Gosport Independent Panel

Summary of GMC privileged documents to be disclosed to Panel

Pages	Document	Date	Summary	Waive LPP?
1-6	Covering letter and instructions to Robert Englehart QC to advise on re-referral of Dr Barton to IOC	05/12/2003	History of Dr Barton case given beginning in July 2000. IOC made no order in June 2011, 21 March 2002 and 19 Sep 2002 (after PPC referral to PCC). Police re-opened investigation and provided summary info on 30 Sep 2003 to us. Offered copies of evidence but wanted assurance would not be disclosed to Dr Barton as she had yet to be interviewed, to which we could not agree. Screener decided on 6 Nov 2003 not to refer back to IOC as no new evidence to rely on. Counsel asked to confirm should not refer back to IOC	Yes
7-12	Advice from Robert Englehart QC on referring Dr Barton back to IOC	10/12/2003	Nothing by way of fresh evidence that would justify case being referred back to IOC. If circumstances change, then referral may become appropriate. At 19 Sep 2002 IOC hearing, Legal Assessor advised that no new information so order should not be imposed. Police themselves did not think that at time, Dr Barton posed a risk to public. If new evidence, position should be reviewed	Yes
13-32	Case summary and comments report from Eversheds	14/02/2007	Summary of each patient case being investigated – chronology of care and evidence obtained. Then legal advice on merits of each patient case and whether suitable to procced to FTP Panel. Overall sufficient evidence to refer this case to Case Examiner. The role of other named practitioners will need to be considered	Yes
33-66	Eversheds Rapid Resolution Report	27/02/2007	Case summary, detailed chronology. Reference to police investigations, patient cases, evidence obtained, IOC hearings, detailed analysis and advice on merits of each patient case (similar to previous document), case strategy	Yes
67	FFW monthly case report	May 2007	Case summary, investigations carried out, recommendations, prospects of success	Yes
68-69	FFW monthly case report	June 2007	Case summary, investigations carried out, recommendations, prospects of success	Yes

70-71	FFW monthly case report	July 20007	Case summary, investigations carried out, recommendations, prospects of success	Yes
72-73	FFW monthly case report	Aug 2007	Case summary, investigations carried out, recommendations, prospects of success	Yes
74-87	Code A			
88-93				
94-111				
112-123				

	outstanding evidence		explanation of Dr Barton's role. Advice to solicitors on further documents to obtain and better quality copies of some documents needed.	
124-125	FFW monthly case report	Oct 2007	Case summary, investigations carried out, recommendations, prospects of success	Yes
126-127	FFW monthly case report	Dec 2007	Case summary, investigations carried out, recommendations, prospects of success	Yes
128-129	FFW monthly case report	Sep 2007	Case summary, investigations carried out, recommendations, prospects of success	Yes
130-135	Code A			
136-137				
138-139	FFW monthly case report	Jan 2008	Case summary, investigations carried out, recommendations, prospects of success	Yes
140-141	FFW monthly case report	Feb 2008	Case summary, investigations carried out, recommendations, prospects of success	Yes
142	FFW monthly case report	Apr 2008	Case summary, investigations carried out, recommendations, prospects of success	Yes
143-150	Code A			
151-152	Instructions to GMC Legal from IO for new IOC hearing on Dr Barton	Undated	Instructions and sanction to seek against Dr Barton at new IOC hearing on 11/07/2008	Yes
153	FFW monthly case report	May 2008	Case summary, investigations carried out, recommendations, prospects of success	Yes
154	FFW monthly case report	Aug 2008	Case summary, investigations carried out, recommendations, prospects of success	Yes
155	FFW monthly case report	Oct 2008	Case summary, investigations carried out, recommendations,	Yes

			prospects of success	
156	FFW monthly case report	Dec 2008	Case summary, investigations carried out, recommendations, prospects of success	Yes
157	FFW monthly case report	Jan 2009	Case summary, investigations carried out, recommendations, prospects of success	Yes
158-160	Draft letter from FFW for GMC to use	Undated	Explains police investigations, progress of GMC investigation and hearing date 8 June-21 Aug 2009	Yes
161	Instructions to GMC Legal from IO for review IOC hearing on Dr Barton	Undated	Instructions and sanction to seek against Dr Barton at review IOC hearing on 03/11/2009	Yes
162-190	Code A			
191-195	FFW meeting note	20/11/2002	Meeting with Hampshire Police, GMC and FFW – not really privileged	Yes
196-198	FFW note of meeting with GMC	03/10/2002	Meeting between GMC and FFW. Discussed timescale for investigation, Dr Barton's case before IOC, allegations from 1991 and that Dr Reid and nurses involved could be subject to regulatory proceedings themselves.	Yes
199-200	Letter of advice FFW to GMC	09/10/2002	Advice that nothing within recent material that would justify referral back to IOC.	Yes
201-609	FFW bundle of transcripts from FTP Panel hearing into Dr Barton	09/06/2009-30/06/2009	Transcripts from selected days of hearing where other doctors gave evidence – presumably provided to Tom Kark to allow him to provide advices in relation to other doctors – not really privileged	Yes
610	Covering letter FFW to GMC	16/07/2010	Providing copies of counsel's advices regarding Drs Lord, Tandy and Reid and transcripts referred to when drafting advices	Yes
611-627	Code A			

			succeed as would need to rely on evidence of Dr Lord who gave evidence following previous GMC decision not to prosecute her.	
628-639	Code A			
640-665				
666-668	Internal GMC memo Michael Hudspith to Venessa Carrol and Michael Keegan	03/10/2002	Summary of Barton related cases x 5 relating to treatment of patients that did not feature in recent PPC papers. Not privileged	Yes
669	Fax cover sheet GMC Legal to Mark Shaw QC	21/01/2005	Mentions some items of correspondence with police from May 2004 onwards	Yes
670-674	Covering letter and instructions to Mark Shaw QC to draft letter to Hampshire Police	20/01/2005	Letter to request disclosure from police for patient case of Elsie Devine	Yes
675	Handwritten note of conference with counsel	14/06/2004	Refers to contacting CMO's office, IOC bundle and s35A request for medical records from police.	Yes
677-680	Email Mark Shaw QC to Peter Steel attaching handwritten notes from conference	26/05/2004	Refers to referral to IOC, proceeding with investigation, timetable from police, disclosure from police and to doctor	Yes
681-684	Notes for consultation on 26 May 2004 by Mark Shaw QC	26/05/2004	Refers to GMC needing to progress with its own investigation, obtaining disclosure from police and why this means disclosure to doctor. Refers to potential conflict of interest as advised police and GMC and asked to consider whether GMC can challenge police decision.	Yes
685-686	Instructions to Mark Shaw QC to advise on Baker repot	08/06/2004	Asked to consider report and advise on merits of JR of police failure to disclose information.	Yes
687	Email from Mark Shaw QC to Peter Swain	26/05/2004		Yes

