.55	.45
2000	736	9	492	8	12.23	16.26	82	0	1.00	-1.00
2001	779	22	505	9	28.24	17.82	84	0	2.37	-2.37
2002	770	24	508	7	31.17	13.78	85	0	2.65	-2.65
Total observed - expected										-7.86

Chapter Seven: Conclusions

In this audit or review, information has been obtained from a variety of sources about the care delivered to patients of the Department of Medicine for Elderly People at Gosport War Memorial Hospital, including death notifications stored by National Statistics, the counterfoils of medical certificates of cause of death, clinical records, controlled drug registers, and ward admissions books. Whilst there are inevitable reservations about the completeness of these sources, when viewed together they enable conclusions to be reached. In this Chapter, the reservations about the data used in the review are summarised, the findings are outlined, and conclusions are presented. Relevant recommendations are also made.

The sources of information

It has not been possible to undertake a comparison of mortality rates between Gosport and other community hospitals because centrally held Hospital Episode Statistics data do have sufficiently detailed provider codes to identify groups of patients similar to those admitted to Gosport. However, whilst such an analysis would be desirable, I would not expect that the findings would significantly alter the conclusions of this review.

The notifications of deaths provided by National Statistics were a reliable source of information about the numbers of deaths certified by Dr Barton and the comparison general practitioners. Therefore, conclusions based on this information can be regarded as safe. It should be noted, however, that notifications would not have included information about cases certified by coroners. The data provided by National Statistics corroborate the numbers of deaths identified from the counterfoils of MCCDS that had been stored at Gosport hospital. Consequently, the findings from

the analysis of the counterfoils can also be regarded as reliable, although the lack of information about cases investigated by the coroner must be noted again.

The data contained in the controlled drugs registers are likely to have been reasonably accurate and complete, although it is not possible to verify this through comparison with another source. The administration of controlled drug registers must be recorded in registers, and the registers at Gosport did appear to have been maintained correctly. Ward admission books are not required to be maintained to such a standard, and the policy on admission books varied in different wards. Only Dryad ward's book was found to be a satisfactory source of information. The admission books are therefore the source of information about which there should be most caution. Nevertheless, significant weaknesses in the information in the books were not detected during the review, and they probably do represent a reasonable record of the admissions of patients to the ward.

Summary of findings

The investigation of a random sample of records indicated that:

- Patients admitted to Gosport hospital were elderly, had severe clinical problems, and had commonly been transferred from acute hospitals after prolonged in-patient stays. Although some were admitted for rehabilitation, most were believed to be unlikely to improve sufficiently to permit discharge to a nursing home.
- Of the 81 patients in the sample, 76 (94%) had received an opiate before death, of whom 72 (89%) had received diamorphine.
- When administered by syringe driver, diamorphine was invariably accompanied by other medication, most commonly hyoscine and midazolam.

- The mean starting dose of diamorphine was greater than would have been expected if the rule of thumb of giving one third of the total daily dose of morphine had been followed.
- Opiates were used for patients with all types of conditions, including strokes, heart conditions, and end stage dementia.
- There was little evidence of the three analgesia steps recommended in palliative care (non-opiate, then weak opiate, then strong opiate).
- Opiates were commonly prescribed on admission, although not administered until some days or even weeks later.
- Some records failed to indicate that an acute deterioration in a patient's condition had been followed by a careful assessment to determine the cause. Opiates may have been administered prematurely in such cases.
- The records commonly did not report detailed assessments of the cause of the patient's pain.
- The pattern of early use of opiate medication was evident from 1988.
- The records did not contain full details of care. Only 48 (59.3%) contained sufficient information to enable a judgement to be made about the appropriateness of care. In 16 of these, I had some concerns about the indications for starting opiates, the investigation of pain, or in the choice of analgesic.
- Dr Barton did not report recent fractures, including fractured hips, on MCCDs. These cases were commonly reported as having died from bronchopneumonia.

The counterfoils of MCCDs stored at Gosport hospital indicated that:

- Dr Barton had issued 854 certificates from 1987.

- The number of certificates was between 30 and 40 per year between 1988 and 1992, when Dr Barton was responsible for patients in Redclyffe Annexe and some in the male and female wards. The numbers increased to between 80 and 107 per year between 1993 and 1999 when Dr Barton became responsible for patients in Daedalus and Dryad wards.
- Dr Barton issued between nil and six MCCDs per week. There were no clear clusters of deaths.
- Dr Barton was more likely than other doctors to give bronchopneumonia with *other conditions or bronchopneumonia only as the cause of death.*

The investigation of Dryad ward's admissions books indicated that:

- Of the 684 patients admitted between 1993 and 2001, 405 (59.2%) died in the ward.
- The mean age of the people admitted was 82.7, and around three quarters had been transferred from an acute hospital.
- There was a change in the patients admitted to the ward from around 1997. After that year, there was an increase in the proportion of patients who had been admitted for respite care, and by 1999, the proportion of patients who died had decreased.
- The proportions of patients who died in each hour of the day were as would normally be expected.

The investigation of controlled drugs registers indicated that:

- Patients in whom the MCCDs had been issued by Dr Barton were more likely to have received an opiate before death.

- The greater use of opiates was found in relation to all causes of death except cancer, although when this analysis was confined to patients in Redclyffe Annexe, there were no significant differences between Dr Barton and other doctors.
- Dr Barton did not prescribe opiates to individual patients for longer periods of time than other doctors.

The investigation of MCCDs indicated that:

- The counterfoils stored at Gosport hospital were an accurate record of the deaths in the hospital.
- There was no evidence that more than the expected number of deaths had been certified by Dr Barton. In fact, the number was less than expected if Dr Barton had undertaken an equal share of the workload in general practice.
- A greater proportion of MCCDs issued by Dr Barton were for female patients, and were more likely to have been certified as dying from heart conditions. These findings are probably incidental and are not reason for concern.

Conclusions

Patients admitted to Gosport were elderly and with severe clinical problems. Most had been transferred from acute hospital settings after a period of intensive management, at the end of which it had been concluded that further intensive management would have little or no benefit. Patients were transferred to Gosport either for rehabilitation or for continuing care (defined by CHI as 'a long period of treatment for patients whose recovery will be limited').

In this group of very ill and dependent patients, a practice of liberal use of opiate medication can be discerned from the findings of the review. Patients who

as documentary evidence are considered, can conclude whether lives were shortened by the almost routine use of opiates before death, but I would expect such case by case investigations to conclude that in some cases, the early resort to opiates will be found to have shortened life. I would also expect that in a smaller number of cases, the practice will be found to have shortened the lives of people who would have had a good chance of surviving to be discharged from hospital.

From the evidence considered in this review, it is not possible to determine how the practice of almost routine use of opiates at Gosport originated. Whilst much of the review has focused on the work of Dr Barton, this is because she issued the MCCDs and made most of the entries in the clinical records. However, this should not be taken as meaning that she was the origin of the practice, she may merely have been implementing it. Indeed, the practice may have been introduced before Dr Barton began work in Gosport as a clinical assistant in 1988.

Recommendations

1. Investigations should continue into the deaths of individual patients. The findings of this review reinforce concerns about what may have occurred in these cases.
2. In the continuing investigation into deaths in Gosport hospital, information about the rota followed by Dr Barton and her partners should be obtained and used to explore patterns of deaths.
3. Hospital teams who care for patients at the end of life should have explicit policies on the use of opiate medication. These policies should include guidance on the assessment of patients who deteriorate, and the indications for commencing opiates. The development of national guidelines would assist the development of local policies.

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4. The findings reported in this review should not be used to restrict the use of opiate medication to those patients who need it. Indeed, there are reasons to suspect that some patients at the end of life do not receive adequate analgesia.
5. In this review, evidence has been retrospectively pieced together from a variety of sources. Continued monitoring of outcomes at a local level might have prompted questions about care at Gosport hospital before they were raised by relatives, but continued monitoring is difficult with current data systems. Hospital episode statistics are an important resource, but continued prospective monitoring of the outcomes achieved by clinical teams requires a more detailed set of codes.

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WITNESS STATEMENT

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

URN //

Statement of : STEVEN ALEC WATTS

Home Address:

Post Code :

Home Telephone No: **Mobile / Pager No:**

E-Mail Address *(if applicable and witness wishes to be contacted by e-mail)*:

Contact Point *(if different from above)*:

Address:

Work Telephone No:

Male ☐ **Female** ☐ **Date and Place of Birth:** Place

Maiden name: **Height:** **Ethnicity Code:**

State dates of witness non-availability:

I consent to police having access to my medical record(s) in relation to this matter	**Yes** ☐ **No** ☐ **N/A** ☐
I consent to my medical record in relation to this matter being disclosed to the defence	**Yes** ☐ **No** ☐ **N/A** ☐
The CPS will pass information about you to the Witness Service so that they can offer help and support, unless you ask them not to. Tick this box to decline their services.	☐

Does the person making this statement have any special needs if required to attend court and give evidence? *(e.g. language difficulties, visually impaired, restricted mobility, etc.).* **If 'Yes', please enter details.**	**Yes** ☐ **No** ☐
Does the person making this statement need additional support as a vulnerable or intimidated witness? If 'Yes', please enter details on Form MG2.	**Yes** ☐ **No** ☐
Does the person making this statement give their consent to it being disclosed for the purposes of civil proceedings *(e.g. child care proceedings)***?**	**Yes** ☐ **No** ☐

Statement taken by *(print name)*:

Station:

Time and place statement taken:

Signature of witness: .....

Signed : **S.A.WATTS.** Signature witnessed by : _____

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Statement of : STEVEN ALEC WATTS

Age if under 18: *(if over 18 insert 'over18')* **Occupation:**

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

Signature: ..... **Date:** 30TH September 2004.

Tick if witness evidence is visually recorded ☐ *(supply witness details on rear)*

I am Detective Chief Superintendent Steven WATTS, Head of Hampshire Constabulary Criminal Investigation Department and am the senior investigating officer in respect of a police investigation named 'Operation ROCHESTER', an investigation into the circumstances surrounding of death of 88 patients occurring principally during the late 1990's at Gosport War Memorial Hospital, Hampshire.

This investigation followed allegations that during the 1990's elderly patients at Gosport War Memorial Hospital received sub optimal or sub- standard care, in particular with regard to inappropriate drug regimes, and as a result their deaths were hastened.

The strategic objective of the investigation is to establish the circumstances surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service (CPS), to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths.

During the investigation, a number of clinical experts have been consulted.

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On the 9th November 2000 Professor Brian LIVESLY reported on the death of a patient, Mrs. RICHARDS.

On the 12th February 2001 Professor FORD reported in respect of the deaths of five patients RICHARDS, CUNNINGHAM, WILKIE, WILSON and PAGE

On the 18th October 2001 Professor MUNDY reported on the deaths of patients CUNNINGHAM, WILKIE, WILSON and PAGE.

The aforementioned reports have all previously been made available to the General Medical Council.

Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths, and concluded that, "a number of factors contributed to a failure of trust systems to ensure good quality patient care".

Between September 2002 and May 2004 the cases of 88 patients including those named above, at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxicology, general medicine, palliative care, geriatrics and nursing.

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All the cases examined were elderly patients (79 to 99yrs of age) theirs deaths occurring at Gosport War Memorial hospital between January 1996 and November 1999. A common denominator in respect of the patient care is that many were administered Opiates authorized by Dr Jane BARTON prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patients concerned, examining in detail patient records, and to attribute a 'score' according to their findings against agreed criteria. A further group of cases were included in this review following a report by Dr BAKER, commissioned by the Chief Medical Officer. That report is confidential to the CMO and may not be discussed further without his agreement.

The team of experts has 'scored' the cases as follows.

<u>Category one-</u> **There were no concerns in respect of these cases upon the basis that 'optimal care' had been delivered to patients prior to their death.**

<u>Category two -</u> **Specific concerns that these patients had received 'sub optimal' care.**

These cases are currently undergoing a separate quality assurance process by a medico legal expert to confirm their 'rating'. Nineteen of these cases that have been 'confirmed', have been formally released from police investigation and handed to the General Medical Council for their consideration. A number of cases

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have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.

Category three **Patient care in respect of these cases has been assessed as 'negligent, that is to say outside the bounds of acceptable clinical practice'.**

The police investigation into these cases is, therefore continuing.

The five experts commenced their analysis of patient records in February 2003. It is anticipated that their work will be finalized in October 2004 as will the quality assurance process by medico legal expert.

As part of the ongoing investigative strategy, since May 2004 a further tier of medical experts, in Geriatrics and Palliative Care have been instructed to provide an evidential assessment of the patient care in respect of on the 'Category three' cases. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service.

At the same time, the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness/suspect interviews, deal with exhibits, complete disclosure schedules, and populate the major crime

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investigation 'Holmes' system a national police IT application used to record and analyze information relating to serious/complex police investigations.

To date 330 witness statements have been taken and 349 officer's reports created. 1243 'Actions' have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of the Hampshire Constabulary.

Whilst investigations will be fully completed in respect of all of the 'Category three' cases, a small number of sample cases have been selected and work is being prioritized around those with a view to forwarding papers to the CPS as soon as possible by way of expedition. Timescales for this action are clearly dependant upon completion of expert review of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process,

In the event that there is considered a sufficiency of evidence to forward papers to the CPS, it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.

I understand that the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Order Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee.

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In my view, this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professionals involved in this enquiry.

Police investigative interviewing operates from seven basic principles, which are laid out in Home Office Circular 22/1992. The first of these being that

"Officers seek to obtain accurate and reliable information from suspects, witnesses or victims in order to discover the truth about matters under police investigation."

Investigative interviewing should be approached with an open mind. Information obtained from a person who is being interviewed should always be tested against what the interviewing officer already knows or what can be reasonably established.

This investigation is currently following various lines of enquiry seeking to establish whether or not any criminal offence has been committed. At present it has not been established that this is the case or in fact whether or not any person is potentially culpable. Once an individual has been identified then decisions have to be made as to what they need to be interviewed about and what information it is proper to disclose to that person prior to their being interviewed.

Decisions as to what the police have to disclose prior to interviews under caution are covered by various aspects of case law, in particular R v Argent (1997). The court commented in this case that the police have

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no obligation to make disclosure. In R v Imran and Hussein (1997) the court agreed that it would be wrong for a defendant to be prevented from lying by being presented with the whole of the evidence against him prior to interview.

R v Mason (1987) covers disclosing or withholding information, the process must be justifiable and conducted in the full knowledge of the likely consequences. These consequences could affect not only any subsequent interview but also potentially the whole investigation and any subsequent trial.

Article 6 Human Rights Act deals with the right of an individual facing criminal charge to have a fair and public hearing

Advance disclosure of documentation prior to interviews under caution gives any potential suspect the opportunity to interfere with the interviewing of other witnesses who may have information beneficial to the case.

Furthermore the suspect does not have the opportunity to respond to questioning in an uncontaminated way. They may well respond with answers that they think the police wish to hear. This is unfair to the individual concerned.

Finally early disclosure of material can lead to a suspect fabricating a defence or alibi.

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The Police have an over riding responsibility to conduct an effective and ethical investigation and a have a legal and moral duty to be scrupulously fair to suspects. In addition the police carry an additional responsibility to representing the interests of the victims of crime and society in general. Therefore to provide a guilty suspect with the ability to fabricate a defence around police evidence does not serve those wider interests.

As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case.

I understand that there is a voluntary agreement in place between Dr BARTON and the Fareham and Gosport Healthcare Trust of November 2002, the following is a quotation from an e mail message to the investigation from the trust in respect of that matter.

'Dr BARTON has undertaken not to prescribe benzodiazepines or opiate analgesics from the 1st October 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.

Dr Barton will not accept any house visits if there is a possible need for such drugs to be prescribed.