	attaching notes of consultation on 26 May 2004			
688-690	FFW Note of meeting with GMC	03/10/2002	Different format to earlier version. Meeting between GMC and FFW. Discussed timescale for investigation, Dr Barton's case before IOC, allegations from 1991 and that Dr Reid and nurses involved could be subject to regulatory proceedings themselves.	Yes
691-692	Letter FFW to GMC	17/12/2002	Provides a copy of meeting note from 03/10/2002, police have asked for GMC investigation to be stayed, documents requested from CHI.	Yes
693-694	Letter FFW to GMC	09/01/2003	Any investigation at moment might prejudice police investigation. Advice that GMC documents should be disclosed to police under s35B MA.	Yes
695	Emails between FFW and GMC	15/01/2003	Police should make formal request for disclosure.	Yes
696-698	FFW note of meeting with GMC	05/02/2003	FFW had considered CHI documents and witnesses interviewed. Would write formal letter to police asking them to send formal request for disclosure.	Yes
699-710	Advice from Mark Shaw QC	25/05/2005	Following conferences on 26 May and 14 June 2004. Regarding GMC making a s35A request to Hampshire Police to obtain material to allow its investigations to start. Raises queries to be raised with police	Yes
711-715	Chronology from Mark Shaw QC	25/05/2005		Yes
716	Email from Mark Shaw QC to Toni Smerdon	08/06/2005	Attaching copy of advice from 25 May 2005	Yes
717	Fax GMC Legal to Mark Shaw QC	25/05/2005		Yes
718-719	Internal GMC memo Paul Hylton to Paul Phillip	17/09/2004	Refers to disclosure of documents from police relating to 19 patients. For 14, it could be argued that Dr Barton's treatment could amount to SPM. Bundle to be prepared for referral to IOC. Not privileged	Yes
720-722	Internal GMC memo Toni Smerdon to Linda Quinn	09/10/2003	No new evidence since previous IOC decisions to justify referring back to IOC.	Yes
723	FFW case report	Nov/Dec 2002	Case summary, investigations carried out, recommendations, prospects of success	Yes
724	GMC note of meeting with FFW	03/10/2002	Refers to action points from meeting with FFW.	Yes
725	FFW case report	Sep 2002	Case summary, investigations carried out, recommendations, prospects of success	

726	Letter GMC to FFW	18/12/2002	Instructions that GMC can agree to say investigation pending outcome of police investigation. Agrees to FFW visiting CHI offices.	Yes
727	GMC memo Venessa Carrol to Fiona Horlick (counsel)	16/09/2002	Attaches Instructions for IOC hearing for Dr Barton on 19/09/2002	Yes
728	Instructions to GMC Legal from IO for IOC hearing for Dr Barton	undated	For IOC hearing on 19/09/2002. Refers to latest information and sanction.	Yes
729-730	Note FFW to Mark Shaw QC requesting advice on police disclosure	25/05/2004	Provides IOC decision from 2002 and correspondence with police and asks whether police stance on non-disclosure is reasonable	Yes
731-734	Instructions to counsel FFW to Leading counsel	03/02/2010	Requests advice on position GMC should adopt if CHRE decides to refer FTP Panel determinations in Dr Barton's case to High Court	Yes
735-764	Eversheds Case Analysis and Case Strategy	27/04/2007	Refers to evidence gathered in relation to each patient case and gives initial view on merits of each. Recommends pursuing a sample of cases.	Yes
765-766	Suggested draft charges re: Mrs Lavender	26/03/2007	From Eversheds	Yes
767-768	Suggested draft charges re: Code A	22/03/2007	From Eversheds	Yes
769-770	Suggested draft charges re: Mrs Spurgin	22/03/2007	From Eversheds	Yes
771-772	Suggested draft charges re: Mr Packman	27/03/2007	From Eversheds	Yes
773	FFW monthly case report	Oct 2007	Case summary, investigations carried out, recommendations, prospects of success . With handwritten comment at bottom	Yes
774-794	Code A			
795-796	Action points from conference	Undated	Refers to patient cases that we will proceed with and those we will not.	Yes
797-801	Code A			

802-809	Schedule of complaints		Refers to each patient case, strength of complaint, PPC outcome and Eversheds comments and analysis	Yes
810-830	FFW Attendance Note of conference with Code A GMC and Professor David Black (expert)	30/10/2007	As above, but with annotations	Yes
831-848	Code A	17/01/2008	Highlighted. As above	Yes
849-850	Draft letter from FFW	Undated	As above, but different format	Yes
851-895	Copy of GMC Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 198		Annotated. Not privileged	Yes
896	Patient Schedule	undated	For use at hearing? Identification key for patients.	Yes
897-899	Letter FFW to process server enclosing witness summonses for service	04/06/2009	Not privileged	Yes
900-901	Letter FFW to Legal Assessor for Dr Barton FTP Panel hearing	03/06/2009	Key documents for hearing enclosed. Not privileged	Yes
902-903	Emails and notes about calls between FFW and John White at Blake Lapthorn	16/06/2009	re evidence of Mrs Gillian McKenzie. Not privileged	Yes
904	Letter Blake Lapthorn to FFW	02/06/2009	BL act for Gillian McKenzie. Refers to GM's position about giving evidence. Not privileged	Yes
905-906	Letter FFW to Blake Lapthorn	01/06/2009	About Mrs McKenzie not giving evidence. Not privileged	Yes
907	Letter Blake Lapthorn to FFW	29/05/2009	About Mrs McKenzie not giving evidence. Not privileged	Yes
908	Letter Blake Lapthorn to FFW	22/05/2009	About Mrs McKenzie's evidence. Not privileged	Yes
909	FFW note of voicemail message from Gillian McKenzie	21/05/2009	Not privileged	Yes
910-911	Covering email and read receipt FFW to Blake Lapthorn	21/05/2009	Not privileged	Yes
912-914	Draft letter FFW to Blake Lapthorn sent to GMC	21/05/2009		Yes
915-918	Attendance notes of calls between FFW and John Whilte at Blake Lapthorn	07/05/2009-15/05/2009	Re: proceeding with Gladys Richards case at hearing. Not privileged	Yes