Problems may arise with her work for Health-call as a prescription may be required for a 14 day supply of benzodiazepines for bereavement.

Dr BARTON also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patient's notes.

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During a 13month periods from April 2003 Dr BARTON had written a total of 20 prescriptions all for 2mg diazepam to relatives of deceased and had not prescribed any diamorphine, morphine or other controlled drug.'

I have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim order committee during September 2002.

Arthur CUNNINGHAM - this has been assessed as a category three case and is being investigated accordingly.

Robert WILSON - again a category three case.

Gladys RICHARDS.- Assessed as a category two case by the clinical team, this assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004.

Alice WILKIE. – No further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points;

1. There is no admissible evidence at this time of criminal culpability in respect of any individual.
2. The information adduced by the investigation thus far, and the findings of the experts lead me to have concerns that are such that, in my judgment the continuing investigation and the high level of resources being applied to it are justified.

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GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

THURSDAY 7TH OCTOBER 2004-10-30

CHAIRMAN: DR MACKAY

CASE OF

JANE ANN BARTON

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

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

T A REED & CO

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

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

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

THE CHAIRMAN: We will refer to this as C1.

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

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

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

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

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

THE CHAIRMAN: D1.

MR HENDERSON: That you have in front of you a file note of a meeting held on the 9th October 2002 a meeting at which Dr Barton was present when Dr Sommerville in the second paragraph confirmed that Dr Barton=s offer of a continued voluntary ban on OP prescribing. This was agreed despite the fact that the GMC does not require it. It was pointed out that this has implications for the remaining practice members. Dr Barton had been advised by her medical defence society to carry a single vial of diamorphine in case she was presented with an absolute medical emergency. It was confirmed that the above arrangement does not, in practice, compromise the patients= safety in her practice list, thanks to the partners in the practice for accepting and dealing with this voluntary restriction. JB agreed her voluntary restriction covers opiates. Benzodiazepines would be prescribed strictly within BNF guidelines.@ It goes into monitoring arrangements with which I do not think is pertinent at the moment unless my friend wants me to read them out. So it would appear that there is in place some form of voluntary undertaking on the part of Dr Barton. The obvious point I will take on behalf of the Council is that it is of course an unwritten undertaking of no particular duration and capable of being withdrawn at any time and incapable of enforcement by the General Medical Council. It is not something which would come to the notice of anybody making enquiries in relation to Dr Barton whereas conditional registration has that important and significant effect. That is a matter which I am conscious you will be perfectly familiar with as being of importance,. Now that the Council for Regulation of Health Care Professionals has appealed a number of cases concerning doctors in the course of the past 12 months or so, we can see the importance that is attached to the public availability of information so that the public can be confident that those things that ought to be able to be known by the public are known by the public, whether they be prospective employers or prospective patients. This sort of undertaking is unfortunately not in any way known to any such persons.

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

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

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

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

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

AWhere the Interim Orders Committee are satisfied that it is necessary for the protection for the protection of members of the public or is otherwise in the public interest or is in the interests of a fully registered person, for the.registration of that person to be suspended or to be made subject to conditions, the Committee may make an order ....@

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

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

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

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

THE CHAIRMAN: This will be C2.

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

"The IOC ordered that the claimant=s registration as a medical practitioner should be suspended with immediate effect for a period of 18 months. It was further ordered that the suspension should be reviewed by the IOC at a further meeting to be held within six months.

The claimant is a general practitioner of premises in the south east of England. Allegations of indecent assault are made against him by two of his nieces (now aged 15 and 13 years). Their father complained to the Social Service Department of the County Council and the Health Authority also became involved. The GMC were informed of the allegations. On the 28th February 2001 the claimant was charged by the police with six counts of indecent assault. He was granted bail subject to conditions. By virtue of Articles 3 and 10 of the Medical Act 1983 Amendment Order 2000 the 1983 Act was amended by the addition of Committee and a new section.@

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

A The IOC has its origins in the Amendment Order. Similar, though somewhat different, powers were formerly exercised by a different committee of the GMC. At the hearing on 2nd March 2001 both the claimant and the GMC were represented by counsel. The hearing was conducted by a committee of five members advised by a legal assessor. Some of the

argument before the Committee turned upon the possibility of an interim conditional registration. It is common ground that it is not open to the court to take that course upon this application. The power of the court, subject to its power under section 41A(10)(c) is either to quash or to uphold the order of the IOC.@

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

A The determination complained of was:

A.... the Committee has carefully considered all the evidence before it today.

In accordance with Section 41A of the Medical Act 1983, as amended, the Interim Orders Committee has determined that it is necessary for the protection of members of the public, is in the public interest and is in your own interests to make an order suspending your registration, for a period of 18 months with effect from today.

In reaching the decision to suspend your registration the Committee has concluded that there is prima facie evidence of indecent behaviour that, if proved, would seriously undermine the trust the public is entitled to place in the medical profession. The Committee has considered the submission made on your behalf that if an order were to be imposed, interim conditions would adequately protect patients. However, after considering all the circumstances in the case, and having regard to its duty to protect the public interest, the Committee has determined that it must suspend your registration.@

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

We come to paragraph 15:

AMr Peacock, who appears for the claimant before this court, also appeared for him before the IOC, and accepted, as in my judgment he had to accept in relation to the charges: AThey are plainly very serious and the doctor is well aware that they are, if proved, extremely serious, and if accepted by a jury in a criminal court of trial they are likely to result in a sentence of imprisonment and further conduct proceedings@. It is clear that the allegations have been considered by representatives of the relevant local authorities and by the police, whose code of practice provides that before criminal proceedings are brought there must be Aenough evidence to provide a realistic prospect of conviction@.@.

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

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

A Mr Peacock also makes the point that the IOC have relied upon all three grounds in section 41A(1) and have done so cumulatively. If any of them fail, and Mr Peacock submits that the concept of protection of members of the public and the concept of the interests of the claimant himself must fail, then the entire case falls. I say at once that I do not accept that submission. Based, as it is, on the wording of the second paragraph of the determination, it appears to me that, provided one of the criteria was satisfied, the fact that one or more of the others was not satisfied does not, in the circumstances of this case, invalidate the conclusion of the Committee. The wording does not suggest that the satisfaction of all three criteria were, in the view of the Committee, necessary to a conclusion that an order should be made against the claimant.

The second submission is that the Committee were not considering, as the Committee in some of the cases cited were considering, a case where there was a conviction in a criminal court. In this case there is only an allegation or a series of allegations. It is not correct Mr Peacock submits that, even if the allegations are serious, as he has to accept those in this case are, it was appropriate in present circumstances for the IOC to make an order on the mere making of an allegation. He submits that the fact that the police have decided to charge the claimant makes no difference. The Committee must not be permitted to approach its work on the basis that the police would not have charged the claimant if had not done it. That approach, Mr Peacock submits, is quite contrary to legal principle. Mr Peacock draws attention to the difficulties facing a defendant before the IOC in circumstances such as the present. There are obvious constraints on calling evidence before a Committee when criminal proceedings have been commenced. I accept that there may well be difficulties, but the IOC must consider the case on the basis of the material which the GMC and the defendant see fit to call before them.

I am far from criticising the claimant and those who represented him for not in the circumstances of this case calling evidence. I do not leave the point however without stating that there could be cases in which material placed before the Committee when criminal charges were pending might, having regard to the duties of the Committee place allegations of criminal conduct in a very different light from that in which they might otherwise have appeared.@

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

A When pressed on the point, Mr Peacock put his third submission rather as a lack of consistency by the Committee, or of disparity between its decision in this case and its decision in other cases. There has been some reference to other decisions of the Committee. I acknowledge the constraints which rest upon both parties in giving particulars of other cases. However, it is essential, as Lord Upjohn put it, that each case is considered upon its own particular circumstances.@

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

A Reference to other cases which Mr Peacock rightly accepts would not be binding upon the Committee is of limited value. Moreover, on the limited information which has been provided by the parties, I am far from satisfied that there can be said to be any inconsistency between the decision taken by the IOC in this case and its decisions in other cases. It is not necessary for present purposes to give details of those other cases.

23. Reference has been made to Article 6.1 of the European Convention. In my judgment in present circumstances that adds nothing to the duties already required by English law. I see no merit in the submission that the decision of the IOC fails either on the ground of lack of reasoning or by reason of disparity between this and other decisions.

24. I have referred to the limited nature of the material which was before the IOC. It was for them to examine the material before them with care. It is plainly a worrying situation when a professional man may be suspended on the basis of allegations of criminal conduct which, as yet, are untested in a court of law. I cannot however accept that the power to suspend by way of interim order provided in section 41A must not be exercised because the allegations are untested in court. Nor, in my judgment, can it be said that the exercise of the power to suspend was inappropriate because the conduct alleged was not towards patients of the claimant.

25. The allegations in this case are undoubtedly serious. They are of offences against the person. Whether or not they are eventually proved it cannot be said that they plainly and obviously lack substance.@

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

AThey involve an alleged breach of trust towards vulnerable young people. The alleged offences have an obvious impact upon the fitness of the claimant to have that intimate contact with patients which is a necessary part of his duties as a doctor. That being so, it cannot in my judgment be said that the IOC erred in law in reaching the conclusion they did. They were entitled in their discretion to do so on all three grounds in section 41A in my judgment, especially having regard to the breach of trust alleged.@

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So much for the first Interim Orders Committee hearing.

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

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

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

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

A At the age of 91 years Mrs Gladys Richards was an inpatient in Daedalus ward at Gosport War Memorial Hospital. A registered medical Practitioner prescribed the drugs diamorphine, haloperidol, madazolan and hypascine for Mrs Richard. These drugs were to be administered Subcutaneously by a syringe driver over an undetermined number of days. They were given continuously until Mrs Richards became unconscious and died. During this period there is no evidence that Mrs Richards was given life sustaining fluids or food. It is my opinion that as a result of being given these drugs Mrs Richards=s death occurred earlier than it would have done from natural causes.@

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

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

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

Then on paragraph 5 page 29,

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

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

If I can go to the conclusion on page 32

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

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

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

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

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

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

At that time also Dr Barton prescribed for Mrs Richards diamorphine hyoscine and midazolam. These drugs were to be given subcutaneously and continuously over

periods of 24 hours for an undetermined number of days and the exact dosages were to be selected from wide dose ranges.

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

It is noted that although prescribed on the day of her admission to Daedalus ward at Gosport War Memorial Hospital these drugs, diamorphine, hyoscine and midazolan, were not administered at that time.@
It then goes through the sequence and I have taken you through the prescriptions so far. At paragraph 7.10 he said:

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

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

Neither midazolam nor haloperidol is licensed for subcutaneous administration.

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

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

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

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

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

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

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

which was available at the first hearing. It was part of the material which was put before the second hearing on the 2lst March and led to the making of no order.

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

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

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

Then can I go to Comments:
A All the prescriptions for opioid analgesics are written in the same hand, and assume they are Dr Barton=s prescriptions although the signature is not decipherable. Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two does of oral morphine, the 24 hour dose requirement of Diamorphine could not therefore be established. The dose of diamorphine prescribed gave a tenfold range from 20mg to 200mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Mr Barton on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication.@

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

Alice Wilkie is considered on page 55. He notes in the latter part of the first paragraph that the dose of 30mgs was given on the 20th August of Midazilam apparently by Dr Barton and the patient was given another 30mg of Diamorphine on the 2lst August and died later that day. The Comment was:

A There was no clear indication for an opioid analgesic to be prescribed and no simple analgesics were given and there was no documented attempt to establish the nature of her pain. In my view the dose of Diamorphine that was prescribed at 30mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the diamorphine prescription gave a tenfold range from 20mg to 200mg in 24 hours.@
Alice Wilkie is a case where it is said by the police in their statement at page 465 ANo further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.@

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

A A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16th October again in Dr Barton=s handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of diamorphine was given on 16th October and the nurses commented later that the Apatient appears comfortable.@ The dose was increased to 40mg the next day when copious secretions were suctioned from Mr Wilson=s chest.@

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

A Mr Wilson was clearly in pain .from his fractured arm at the time of transfer to Dryad ward. Simple analgesics was prescribed but never given there was an entry earlier in the episode of care that Mr Wilson had refused paracetomol. No other analgesia was tried prior to starting morphine. Mr Wilson had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in diamorphine. Once against the diamorphine prescription had a tenfold dose range as prescribed.

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

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

The next patient was Eva Page and known to suffer with hypertension, ischaemic heart disease with heart failure and paroxysmal atrial fibrillation, depression, episodic confusion and had sustained a minor stroke in the past. The comments page 57:

A Mrs Page had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. When she was transferred to Dryad Ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding her symptom control and she was started on opioid analgesia.in my view inappropriately following her spitting out of medication and she was given a topical form of an opioid analgesic, fentanyl. A decision was taken to start a syringe driver because of her distress, this included Midazolam which would have helped her agitation and anxiety.

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

CONCLUSIONS: I felt that the nursing records at Gosport War Memorial Hospital were comprehensive on the whole. The reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath, or cough requiring relief. In several of the cases concerned oral morphine was not given for long enough to ascertain the patient=s dose requirements, the reason for switching to parenteral diamorphine via subcutaneous infusion was not documented and the prescription of a tenfold range 20 mg to 200 mg of diamorphine on the as required section of the drug charge is in my view unacceptable. In my view the dose of diamorphine should be prescribed on a regular basis and reviewed regularly my medical staff in conjunction with the nursing team. There was little indication why the dose of diamorphine was increased in several of the cases and the dose appears to have been increased without the input of medical staff on several occasions.

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

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

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

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

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

B The under Summary:

AGladys Richards was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedualus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Barton. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death.@

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

A I consider the decision by Dr Barton to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent underlined instruction doses of oramorph earlier in the day. I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200 mg/24 hr prn, hyoscine 200-800 microg/24 hr and midazolam :20-80 mg/24hur to be poor practice and potentially very hazardous. A

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

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

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

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

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

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

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

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

Then Eva Page the summary at page 92:

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

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

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

7.4: In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used

only when the patient is unable to take medicines by mouth, has malignant bowel obstructions or where the patient does not wish to take regular medication. In only one case were these criteria clearly fulfilled, i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive does and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

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

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

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

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

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

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

THE CHAIRMAN: We have all read it.

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

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

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

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

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

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

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

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

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

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

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

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

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

The earlier advice I pass over at page 453.

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

(Adjourned for a short time)

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

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

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

A An investigation surrounding the death of 88 patients occurring principally during the late 1990s at Gosport War Memorial Hospital. This investigation followed allegations that during the 1990s elderly patients at Gosport War Memorial Hospital received sub optimal or substandard care in particular with regard to inappropriate drug regimes and as a result their deaths were hastened.

The strategic objective of the investigation is to establish the circumstance surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths

During the investigation a number of clinical experts have been consulted.@.

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

AThe Aforementioned reports has all been made available to the GMC. Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths and concluded that A a number of factors contributed to a failure of trust systems to ensure good quality patient care.@ Between September 2002 and May 2004 the cases of 88 patients including those named above at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxically, general medicine, palliative care, geriatrics and nursing. All the cases examined were elderly patients (79 to 99 years of age) their deaths occurring at Gosport War Memorial hospital between January 1996 and November 19999. A common denominator in respect of the patient care is that many were administered opiates authorised by Dr Jane Barton prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patient4s concerned, examining in detail patient records, and to attribute a score according to their findings against agreed criteria. A further group of cases were included in this review following a report by Dr Baker commissioned by the Chief Medical Officer. That report is confidential to the CMO and may not be discussed further without his agreement.@

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

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

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

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

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

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

AA number of cases have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.@

Category 3 patient care in respect of these cases has been assessed as Anegligent, that is to say outside the bounds of acceptable clinical practice@. The police investigation into these cases is therefore continuing. The five experts commenced their analysis of patient records in February 2003. That is my next block in the chronology. AAs part of the ongoing investigative strategy, since May 2004, a further tier of medical experts,in geriatrics and palitiative care have been instructed to provide an evidential assessment of the patient care in respect of in the category three cases.. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service. At the same time the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness suspect interviews, deal with exhibits, complete disclosure schedules and populate the major crime investigation AHolmes@ system a national police IT application used to record and analyse information relating to serious/complex police investigations. To date 330 witness statements have been taken and 349 officers reports created.. 1243 actions have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of .Hampshire Constabulary. A

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

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

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

Back to the statement if I may.