919-920	Letter FFW to Gillian McKenzie	01/05/2009	Re: giving evidence at hearing. Not privileged	Yes
921-922	Letter FFW to Blake Lapthorn	30/04/2009	Re: Gillian McKenzie giving evidence at hearing. Not privileged	Yes
923-924	Letter FFW to Blake Lapthorn	30/04/2009	Re: 10 other families which BL also act for. No provisions for witnesses, families or other interested persons to be represented at hearing. Not privileged	Yes
925	Biog details for John White at Blake Lapthorn	07/05/2009	Not privileged	Yes
926	Attendance note of call FFW and John White at Blake Lapthorn	24/04/2009	Re: Gillian McKenzie and other families. Not privileged	Yes
927	Letter Eversheds to Hampshire Police	20/12/2006	Requesting disclosure. Not privileged	Yes
928-929	Index to GMC bundle of papers	Undated	Not privileged	Yes
930	Note of GMC phone call from Gillian McKenzie	02/06/2009	RE Gladys Richards case featuring at hearing. Not privileged	Yes
931-932	Letter Coroner for Portsmouth and SE Hampshire to FFW	28/04/2008	Inquests to be opened in very near future Not privileged	Yes
933	S35A request to Dept of Health for Baker report	27/02/2008	Not privileged	Yes
934	Letter Dept of Health to GMC	11/02/2008	Can supply Baker report provided s35A request is made. Not privileged	Yes
935	Letter June Bailey (daughter of Jean Stevens) to Mr Hinton	19/08/2005	Unhappy at mother's death being accidental. Possibly letter to Coroner's officer or police. Not privileged	Yes
936-937	Letter Hampshire Police to Mr Ernest Stevens	21/07/2005	Re: death of Jean Stevens. Not privileged	Yes
938	Code A	20/04/2010	Not privileged	Yes
939-945	CHRE notes of s29 meeting on 23 and 29 March 2010	31/03/2010	Reviews outcome of Dr Barton FTPP hearing. S29 test not met. Not privileged	Yes
946-947	CHRE statement on outcome in Dr Barton hearing	31/03/2010	Not privileged	Yes
948	GMC statement following CHRE decision	undated	Not privileged	Yes
949-950	Letter Gillian McKenzie to GMC following CHRE decision and GMC statement	15/04/210	Complains about hearing outcome. Not privileged	Yes
951-961	Expert report of Dr David Black regarding	09/07/2008	Not privileged	Yes

	case of Elsie Devine			
962-964	GWMH pre-inquest hearing report	19/01/2009	Not privileged	Yes
965-975	FTPP determination on serious professional misconduct and sanction	29/01/2010	Not privileged	Yes
976-977	Emails between Prof Gary Ford and FFW	17/12/2009 04/02/20010	Re: release of Prof Ford's expert reports to families	Yes
978	Letter Code A to GMC re Prof Ford's reports	10/01/2010	Not privileged	Yes
979-982	Emails between Code A and GMC and FFW	08/12/2009 12/01/2010	Not privileged	Yes
983	FFW monthly case report	June 2009	Case summary, investigations carried out, recommendations, prospects of success	Yes
984-1052	Code A			
1053-1070				
1071-1140				
1141	Expert review of Edna Purnell case	undated	Not privileged	Yes
1142	Letter Hampshire Police to Mr Wilson	18/09/2002	First page only. Undated. Not privileged	Yes
1143-1146	Emails between Eversheds and GMC regarding Jean Stevens case	05/03/2009 12/03/2009	Refers to police re-categorising case of Jean Stevens.	Yes
1147-1148	Letter Hampshire Police to Mr Stevens	21/07/2005	Re: Jean Stevens case. Not privileged	Yes
1149-1160	Note regarding Dr Barton case by Eversheds	23/02/2007	Refers to background, three police investigations, IOC referral, Eversheds work on case and category 3 patient cases.	Yes
1161-1162	Note of tel call from GMC to Eversheds	14/02/2007	Re: contact with Ernest Stevens	Yes
1163	Email Eversheds to GMC	14/02/2009	Re: contact with Ernest Stevens	Yes
1164	Note of tel call from Eversheds to GMC	26/01/2007	Refers to Eversheds reading of police material and their approach to investigation.	Yes
1165	Email Eversheds to GMC	22/12/2006	Refers to category 3 patient cases and criticisms made. Discloure requested from police which amounts to 45 files.	

1166	Internal Eversheds email	21/12/2006	Re: evidence that can be admitted at IOP hearing	Yes
1167-1168	Email Eversheds to GMC attaching draft letter to be sent to Hampshire Police	20/12/2006	Request for disclosure from police	Yes
1169-1170	Annotated drafts of above email and letter	undated		Yes
1171	Note of tel call from GMC to Eversheds	06/11/2006	Refers to police decision on whether prosecuting and letter to police asking for update.	Yes
1172-1176	Advice letter Eversheds to GMC	12/11/2004	Discusses police disclosure and lack of response to letter from May 2004. Need to resurrect 5 cases referred to PCC. Police might decide to JR challenge GMC decision to proceed with five cases. S35A request to police referred to.	Yes
1177-1184	Eversheds annotated notes of file review	05/11/2004		Yes
1185-1214	Eversheds Case analysis and Case Strategy	27/04/2007	As above. Annotated	Yes
1215-1226	Agenda for FTPP hearing for Dr Barton	08/06/2009	Annotated. Not privileged	Yes
1227-1295	Code A	04/06/2009	Not annotated	Yes
1296-1306	Annotated spreadsheet of patient cases	undated		Yes
1307-1308	FFW monthly case report	June 2007	Case summary, investigations carried out, recommendations, prospects of success . Annotated	Yes
1309	FFW monthly case report	Nov 2007	Case summary, investigations carried out, recommendations, prospects of success . Annotated	Yes
1310	FFW monthly case report	Sep 2007	Case summary, investigations carried out, recommendations, prospects of success . Annotated	Yes
1311	FFW monthly case report	Sep 2007	Case summary, investigations carried out, recommendations, prospects of success . Annotated	Yes
1312-1320	Annotated witness schedule for FTPP hearing	undated		Yes
1321	FFW monthly case report	Jul 2008	Case summary, investigations carried out, recommendations, prospects of success . Annotated	
1322	FFW monthly case report	Jun 2008	Case summary, investigations carried out, recommendations,	Yes