A Whilst investigations will be fully completed in respect of all the category three cases a small number of sample cases have been selected and work is being prioritized D around those with a view to forwarding papers to the CPS as soon as possible by way of expedition.@

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

A Timescales for this action are clearly dependent upon completion of expert review E of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process. In the event that there is considered a sufficient of evidence to forward papers to the CPS it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.@

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

AI understand the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Orders Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee. in my view this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with G health care professionals involved in this enquiry. Police investigative interviewing operates from seven basic principles .....@

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

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

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

A As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case. I understand that there is a voluntary agreement in place between Dr Barton and the Fareham and Gosport Healthcare Trust of November 2002....@

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

AI have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim orders committee during September 2000.
Arthur Cunningham - this has been assessed as a category three case and is being investigated.
Robert Wilson - again a category three case.
Gladys Richards - assessed as a category two case by the clinical team, this assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004.
Alice Wilkie - no further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points:
1. There is no admissible evidence at this time of criminal culpability in respect of any individual.
2. The information adduced by the investigation thus far and the findings of the experts lead me to have concerns that are such that in my judgment the continuing investigation and the high level of resources being applied to it are justified.@

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

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

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

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

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

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

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

On 7 October 1996 Mrs Taylor was felt to be in pain and was prescribed fentanyl patches. Mrs Taylor was noted to be in a great deal of pain and the strength of the fentanyl patches were increased.

On 18th October following a very unsettled night when Mrs Taylor appeared to be distressed and in pain a syringe driver was set up with 40mgs of diamorphine and 20 mgs of midazolam over twenty four hours.

Although Mrs Taylor had a severe stroke which left her unable to swallow or speak, she was being tube fed. However she was prescribed rapidly escalating does of opioids without there appearing to be a comprehensive assessment made for her pain.

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

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

A He was diagnosed with as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission. He was then administered 10 mgs temazepam apparently which had been written up for him. The experts criticised the use of a small dose of temazepam in a patient who is cyanosed. They note though that Mr A bbatt was already very.unwell.@

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

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

AIn December.1993 he was complaining of generalised pain and started on Oramorph. Dr Lawson notes that Mr Batty went from little analgesis to oramorph 60mgs in twenty four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment. The experts review has determined that the treatment was sub optimal due to the high does especially midazolam. Cause of death was felt to be unclear by the expert team.@

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

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

MR HENDERSON: You are absolutely right.

THE CHAIRMAN: I think also with Mr Taylor.

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

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

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

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

A A syringe driver.was set up with a high dose of diamorphine and midazolam. Mr Carby died forty five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Dr Naysmith noted that he ay well have received less than normal since he had low blood pressure and was peripherally cyanosed.

The cause of death was shown as cerebral vascular accident and was certified by Dr Barton. Mr Carby was cremated.

The large dose of diamorphine makes the care sub optimal but it had no effect on Mr Carby=s prognosis.@

That is the supplementary evidence.

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

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

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

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

MRS MACPHERSON: There is no further information available to us which would indicate why the President made his decision?

MR HENDERSON: That is correct.

THE CHAIRMAN: We do not have any further questions. Mr Foster?

MR FOSTER: I should begin by saying that I am very grateful to my learned friend for his thoroughness and for his even-handedness. Both of those things mean that I can be a lot briefer than I originally thought that I would have to be. I have to say a little bit about the background and could I begin by inviting you to look again at the letter which is at page 404 of the bundle MDU written on Mrs Barton=s behalf in August 2002. My learned friend has referred to this and I know you have read it before and I k now you will read it again but there are some matters which I wish to highlight. It is Dr Barton=s position that she was forced because of the conditions in which she had to work to choose between optimal note keeping and proper patient care and notekeeping was a casualty, patient care was not. If you look at pages 404 and 405 you will see that she compressed her clinical sessions at the hospital into three and a half sessions each week. In the two wards over which she had responsibility there were a total of 48 beds for her patients care which were extremely high, and he points out in paragraphs 3 and 4 on page 405 which indicates that Dr Barton lacked effective consultant support and indeed during the time in which the formal allegations took place the second consultant Dr Tandy was on leave, so already he inadequate consultant support if there was any was cut in half.

The penultimate paragraph on page 405 tells the story of Dr Barton=s frantic life. She arrived at the hospital at 7-30 and she would visit both wards, reviewing patients and

liaising with staff before she commenced he general practitioner duties at 9 am. She visited the wards, she would do her general practitioner appointments between nine and lunch time and would often go back at lunch time to review patients and then after doing her afternoon session as a general practitioner she would frequently go back to the hospital about seven and stay there for sometime.

That is a picture of an extremely concerned and diligent doctor doing her best under horrific circumstances. Those circumstances were made clear by Dr Barton to the management on a number of occasions APlease help, we need more funds, we need more staff@ but unfortunately those tries went unheeded. With the benefit of hindsight it might very well be the case that the wisest thing to have done would be to have resigned and of course Dr Barton facing the problems that she has faced over the last few years regrets very much that she did not do that. That would have been the only way in which the management would have taken any notice, but unfortunately she did not want to let the patients down, she did not want to let down the nurses with whom she had a very close relationship and so she battled on. In battling on she did not make the notes that she should have made therefore it is not clear, it is accepted in relation to many patients, just what the clinical indication was for the prescription which is recorded.

This is a case of poor documentation, it is not case of poor patient care. My learned friend has taken you to the transcript of Dr Barton=s evidence on page 413 and when you are making your deliberations today I would invite you to look at that again. There is some useful cross-referencing which deals with the position of the hospital which is to be found in the Commission about Health Improvement Report which was published in July 2002. I do not propose to burden you with what is a bulky document, there are quite enough pages in this case. There are a few passages I wish to highlight.

THE CHAIRMAN: Has Mr Henderson seen this?

MR FOSTER: No, I do not imagine there will be huge surprises. Does Mr Henderson want to see it?

Mr HENDERSON: The answer is yes I want to, what I suggest when we have the break I suggest my learned friend goes ahead and if he could make it available to me during the lunch hour adjournment and anything I ought to say I will let you know, would that be a convenient way of dealing with it?

THE CHAIRMAN: Yes.

MR FOSTER: There are three paragraphs I wish to refer. The first is paragraph 6. 8, this relates to the appraisal of supervision of clinical assistance. (Paragraph read) There the commission concluded that the work place was intolerable and the sessions that were allocated to Dr Barton were inadequate to deal with the work she was required to do. The next paragraph is 7.9 (Paragraph read) Finally in this report there is a heading at 7.11 headed AOther trust lessons@. (Paragraph read)

That is a long boring list which indicates what had to be done in order to do properly the job which Dr Barton was required to do. The conclusion I would invite you to draw from that is that Dr Barton was operating in circumstances which made full notekeeping quite impossible.

The other important bit of background which has been referred to repeatedly this morning of course is that there have been three successive IOCs hearing which have not found any order is necessary. In the transcript at page 438 of the bundle, which relates to the IOC hearing on the 19th September 2002 there was a good deal of discussion between the Committee and the legal assessor and counsel about whether it was proper to make any order no new evidence having been adduced. It was decided there that no new order should be made because there was no significant new evidence. That in my submission is the proper way to deal with it in my submission. The question therefore arises what has changed since the last IOC hearing?
The important point which my friend makes is that the test which was applied on previous occasions is wrong and accordingly you have to reconsider all the material which was before previous Committees and apply the proper test, that was part of the reason for detailed consideration of all the previous evidence. He invited your attention to the case of Dr X and he invited you to adopt an alternative test which said if you are satisfied (a) in all the circumstances of this particular case that there may be impairment of Dr Barton's fitness to practice which poses a real risk to members of the public or may adversely affect the public interest or her interests and (b) on balancing her interests and the interests of the public an interim order is necessary to guard against the risk then the order should be made. I do not have a lot of dissent to that formulation save I suggest it should read if you are satisfied (a) in all the circumstances of this particular case a sufficiently robust case has been made that there may be impairment of Dr Barton=s fitness to practice; that caveat is necessary to avoid a potentially ludicrous result. If one adopts that formulation then I would respectfully submit that for all intents and purposes the right test has been applied by previous committees. Both Mr Henderson=s formulation of the test and the test which I have formulated today begs the really important question which is the question begged by section 41A itself, how are you satisfied?
Mr Henderson=s test does not answer that question. It cannot be the case having regard to basic principles of fairness described if you like in terms of Article 6, that a malicious allegation by a patient of a serious offence can have the effect of causing the interim orders committee to apply a draconian order affecting a doctor in practice.

There must be implicit in the statutory requirement "to be satisfied" a basic requirement that you look for some evidence. What therefore amounts to satisfactory evidence, evidence sufficiently cogent for you to be satisfied? My learned friend says that the additional evidence which you have in this case is the fact of an ongoing police inquiry. That with respect does not add anything to the position which had obtained previously, the police inquiry had been going on for an awfully long time, yes it is right that we have now been told that the police inquiry will look at among other things the patients whose summarises are contained in the back of the IOC bundle. But we have known for a very long time that patients including these patients had previously been looked at, and there is not the slightest reason to suppose that those patients were not among the patients who were being looked at and in any event my learned friend I would say very fairly down played the weight which you should

attach to those summaries for all the reasons which he has identified; we do not know anything about their authorship, but without wanting to be flippant those summaries could have been compiled by a secretary with medical knowledge in the police department.

The neutral stance I would take is that it is simply more of what we have seen before. If we believe everything which is said in those summaries there is evidence of hurried and in some cases incomplete medical records. There is no indication there has been any inappropriate prescribing. There is sometimes inadequate documentation of the implication of prescribing but again I do not want to be flippant but it is important to understand the context in which this police investigation has happened. This has been an absolutely massive police investigation. When those instructing me spoke to the police in September 2003 my solicitors were told that a team of six detectives had been working full time on the case and as you have heard already that a number of experts have been called in, including experts from nursing, from forensic psychology, general practice, care and so on. I respectfully and rhetorically say that after all that expenditure, money time and manpower is that the best that there can be? They have been unable to put any firm allegations against Dr Barton in the sense of new charges. In relation to the weight which my learned friend says he should attach to the fact that the preliminary proceedings committee have referred to the professional conduct committee, point 1 that is a matter which has already been considered by the committee and, two, a test in which the police are deciding whether to bring charges. We know what the police=s view of the present situation is because Chief Superintendent Watts has been very candid about it and a portion of his evidence has been read out ANo evidence of any criminal charges and we really do not know where we are going to go from here". Again I rhetorically ask should that be sufficient for you to say that there has been new material upon which you could be satisfied that the position has changed from previous IOC hearings and that statutory criteria in section 41A has been met?

Chief Superintendent Watts obviously thought that he had a very cogent point to bring before the committee, that was the issue of the undertaking about the opiates and benzodiazepines prescriptions; he thought as his statement makes clear that he had caught Dr Barton out in breaching her undertaking. That quite plainly is not the case. You have seen the document in D1 Which is the formalised second undertaking which was given. You will see the terms where Dr Barton prescribed diazepam where there was a clinical indication for doing so which was endorsed by the British National Formula. Dr Barton has undertaken the exercise of looking at her prescribing over the period which is dealt with by Chief Superintendent Watts in his statement.A computer print out has been generated and if copies could be handed up. This is D2. My learned friend has seen this. It requires some explanation. It relates to diazepam prescriptions by other partners in the practice where Dr Barton works during the material period. The names of the national health service numbers of the patients have been deleted so confidentiality is secure. You will see at the bottom of the first page Dr Barton=s name and she is described there as the usual doctor, so all the entries under her name relate to prescritpions of diazepam which were given to patients for whom Dr Barton was the usual doctor. That does not mean, as the medical people will know, that all the prescriptions were written out by Dr Barton herself. The prescriptions which were written out by Dr Barton herself are indicated on the right

hand side of the page by the initial JAB. You will see four occasions on which Dr Barton has herself written out prescriptions for diazepam. The other prescriptions were written out by other doctors whose initials appear on the right hand side of the page on behalf of patients who were the usual patients of Dr Barton. In relation to each of the four prescriptions and Dr Barton has gone back and checked all this and they were all for muscular type pain which is a legitimate prescription for that. That indicates Superintendent Watts killer point before you, namely this is a doctor who breaks her undertakings and incontinently prescribes diazepam is a wrong point.

You are left solely with the question whether there is new evidence which justifies the departure from the IOC previous findings that there is need for an order in Dr Barton=s case.

There is no evidence at all that Dr Barton is unable to prescribe safely in the GP context. That is the only context in which she now prescribes. There is every reason to suppose that all the concerns arose solely because of the pressures which arose in an appalling environment which a long time ago now she prescribed, it is a long time now since she was working on these wards and she has no intention of going back.

That being the case no proper public confidence issues arise. In her general practice she has an acceptable work load, the work load is divided between several partners and accordingly record keeping is simply not an issue either. Is it therefore necessary again for there to secure public safety that she has an order in the terms suggested by my learned friend? Absolutely not. The necessary protection was given by the undertakings which she has made and manifestly by this evidence has complied with. The Committee I know will be keen to guard against the tendency which arises in many high profile public cases of complying with what can amount to mob rule of a doctors inability to practice being interfered with simply because people make unsubstantiated allegations.
For all those reasons I suggest that there is no material on which you can properly conclude that the earlier committees were wrong in deciding that no order be made. Those are my submissions.

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

DR STEWART: It is just to clarify a matter to do with the D2, the diazepam. Under the usual doctors, Dr Barton=s list it is quite clear that other doctors whose names appear on this document have prescribed for her patients. Dr Beasley has prescribed morphine on a couple of occasion on Dr Barton=s list and Dr Peters has. What you have not indicated to us is how many of these prescriptions under the names of Dr Knapman Dr Peters, Dr Brigg or Dr Beasley and Dr Brooke were actually written by Dr Barton rather than by the doctors whose names appear at the top of the list. That is information that I think would be useful for the Committee to have if you are asking it to consider that this is an indication of the number of frequency that diazepam prescriptions are prescribed by Dr Barton?

MR FOSTER: I can tell you, sir that none of the other prescriptions under other doctors names were written out by Dr Barton.

DR McCUGGAGE: Just on that point that Dr Stewart made. Perhaps when we look at the prescription under A J Barton under JAB it appears twice. Were there two prescriptions written by Dr Barton.

MR FOSTER: I understand it was an error.

DR BARTON: It was an error, I think what it was when it was pressed down the computer generated two prescriptions.

MS RAZI: I just wanted to check when this report is dated.

MR FOSTER: July 2002.

THE CHAIRMAN: We have in our bundle doctors arrested on suspicion of an offence and we have others who are formally charged and clearly we are aware of the police investigations which have been going on for some time. Has there ever been any stage where Dr Barton has been arrested on suspicion?

MR FOSTER: No, sir. She has been interviewed under caution in relation to the case of Gladys Richards and the police decided there would be no proceedings. The police interviewed her and the papers were sent to the Crown Prosecution Service and the answer came back that was the end of the case.

THE CHAIRMAN: So it was the CPS who decided in that case?

MR FOSTER: Yes.