			prospects of success . Not annotated	
1323-1330	Letter of instruction FFW to Prof Gary Ford	12/12/2008	Not strictly privileged, but would not usually be disclosed unless expert reports do not contain summary of instructions. Suggest disclose	Yes
1331-1356	Drafts of letter of instruction FFW to Prof David Black	18/02/2008	Re: various patients	Yes
1357-1549	Eversheds notes of documents review	12/03/2007	Summarises contents of evidence which is not privileged	Yes
1550-1569	Eversheds case summaries and comments	14/02/2007	Annotated	Yes
1570-1571	Instructions to GMC Legal for IOC hearing	Undated	For IOC hearing on 07/10/2004	Yes
1572-1580	FFW case reports	Sep 2002 – Sep 2003	Case summary, investigations carried out, recommendations, prospects of success	Yes
1581	Email Robert Englehart QC to Toni Smerdon	10/12/2003	Attaches advice dated 10/12/2003 (above)	Yes
1582	Notes from meeting Pharmaceutical Adviser for Fareham and Gosport PCT and Dr Barton on 03/11/2004	04/11/2004	Not privileged	Yes
1583	Notes of meetings Pharmaceutical Adviser for Fareham and Gosport PCT with Dr Barton	05/09/2003	Not privileged	Yes
1584	Letter Toni Smerdon at GMC to Mark Shaw QC	11/05/2005	Further to instructions to draft disclosure request letter to Hampshire Police	Yes
1585-1589	Letter Hampshire Police to GMC	28/04/2005	Response to request for disclosure. Not privileged	Yes
1590	Email Hampshire Police to GMC	28/04/2005	Not privileged	Yes
1591-1593	Letter GMC to Hampshire Police	25/01/2005	Request for disclosure. Not privileged	Yes
1594-1596	GMC template for s35A request and s35A MA	undated	Not privileged	Yes
1597	Letter GMC to Hampshire Police	06/12/2004	Suggesting meeting after PCC hearing on hold at request of police. Not privileged	Yes
1598-1600	Email Toni Smerdon of GMC to Roger Henderson QC re IOC conditions	06/12/2004	Provides draft IOC conditions	Yes
1601-1620	Email Mark Shaw QC to Toni Smerdon of	25/05/2005	Regarding GMC making a s35A request to Hampshire Police to obtain	Yes

	GMC attaching:- - Chronology - Summary of Baker report - Advice		material to allow its investigations to start	
1621-1625	Email Mark Shaw QC to Toni Smerdon of GMC attaching draft letter to Hampshire Police	21/01/2005	Draft letter requests limited disclosure	Yes
1626-1630	Email Roger Henderson QC to Toni Smerdon at GMC with Chronology attached	05/10/2004	Email requests various documents and raises queries prior to advice regarding referral to IOC	Yes
1631-1637	Covering letter and instructions to counsel GMC to Roger Henderson QC	01/10/2004	To represent GMC at IOC hearing for Dr Barton on 07/10/2004	Yes
1638-1656	Email Mark Shaw QC to GMC attaching:- - Draft letter to Hampshire Police - Notes for consultation on 14/06/2004 - Chronology - Summary of Baker Report	14/06/2004	Draft letter querying with police why disclosure will not be provided	Yes
1657	Email Mark Shaw QC to GMC attaching further copy of advice, chronology and summary of Baker report	08/06/2005	No changes since versions circulated on 25/05/2005	Yes
1658	Last page of advice FFW to GMC	26/11/2002	Relating to test for Medical Screener to apply	Yes
1659-1660	Emails between Code A and FFW regarding progress of hearing	08/07/2009	Comments on Prof Ford's oral evidence	Yes
1661	Internal GMC emails regarding medical records	07/10/2004	Not privileged	Yes
1662	Bundle cover sheet for IOC hearing	07/10/2004	Not privileged	Yes
1663-1665	Internal FFW emails regarding disclosure to Coroner	11/08/2004	Discusses disclosure of list of family names and contact details to Coroner under s35B(2) MA	Yes
1666-1733	Code A schedule of review of witness statements	undated	Summarises relevant points of each witness statement for Dr Barton FTPP hearing, counsel's queries regarding evidence and further queries	Yes

Our Ref: TS/Advice/Barton

5 December 2003

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

The Clerk to Mr R Englehart QC
Blackstone Chambers
Blackstone House
Temple
London
EC4Y 9BW

Dear Sir

Further to our telephone call to chambers on 5 December 2003, we now enclose the papers in the case of Dr Jane Barton for Mr Englehart QC's attention.

Once Counsel has had an opportunity of considering the papers perhaps he would be kind enough to telephone Miss Toni Smerdon of Instructing Solicitors on the number set out below with his preliminary view on 8 December 2003 and thereafter provide written advice no later than 11 December 2003.

Yours faithfully

Code A

Toni Smerdon
Principal Legal Advisor

Code A

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In the matter of Dr J Barton

INSTRUCTIONS TO COUNSEL TO ADVISE

To: Robert Englehart QC
Blackstone Chambers
Blackstone House
Temple
London EC4Y 9BW

From: Fitness to Practise
General Medical Council
178 Great Portland Street
London W1W 5JE

Tel: 020 7915 7427
Fax: 020 7915 3634
Email: **Code A**

Ref: TS/Advice/Barton

Enclosures

1. Bundle of papers before the Interim Orders Committee on 19 September 2002.
2. Transcript of the hearing before the Interim Orders Committee on 19 September 2002.
3. Relevant, recent internal memoranda.
4. Telephone note re: Report of Professor Baker.
5. S41A Medical Act 1983 (as amended)
6. Interim Orders Committee (Procedure) Rules 2000

Instructions

1. Instructing Solicitors act on behalf of Paul Philip, Director of Fitness to Practise, General Medical Council in relation to advice sought **urgently** in respect of the Council's decision not to refer at this time Dr Jane Barton to the Interim Orders Committee ('IOC').

2. The history of the case is as follows. The case against Dr Barton began in July 2000 as a police investigation into the circumstances surrounding the death of Gladys Richards, a geriatric patient at Gosport War Memorial Hospital ('GWMH'), and was subsequently extended to four other deaths, Arthur "Brian" Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

3. The IOC first considered Dr Barton's case in June 2001. At that time the police investigation was at early stage and only Gladys Richards' death was being investigated. The information before the Committee was limited and in the circumstances no order was made.

4. By February 2002 the police/CPS had decided against a criminal prosecution and their papers were disclosed to the GMC to decide on issues of potential spm/sdp. The case was screened in February 2002 and referred to the Preliminary Proceedings Committee. The Screener also referred the case back to the IOC.