THECHAIRMAN: At this stage we would normally ask the legal assessor for advice, but since Mr Henderson is going to look at this document at the lunch break it might be better if we break now and reconvene later.

MR HENDERSON: Could I just respond in relation to the legal matter and on the matter of a correction. The first is this my learned friend=s submission seeks to add some words to my test and he is trying to say effectively what does satisfy mean and the test he applied that it must be sufficient robust and goes on to say the basic requirement is that this committee must look at some evidence. This in my submission is obviously more important in this case essentially but I would suggest to you that that reason is wrong. The reason we can see it is wrong is Dr X. We know in Dr X there was no evidence, there was a charge, they did not look at the evidence underlying the charge, therefore in my submission the additional words which he implies do not add anything when he says what he means by it, they actually go further than they properly should.

In relation just to a correction he says we do not know anything about the authorship but in fact we know something. We know what Chief Superintendent Watts has said about it. In addition if one looks at page 507 we know one of the experts, Dr Macey, is expressly identified,therefore it cannot have been, to use my learned friend=s

forensic flourish simply a medical secretary. It may be a medical secretary who typed it but the substance of the matter cannot be limited to that.

In relation to other matters I would like to see the document and I will come back to you.

MR FOSTER: I wonder if I can respond very briefly to that. I would accept that if a police investigation resulted in a charge then that charge is evidence within the ambit of the test proposed, but in the case of Dr Barton we are a million miles from that; not only do we not have any charges, you have it indicated by the police on several occasions to take no action, so to suggest it is parallel with the case of Dr X where there were charges simply do not stand up.

THE CHAIRMAN: Right we will adjourn to 2pm

(Adjourned for a short time)

MR HENDERSON: I mentioned to my learned friend that I wanted to draw attention to one or two passages in this report. It is the only copy with have here. He has highlighted certain passages and when you retire you can look at the report. I could not hear clearly what Dr Barton said but I understood it to be the case that the pressing down twice explained duplication of prescriptions in relation to the 15 items where they are duplicated. I think along side you will see some dates. While obviously that may well be the case, I am not questioning one way or the other, that in relation to the first entry, the third shown, nor the one April 9th, the one after that three from the end, the patient 1959 No 111496, you have got two different dates, one of which was the 7th November and the other 28th October and that would not marry with that explanation. The last is the penultimate one, that is dated 28th May but I merely draw that to your attention.
Can I respond to the report. The function of CHI which produces this report is not to investigate particular doctors and therefore the point my learned friend makes, there is no criticism of individual doctors, with respect is clearly limited, the absence of criticism is not a basis for the answer that none is to be found. This came into existence particularly to deal with systematic or systemic organisational problems in the provision of health care.Its remit is at paragraph 1.4 and I mention this in this context because you will find the passages to which I am going to draw your attention show that one would not generally expect to find individual criticisms and the terms of reference which were agreed on the 9th October 2001 are as follows.

AThe investigation will look at whether since 1998 there has been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within the services of older people inpatient and continuing and rehabilitative care at Gosport War Memorial Hospital. ...(reading to the words) .....care for older people.@

In the context of that remit none the less there are certain key conclusions and at page vii in the key conclusions I will alert you to this:

ACHI concludes that a number of ..... reading to .....were not identified.@

Those are amongst the key findings, the first one under Chapter 4, under the heading

AArrangements for the prescription administration and review@ ACHI have serious concerns ..... reading to ..... Would have been questioned.@

Then in relation to Chapter 5 under the heading of AQuality of care and patient experience.@
A Relatives speaking to CHI had some ..... ward now.@

Then in chapter 4 at paragraph 4.2, a chapter headed AArrangement for the prescription, administration and review of the calling of medicines, police enquiry and expert witness reports@

A Police expert witnesses .....reading to ..... to reach the conclusions in this chapter.@

I have already given you the conclusions in the chapter at the beginning.

Then in relation to paragraph 4.4 on page 13 under the heading AMedicine usage@

A Experts commissioned by the police ..... number of patients treated.@

On the next page you have graphs.

Then paragraph 4.5

A The Trust=s own data ..... 2000 and 2001.@

Then there is the graph. Finally paragraph 7.9, my learned friend read the first sentence and could I read to the end

A Gosport Health Care NHS .....reading to ..... April 2001.@

Sir, are the paragraphs which I thought I would draw your attention to, there is nothing else I wish to say. Thank you very much.

MR FOSTER: Could I just say this there is no new evidence which my friend read out which should alter your approach to this case. You may feel that the simple question for this committee to decide is whether it is proper for the IOC committee to impose conditions on Dr Barton's fitness to practice on evidence primarily of a police officer's assertions that an enquiry is continuing without being able to give a coherent indication as to the nature of the enquiry or the evidence that the enquiry has. In my submission the answer to that question must be No.

THE CHAIRMAN: I will now ask our legal assessor for his advice?

THE LEGAL ASSESSOR: This is an application under section 41A of the Medical Act 1983 for an interim order that conditions should be placed on the registration of Dr Barton. It is not suggested that her registration should be suspended.

I advise that the approach the Committee should now take is to consider all the particular circumstances of Dr Barton=s case as they prevail today. This must include the circumstances as at the time of the three previous hearings when no order was made and to consider it in the light of the new material which is before them today.

I advise that before any order may be made the Committee must be satisfied that by reason of Dr Barton=s intending to practice it is necessary for the protection of the public, or is otherwise in the public interest, for example, to maintain public confidence in the medical profession, or in the doctor=s own interest that conditions should be imposed on her registration. The Committee must consider proportionality. The protection of the public, particularly patients, and the maintenance of confidence in the medical profession, must be balanced against the consequences of an order for the doctor, such as interfering with her ability freely to practice her professional and the staining of her reputation.

Mr Henderson, for the General Medical Council, has suggested a new test should be applied as to when the Committee should make an order. The advice which I have just given is in the same or similar terms to the advice which has always been given to this Committee since its inception with the omission of the words Aby cogent and credible prima evidence@ after Athe Committee must be satisfied@. With that omission my advice is in broad terms identical to Mr Henderson=s new formulation, although perhaps not so elegantly expressed.

Mr Foster, for the doctor, does not criticise Mr Henderson=s new formulation save he speaks to add Athat the committee must be satisfied that a sufficiently robust case has been madeMy advice is this: the Committee must act on the material which the General Medical Council and the defendant sees fit to call before it and that is a quotation from paragraph 18 of the case of Dr X to which reference has been made. This often includes material such as the mere fact of the doctor being charged or arrested for an offence or third party report. which would not possibly be evidence admissible in the criminal court or before the Professional Conduct Committee. That follows necessarily from the nature of the interim Order Committee function and the point in the proceedings at which that function is performed.

However, I advise the Committee that they are not required to act upon any material put before them. They must first consider its weight and quality; put another way, as was done by Pill LJ at paragraph 25 of Dr X they should consider whether the material put before them in support of the application Aplainly and obviously lack substance.@ That may be no more than another way of saying AIs the material credible and cogent?@ If the Committee is satisfied that the material relied upon by the General Medical Council plainly and obviously lacked substance or is not credible and cogent they will not be satisfied that it is necessary to make an order.

That is my advice.

THE CHAIRMAN: Right if you could withdraw while we consider the matter.

(The Committee conferred in private)

THE CHAIRMAN: Dr Barton, the Committee has carefully considered all the information before it today, including the statement dated 30th September 2004 made by Detective Chief Superintendent Watts of the Hampshire Constabulary, the submissions made by Mr Henderson QC on behalf of the General Medical Council and the submissions made by Mr Foster on your behalf.

The Committee has determined that it is not satisfied that it is necessary for the protection of members of the public, in the public interest or in your own interests to make an order in accordance with section 41A of the Medical Act 1983 as amended.

In reaching its decision the Committee has noted that the police investigation is at present ongoing and that you have noet as yet been arrested or charged with any offence. The Committee has taken into account the new material before it today, but it is of the opinion that this taken with the information before the IOC at previous hearings is insufficient to justify the imposition of an interim order. The statement provided by Hampshire Constabulary provides little substantive information and the Committee is unable to place sufficient weight on the supporting documentation.