5. The IOC considered the case for the second time on 21 March 2002 and again made no order.

6. On 28 May 2002 Mrs MacKenzie (daughter of the late Gladys Richards) wrote to the General Medical Council. She copied the letter to David Blunkett MP, the police, Nigel Waterson MP, Peter Viggers MP, the Police Complaints Authority, the CPS and David Parry of Treasury Counsel, concerned about the failures of a police investigation. It was because of this that the police investigation was re-opened.

7. A Rule 6 letter was sent to Dr Barton on 11 July 2002 notifying her that her case would be considered by the Preliminary Proceedings Committee on 29/30 August 2002.

8. In July 2002, CHI 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.

9. On 30 July 2002 Mrs MacKenzie informed the General Medical Council that the police were seeking advice from the CPS about the investigation and as a result were re-considering the five cases.

10. At its meeting on 29 August 2002 the PPC referred the case for inquiry by the Professional Conduct Committee and again referred the case to the IOC. A hearing took place on 19 September 2002 and again no order was made.

11. Counsel has at Tab 1 all the papers which were considered by the IOC at the hearing on 19 September 2002. It includes the papers seen by the IOC previously in June 2001 and March 2002, as well as September 2002. Counsel also has a copy of the IOC transcript for the hearing in September 2002.

12. On 30 September 2003, Linda Quinn, a Senior Caseworker in the Case Conduct Presentation Section, attended a meeting with the police. A copy of the minutes of that meeting are in Tab 3. Ms Quinn spoke to the Director of Fitness to Practise, Paul Philip and Instructing Solicitor was asked to advise whether or not Dr Barton should be referred again to the IOC on the basis of the meeting held with the police. A copy of the memorandum of advice is also in Tab 3. Counsel will note in paragraph 9 on page 2 of the memorandum that following the IOC hearing in September 2002, Hampshire and Isle of Wight NHS Health Authority sent to the GMC a file of correspondence relating to the concerns which had been raised by nursing staff in the use of diamorphine on patients in 1991. The information was considered by Matthew Lohn, Partner at Field Fisher Waterhouse, who provided his written advice which is set out in paragraph 11 of the memorandum.

13. The police re-opened their investigation and in the circumstances a referral to the Professional Conduct Committee has been placed on hold in relation to the deaths of the five patients under Dr Barton's care and the GWMH.

14. A team of 5 medical experts was appointed by the police—experts in the fields of toxicology, geriatric medicine, palliative care, general practice and nursing. The experts reported on the basis of whether the treatment provided to each of the 62 patients was optimal, sub-optimal or negligent; and whether the reasons for the death/harm was natural causes, unclear or unexplained by natural cause/disease.

15. Details of the outcome of the report are set out in the minutes of the meeting with the police on 30 September 2003. The police confirmed that they were to run a quality control check on the findings and then appoint further experts to examine in detail the 15 or 16 cases which fall into the category of negligent, cause of death unclear. The police also confirmed that they were not proposing to interview Dr Barton until the second team of experts had reported, anticipated to be January 2004 at the earliest.

16. Counsel will note that the police asked whether the case could be reconsidered by the IOC on the basis of the information they had supplied. As they were aware that any papers seen by the IOC would also be disclosed to Dr Barton and her solicitors they were unable to provide full details of their investigations as it could jeopardise any further investigation and their eventual interview with Dr Barton.

17. The view taken in relation to a further referral was that there was no "new evidence" which could at this time justify referral to the IOC. The IOC may only make an order in accordance with Section 41A of the Medical Act 1983 (as amended) to protect patients, public interest or a doctor's interest. To make an order the Committee must have before it cogent and credible prima facie evidence. To support a referral back to the IOC the police would need to

provide not only a summary of their investigation to date but also some of the evidence upon which they intend to rely.

18. The advice given was that it would be appropriate however for the matter to be considered again by a Screener who should note that all the information on file has previously been seen by the IOC on at least two occasions, save the new information from the police which is not supported by evidence and then decide, taking into account the IOC criteria, whether a further referral should be made at this stage.

19. It would of course always be open to the Screener to reconsider the matter again once any evidence has been produced by the police. It was further noted it was important to keep the case under a close review and that regular updates should be sought from the police since the decision whether or not the position with regard to a referral to the IOC had changed was dependant on the information received.

20. The Screener considered all the information and the advice on 6 November 2003. A note of the Screener's decision is at Tab 3.

21. Counsel will note at Tab 4 reference to an investigation. Professor Richard Baker's report has been issued to the Chief Medical Officer and the Department of Health, as well as Hampshire Constabulary and the Strategic Health Authority. The GMC has not been sent a copy of the report and it would appear from the telephone note at Tab 4 that the report will not be disclosed.

22. Counsel is requested to consider all the papers and to confirm that in the light of the history of the case and the current position regarding lack of new information that it would not be appropriate for the case to be referred again to the IOC and that the position as set out in the Screener's memorandum of 6 November 2003 still remains.

23. Counsel will find at Tab 5 a copy of Section 41A of the Medical Act 1983 (as amended) and at Tab 6 a copy of the Interim Orders Committee (Procedure) Rules Order of Council 2000.

24. Once Counsel has had an opportunity of considering the papers perhaps he would be kind enough to telephone to discuss his preliminary views with Ms Toni Smerdon on 020 7915 7427 or by email tsmerdon@gmc-uk.org and thereafter to provide an advice in writing by Thursday 11 December 2003. If Counsel could discuss matters with Ms Smerdon on Monday 8 December that would be most helpful.

25. Counsel should also note that any advice given in writing may be placed before Dame Janet Smith who is currently conducting the Shipman Inquiry.

Signed... **Code A** .... Dated......5\12\03......................

IN THE MATTER OF DR. J BARTON

ADVICE

INTRODUCTION

1. I am asked to advise the General Medical Council ("GMC") whether or not I consider that the case of Dr. Barton should now be referred, again, to the Interim Orders Committee ("IOC"). I do not consider that there is - at least as yet - anything by way of fresh evidence available to the GMC which would justify the case being referred back. Nevertheless, circumstances may change in the future. If they do, then it is of course possible that a referral to the IOC may become appropriate. I will now set out my reasons for holding this opinion.

THE FACTUAL BACKGROUND

2. Dr. Barton, a General Practitioner, used to hold a part time post as clinical assistant in elderly medicine at the Gosport War Memorial Hospital in Hampshire. There is presently pending against her a charge of serious professional misconduct arising out of the deaths of 5 elderly patients at the hospital. In short, it is alleged that Dr. Barton was guilty of mis-prescribing opiates for these patients when there was no indicated clinical requirement. Her case was referred by the Preliminary Proceedings Committee to the Professional

Conduct Committee on 29 August 2002 but has been temporarily deferred pending police inquiries which are continuing.