The Committee has taken into account that no concerns have been revealed about your work in General Practice. The Committee has also noted that you have made a voluntary undertaking to Fareham and Gosport Primary Care Trust regarding the prescribing of opiates and benzodiazepines.

Notification of this decision will be served upon you in accordance with the Committee's Procedure Rules.

----oooOOooo----

TELEPHONE MESSAGE PAD

FROM .....

TO .....

TIME/DATE .....

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Julie Gill Code A
- Regional Director of Public Health (SE. Region)

Rachel Dixon Code A
- Chief Medical Officer's office)

Simon Tanner Code A
:- Director of Public Health at Portsmouth Health Authority

Message taken by .....

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Mrs A Macpherson

CASE OF: BARTON, Jane Ann

PROCEEDINGS

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday, 19 September 2002

CHAIRMAN: Mrs A Macpherson

CASE OF:

BARTON, Jane Ann

MS F HORLICK, Counsel, instructed by Messrs Field Fisher Waterhouse, Solicitors to the Council, appeared to present the facts.

MR A JENKINS, Counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

PROCEEDINGS

Transcript of the shorthand notes of T A Reed & Co,
13 The Lynch, Hoddesdon, Hertfordshire, EN11 3EU
Telephone No: 01992 465900

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

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

(Introductions made)

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

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

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

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

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

THE CHAIRMAN: Sorry? They referred to the PCC?

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

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

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

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

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

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

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

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

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

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

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

THE CHAIRMAN: Is there a page number?

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

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

He comments:

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

In his conclusion is:

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

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

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

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

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

THE CHAIRMAN: Can we have a page, please?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

She recorded as her overall condition deteriorated.

> "Medication keeping her comfortable."

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

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

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

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

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

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

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

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

He said:

E

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

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

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

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

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

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

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

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

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

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

At paragraph 39, she says similarly:

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

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

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

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

THE CHAIRMAN: Is this page 72?

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

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

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

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

– apparently underlined –

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

and he gives the amounts –

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

H

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

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

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

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

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

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

I am looking at paragraph 5.12. He says:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MISS DOIG: It is surely Dr Mundy?

MS HORLICK: Dr Mundy, yes.

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

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

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

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

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

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

THE CHAIRMAN: Do you have any recommendations?

MS HORLICK: No, madam.

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

MS HORLICK: Yes.

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

MS HORLICK: That is right, yes.

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

MS HORLICK: Yes, it did.

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

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

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

MS HORLICK: No, madam.

THE CHAIRMAN: It came from the President?

MS HORLICK: That is right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR JENKINS: Indeed.

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

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

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

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

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

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

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

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

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

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

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

MS HORLICK: Madam, no.

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

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

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

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

PARTIES HAVING BEEN READMITTED

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

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

DETERMINATION

THE CHAIRMAN:

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

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

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

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

DR BARTON

NOTES FOR CONSULTATION
Wednesday, 26 May 2004

The principles are, of course, the same as already discussed in relation to VV – hence the linkage of the two cases in this con.

The application of the principles is different.

Caveat: I have only a very brief outline of the facts.

In summary, the Barton case is much more difficult, dangerous and deanding for both police and GMC:

- **Strong and obvious similarities to Shipman:** GP, elderly patients, premature, precipitate and excessive recourse to opiates when no clinical need (no pain) and preliminary drugs/treatments not tried first, poor records, 5 patients before IOC but 57 others during 1990s under police investigation.
- So has capacity to be **daughter of Shipman**: if B were to be found wrongly to have prescribed opiates to "ease the passing" of elderly patients much *after* the Baker report, this case has the potential to explode in police/GMC faces: **alarm bells** should be sounding loud and clear for police and GMC and Toni Smerdon was absolutely right to send severe letter on 5/4/04.

  At the very least, there's the risk of very adverse publicity that strong suspicions exist (strong enough to send to PCC 21 months ago) and GMC is doing nothing (even if it turns out no patients are at risk).

Also more troublesome than VV because:

- In VV, CPS decision is close (c. 1 month).
  In B, it does not seem close at all (police investigation seems to be drifting very slowly – don't know when second team will form a view and B not yet interviewed) and the police cannot even give a timetable. Police delay/behaviour is worse in B than in VV.
- In VV, an IOC i/order is in place so the public is protected.
  B is free to practise, and is practising freely, as a GP (not at GWMH) because the IOC has thrice refused to make an i/order and the voluntary undetaking given by B to the HA not to prescribe opiates lapsed sometime before 9/02. She has access to elderly patients and, for all anyone knows, could be "doing a Shipman" as we speak.

Impossible to advise on JR/unreasonableness because depends on details of the complexity of investigation: what have police been doing, what are extenuating circs?

But my <u>hunch</u> is that GMC has a rather better chance of a successful JR (on basis that police behaviour unreasonable) than in VV ... although still unlikely to succeed and various non-legal reasons why JR is accompanied by unwanted side-effects. In B, allegations known since at least 7/00 and very little progress apparent; not clear at all what happened between 9/02 and 9/03; not clear what has happened since preliminary report of team.

Whether or not it JRs, GMC should:

- **<u>Get on with its own investigation asap</u>**
  I have seen no request/demand from police for GMC to halt its investigation.
  Yet that is what has happened.
  GMC is behaving like a rabbit that has seen police headlights coming towards it on same road and frozen.
  Good reason for this at the start, because police can do legwork for GMC.

But, as a genral principle in all cases, there must come a time when GMC says "enough is enough": past that here!

There is no statutory or PI bar on GMC's investigation, even though holding the PCC hearing itself would be a much bigger step - but we are a long way from that.

Meanwhile, GMC should *use the time* and pursue its own investigation in the normal way.

Currently, there is a *false impasse*: GMC seems to think it needs the police's permission to investigate (see last para of GMC's 4/5/04 letter).

- **Press police for action and explanations** (of any information that can be given about the investigation to focus GMC's own task, of progress of police investigation, what *precisely* is the vice that police fear if they disclose, what's going to happen and roughly when). *At very least a rough timetable for future investigation is needed.*

  The police letter dated 6/10/03 suggests that the risk caused by disclosure to B will not arise after he is interviewed.

  True?

  When will that be?

- **Explain to police** why disclosure to GMC for use before a committee must lead to at least likelihood of disclosure to B (because GMC procedures, where decisions affecting doctors are made (unlike internal investigations), are open and bilateral).

- **Get hold of a copy of Profesor Baker's report** (through CMO?).

GMC should not:

- Put B's case back to IOC.

  It has refused to make an i/order thrice (the third time because there was no new evidence[1]) and in 10/03 a screener refused to refer the case a fourth time because there was no new evidence.

[1] Although I think the lapse of the "voluntary condition" was quite an important new circumstance.

So there's no point in reverting to IOC unless/until police/GMC investigation reveals new information.

Documents

Apparently there were meetings on 20 Nov 2002 and 27 Feb 2004.
Any minutes available?

Notes

No complaint. Information case.

NB: potential conflict

I have serious concerns about the propriety of being instructed by *both* police and GMC.
They have divergent interests on the same issue.
Of course, their overall interests are convergent (bringing B to book in the PI).
But that can e said about a lot of JR litigation.
Their interests are in different spheres (c/p and d/p) and these may well diverge in relation to *how* and *when* to bring B to book.
E.g I am asked whether the police have acted reasonably and what steps GMC should take to persuade/entice/force police to do what they are currently unwilling to do.
If I advise that the police have behaved unreasonably, that means they are exposed to JR and I should have to advise GMC that it could sue them and how best to do it.
That's a clear conflict: might be deterred from giving frank and fearless advice to one side because the other will hear of it and it might be prejudicial to them: both "sides" in same (potential) dispite.
I have dealt with that issue today because asked v.urgently and no-one has had time to think properly about it.
But, subject to comments from others (because this is a provisional view formed in haste and on instinct), I am unhappy about advising both "sides" in the future.