3. The case has been considered by the Interim Orders Committee ("IOC") on no less than 3 previous occasions. The first time was in June 2001. At that time it was only in relation to the death of one of the 5 patients, Gladys Richards, that there were police inquiries on foot. The IOC did not make any order. In February 2002 the screener referred Dr. Barton's case to the Preliminary Proceedings Committee and also referred it to the IOC. The IOC again considered the case on 21 March 2002 and again made no order. The third time when the IOC considered the case was on 19 September 2002 in consequence of the Preliminary Proceedings Committee having referred it back to that Committee at the same time as referring it to the Professional Conduct Committee.

4. At the hearing on 19 September 2002 the IOC again made no order. There was no new evidence beyond what had been before the IOC on 21 March 2002. The Legal Assessor advised the IOC in these express terms:

> I advised the Committee that in the 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.

In declining to make any order, the IOC followed that advice. It is reasonable to assume that if the case is referred back again to the IOC without any new evidence similar, or even more trenchant, advice would be given with the same result.

INTERIM ORDERS

5. Until relatively recently the GMC had no power to suspend a practitioner prior to a final finding in his case. Now, however, section 41A(1) of the 1983 Act provides:

> Where the Interim Orders Committee are satisfied that it is necessary 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 -
> (a) that his registration in the register shall be suspended.....;or
> (b) that his registration shall be conditional on his compliance......

Section 41A goes on to prescribe a fairly elaborate mechanism whereby interim orders have to be reviewed from time to time by the Committee, can only be extended beyond a maximum of 18 months by the Court and are subject to review by the Court.

6. It will be evident that:
   (a) it is not for the GMC itself to decide to impose an interim order but rather it is for the IOC, a separately recognised statutory committee [section 1(3)], to decide whether or not it should do so; and
   (b) as far as 'protection of members of the public' is concerned, the test is one of *necessity* not mere desirability.

THE PRESENT SITUATION

7. Over the past year or so the police have been conducting wide ranging inquiries over the death of every patient who died at the Gosport War Memorial Hospital whilst under the care of Dr. Barton. On 30 September 2003 Linda Quinn of the GMC had a meeting with Detective Chief Superintendent Watts and Detective

Constable Niven. They told her that medical experts instructed by the police had identified 25% of the deaths as giving 'grave cause for concern' but said that they were not able to provide any details of their evidence given that the evidence would, if the case were referred back to the IOC, have to be disclosed to Dr. Barton.

8. By his letter of 6 October 2003 DCS Watts stated that if the GMC were to reassure him that material emanating from the police would not be passed on to Dr. Barton or her representatives he might be willing to provide 'at a future time' more detailed information. Obviously, the GMC could not give such an assurance, particularly if there were to be a further hearing before the IOC. Otherwise, however, DCS Watts said that more work needed to be done by the police to determine if Dr. Barton does present a risk to the public given, in particular, that she no longer works at the hospital. It would only be if the police decided that Dr. Barton presented a real risk to the public such that her case should be referred to the IOC that they would be willing to furnish evidence to the GMC. It now appears from Linda Quinn's attendance note of a telephone conversation that the police have a report from Professor Baker but are not prepared, at least at present, for it to be furnished to the GMC.

CONCLUSION

9. The criteria for the IOC are (1) *necessity* for public protection (2) public interest or (3) the practitioner's own interest. As DCS Watts pointed out in his letter of 6 October 2003, Dr. Barton no longer works at the Gosport War Memorial Hospital. As I understand it, there has never been any suggestion of criticism of Dr. Barton's work in general practice. It is difficult to see why on the basis of the present *evidence* the immediate suspension or imposition of conditions is

necessary. Indeed, it would seem from DCS Watts' letter that the police themselves do not at present think that there is such a risk to the public that they should disclose their information to the GMC. If the case simply goes back to the IOC for a fourth time with the available evidence as it now is one can only assume that the legal assessor's advice and the result would be the same as on the last occasion.

10. Whilst I do not think that on the present evidence available to the GMC there are grounds for referral back to the IOC, circumstances may change. If new evidence is provided by the police, the position should be reviewed in the light of that evidence. Also, if Dr. Barton were in fact to be charged by the police with a serious criminal offence the position would need to be reconsidered in the light of the following observations of Stanley Burnton J in *Walker v GMC* [2003] EWHC 2308 (Admin) at paragraph 40:

> While it must be right that, where there are multiple manslaughter charges against a doctor, very serious consideration must be given to an interim suspension, of course such a measure cannot be applied as a matter of course. The decision and the jurisdiction are those of the IOC and not of the Crown Prosecution Service. But, when one takes into account, as I have already stated, that such charges are not prosecuted except on substantial grounds, an IOC will, in cases where there has been no previous consideration of the relevant facts, give the greatest and most anxious consideration to an interim suspension of the doctor in question. Confidence in the medical profession will be at risk if doctors who face charges of that seriousness are free to practice during the dependency of the criminal proceedings.

10 December 2003

ROBERT ENGLEHART QC

Blackstone Chambers

IN THE MATTER OF DR. J BARTON

ADVICE

Fitness to Practise

General Medical Council

178 Great Portland Street

LONDON W1W 5JE

Ref: TS/Advice/Barton

GENERAL MEDICAL COUNCIL AND DR. BARTON

CASE SUMMARIES AND COMMENTS

1. **Pittock**

1.1 Aged 82 on admission. One of the experts - Black - believes patient was probably terminally ill on admission.

1.2 Patient was assessed by Dr. Lord on the day before his admission - assessed his prognosis as being poor. Chances of survival slim. Unlikely to survive for long.

1.3 On transfer to Dryad Ward, Dr. Tandy, Consultant Geriatrician, had overall medical responsibility. (She worked on the Ward until late 1996.) Her responsibilities included a Ward Round once a fortnight.

1.4 Dr. Tandy saw the patient on 10 January 1996, five days after he was admitted. She prescribed 5mg Oramorph to alleviate pain and distress.

1.5 Dr. Barton, in her witness statement, "believes" (emphasis added) that she reviewed the patient on 15 January 1996 and "believes" that his condition had deteriorated with significant pain and distress.

1.6 It appears that Barton prescribed Diamorphine on 15 January 1996 - it also appears that this was without reference to Dr. Tandy.

1.7 Dr. Tandy, in her witness statement, comments that she would have used a lower dosage of Diamorphine and Midazolam - her practice being to use the lowest dose to achieve the desired outcome, and to reduce adverse effects.

1.8 Nurse Hamblin, the Sister, refers to an increased dosage of Diamorphine on 18 January, six days before the patient died. **[Check to see whether the increase in dosage was authorised/sanctioned by Dr. Barton.]**

1.9 The key clinical team observed that the patient was physically and mentally frail. The team concluded that the patient was probably Opiate toxic, but notwithstanding this, the dose was not reduced. Cause of death - unclear. Opiates "could" have contributed.

1.10 Two experts have reviewed the case, Dr. Wilcock, expert in Palliative Medicine, Dr. Black, a specialist in Geriatric Medicine.

1.11 As a general observation in this and the other cases, Dr. Wilcock tends to be more bullish in his conclusions compared to Dr. Black who is more circumspect.

1.12 Wilcock refers to Barton's poor medical note keeping. In her witness statement, Barton admits to this, but seeks to explain the deficiency with reference to

substantial work place demands. Says that a choice had to be made between detailed note making or spending more time with the patients. Also seeks to explain the policy of "pro-active prescribing" with reference to the demands of work. **[This is a reference to prescribing doses of Diamorphine and other drugs within a range of doses to be administered on an "as required" basis. This needs to be fully investigated to determine whether or not nurses sought authorisation from Dr. Barton before administering medication which had been prescribed in this fashion, and/or when increasing a dose. It is also not clear why it was necessary to prescribe in this way given that Dr. Barton attended the hospital every weekday.]**

1.13 Wilcock says that the patient's pain was not appropriately assessed. We need to check how he reached this conclusion. Is it a case that there was no written assessment? Is there any evidence that a proper assessment was made, but not recorded in the notes?

1.14 Wilcock refers to the inappropriate administration of Opiates to relieve anxiety and agitation. **[Check records to identify day/days on which this occurred. Also check to make sure that at the same time the patient was not suffering pain at the same time which would justify the prescribing of Opiates. Also check whether this criticism is directed solely at Barton or whether it includes the prescription of Oramorph issued by Dr. Tandy on 10 January1996.]**

1.15 Wilcock refers to doses of Diamorphine in the range 40-120mgs as being excessive to the needs of the patient and far in excess of an appropriate starting dose. Says that an appropriate dose would be 10-15mgs. **[We need to check what dosages were actually administered as opposed to being prescribed.]**

1.16 Wilcock's overall conclusion is that Barton breached her duty of care to the patient by failing to provide treatment with skill and care, but "it is difficult to exclude completely the possibility that the dose of Diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death".

1.17 Wilcock also believes that the certified cause of death - Bronchopneumonia appears to be the most likely cause of death.

1.18 Dr. Black, in his report, refers to the patient's condition being extremely frail. The patient was at the end of a chronic period of disease spanning more than 20 years. The patient suffered from depression and drug related side effects.

1.19 Black refers to a problem in assessing the standard of care due to a lack of documentation. He agrees with Wilcock in that the lack of notes represents poor clinical practice.

1.20 Black refers to "suboptimal" drug management. **[Check to see this is directed solely at Barton or whether it also includes Dr. Tandy.]**

1.21 Black notes that the starting dose of 80mgs of Morphine was approximately three times the dose that is conventionally applied. Black also says that the combination of drugs (Diamorphine and Midazolam/Noizinan) are likely to have caused excessive sedation and may have shortened the patient's life by a short period of time - "hours to days" - "medication likely to have shortened the patient's life, but not beyond all reasonable doubt".

1.22 Other features noted include the following: the patient's own GP, Dr. Brigg, was consulted about the patient on 20 January 1996 - four days before the patient died. **[We need to check the circumstances in which Dr. Brigg became involved. To what extent did he review his patient's medication as prescribed by Dr. Barton. It appears that he did not vary the prescription for Diamorphine and therefore presumably believes it was appropriate.]**

1.23 Police have taken a statement from the patient's daughter, Mrs. Wiles, who is also a retired Registered Mental Nurse. Her understanding is that her father was transferred to Dryad Ward for terminal care. She believes that he died through "self neglect" - he was extremely frail and had lost the will to live. She did not take issue with the fact that her father was prescribed Morphine and she considered this to be appropriate.

Initial View

1.24 There is sufficient evidence to pursue the charges relating to inadequate note keeping, inadequate assessment (possibly) and prescribing/administering medication, including Diamorphine, in excess of the patient's needs. The conclusions of the two experts are not strong enough to sustain a charge that the standard of care resulted in premature death. Further work needs to be done with the experts to particularise the charges and to clarify whether Dr. Tandy is also culpable.

1.25 The police file contains 19 statements taken from witnesses of fact. Approximately ten of these would appear to be "key witnesses".

1.26 Our overall assessment is that this case is possibly suitable for a referral to the Fitness to Practice Panel, but is not one of the strongest cases.

2. **Lavender**

2.1 The patient was aged 83 when she was admitted to Daedelus Ward on 27 February 1996.

2.2 Her son refers to the fact that she was transferred to Daedelus from the Haslar Hospital where she had been recovering from a fall. The son says she was making an excellent recovery and the Occupational Therapist was considering a possible return of the patient to her home. She was coherent and walking with the assistance of a frame. A couple of days after admission to Daedelus Ward, Dr. Barton told the son that his mother had "come here to die". His mother deteriorated rapidly. The witness was not aware that Diamorphine was being administered by a syringe driver until the day prior to her death.

2.3 The patient was seen by Consultant Geriatrician, Dr. Tandy a few days before she was transferred to Daedelus Ward. The Doctor recorded that the patient had most likely suffered a brain stem stroke leading to the fall. Agreed to transfer of the patient to Daedelus Ward for rehabilitation. **[Check whether Dr. Tandy had any further involvement in the patient's care. Note that the other Consultant, Dr. Lord, was on annual leave between 23 February and 18 March 1996 and had no input into the treatment or care of this patient. She also says in her statement that no locum cover was arranged in her absence.]**

2.4 Barton's statement confirms that she did an assessment on the patient's transfer to Daedelus Ward. It says that the prognosis was not good. The patient was blind, diabetic, had suffered a brain stem stroke and was immobile.

2.5 Morphine was first prescribed on 24 February. The dose was increased on 26 February because the patient's bottom was very sore (pressure sores).

2.6 Barton wrote up a "pro-active prescription" for further pain relief which included Diamorphine. It was "pro-active" on the basis that nursing staff could contact her if necessary and she could authorise dosages as necessary within the dosage range.

2.7 Barton saw the patient again on 29 February and 1 March and noted that her condition was slowly deteriorating.

2.8 On 4 March, the dosage of slow-release Oramorph was increased.

2.9 Barton saw the patient again on 5 March and claims that the pain relief was inadequate. Barton authorised the administration of Diamorphine and Midazolam by syringe driver. Barton claims that the doses were appropriate in view of the uncontrolled pain. The patient died on 6 March. Barton certified death as Cerebrovascular Accident.

2.10 Dr. Black reports that it is likely that the patient was suffering from several serious illnesses and entering the terminal phase of her life when she was admitted. He notes that she was suffering constant pain to her shoulders (in addition, there were serious abnormalities in various blood tests).

2.11 He believes that the patient was mis-diagnosed (presumably both prior to her admission to Daedelus Ward (at the Haslar Hospital) and after her admission). The patient had, in fact, suffered a quadriplegia resulting from a spinal cord injury, secondary to her fall.

2.12 Black says that negligent medical assessments took place both at the Haslar and the Gosport Hospitals. In particular, her medical diagnosis was made to determine the cause of the pain, which he says is consistent with spinal cord fracture. **[From what he says, there was a joint failure to conduct a proper assessment and the doctor(s) responsible for the patient's care at Haslar are also culpable.]**

2.13 **Check to see whether Black has considered the fact that Dr. Lord, the Consultant, was on leave at the time. Should Barton have sought specialist advice elsewhere?**

2.14 Both Black and Wilcock refer to excessive doses of Diamorphine/Midazolam (Wilcock, in addition, thinks that earlier dosages of Morphine may also have been inappropriate/excessive to the type of pain experienced).

2.15 Wilcock says that the excessive doses of Morphine/Midazolam could have contributed towards her death. Black cannot say beyond all reasonable doubt that the patient's life was shortened.

Initial Views

2.16 The probability that the cause of pain was misdiagnosed, not only by Dr. Barton, but by the doctors at Haslar, before the patient was transferred to Gosport, makes this case more difficult to assess.

2.17 Further work needs to be done to determine whether a stronger case can be made relating to Dr. Barton's failure to seek specialist advice in view of the deterioration in the patient's condition leading to increased dosages of Morphine and the use of Diamorphine.

2.18 Both experts agree that at least some of the dosages of Diamorphine/Midazolam were excessive to the patient's needs. The opinions of the experts are not strong enough to sustain a charge that the patient's life was shortened.

2.19 Police took 32 witness statements and approximately 15 witnesses would fall within the category of "key witnesses".

2.20 There is sufficient evidence to refer the case on the basis of the excessive use of Diamorphine/Midazolam and possibly the failure to seek specialist advice, as part of an assessment to diagnose the underlying cause of a patient's pain.

2.21 The inappropriate prescribing of Diamorphine/Midazolam may only relate to one or two particular occasions. There may be other cases where prescribing took place over a longer period and where a stronger case may be made out.

3. **Lake**

3.1 The patient was aged 84 when she was admitted in August 1998. She had suffered a fall and broken a hip. She spent 2-3 weeks at the Haslar Hospital where she received a new hip. She was transferred to Gosport to recuperate and was expected to be discharged at some stage.

3.2 Patient died within 3 days of admission. On the first day at Gosport, she was able to talk to her family. On the second day, she became agitated and distressed. The next day, she was asleep and unable to respond either orally or through hand gestures. During the last two days of her life, she was receiving medication through a syringe driver. **[The case summary gives the (perhaps misleading) impression that there was very little wrong with her general health when she was first admitted to the Hospital following her fall. However, the notes later refer to an earlier admission to hospital in June where there is a record of her suffering from chronic renal failure and irregular heart beat. There is also reference in her medical history to a heart attack, irregular heart beat and raised blood pressure. In addition, she had poor circulation in her fingers and difficulty in swallowing.]** Despite these and other ailments, at the time of her fall, she was usually mobile, independent, and self caring. Following her hip replacement operation, she had problems with vomiting and shortness of breath. Blood tests revealed on-going renal impairment. On 10 August, she was reported to be unwell, drowsy and experiencing vomiting and diarrhoea. Her pulse increased and became irregular.

3.3 An x-ray revealed an infection at the base of the left lung and no heart failure. She was given antibiotics intravenously and started to improve.

3.4 Her improvement continued and on 12 August, antibiotics and intravenous fluids were discontinued. Her post-operative recovery was slow.

3.5 She was assessed by Dr. Lord who recorded "It is difficult to know how much she will improve" and she was referred to Gosport for continuing care. The summary in Dr. Lord's assessment recorded the patient as being "frail and quite unwell" and it uncertain as to "whether there will be a significant improvement".

3.6 Nursing records for 15 August record some pain due to arthritis.

3.7 On 17 August, the medical notes record that she was well, did not have a raised temperature or chest pain, that she was mobilising slowly and awaiting transfer to Gosport.

3.8 Her transfer letter written for staff at Gosport noted that she had made a slow recovery from the operation, exacerbated by bouts of angina and breathlessness.

3.9 Dr. Barton made an entry in the patient's medical notes on the day of transfer. This included reference to her operation, and past medical history including angina and congestive heart failure.

3.10 Nursing notes confirm that Morphine was administered on 18 August (5mgs) and 19 August (10mgs). The reason for the dose of Morphine on 18 August is not apparent. The nursing notes indicate that she had settled quite well and was fairly cheerful. On 19 August, she awoke very distressed and anxious and the nursing notes record that the Oramorph that had been given to her had very little effect.

3.11 The nursing notes on 19 August indicate that she was walking, albeit unsteadily. There is also reference in the notes of the patient being very breathless and complaining of chest pains.

3.12 There are various references to prescriptions for Diamorphine. The dosages ranging between 20mgs and 60mgs.

3.13 Dr. Wilcock and Dr. Black highlight a lack of information recorded in the patient's notes. Black regards this as a major problem in assessing the level of care. Both experts make assumptions that the patient was not adequately assessed by Dr. Barton, because there is no indication in the records that a proper assessment took place.

3.14 Dr. Wilcock also assumes that a further assessment did not take place when the patient complained of chest pain.

3.15 Both Doctors are critical of the lack of justification given for the prescription of Morphine and the decision to commence the use of a syringe driver.

3.16 Dr. Wilcock states that the lack of documentation makes it difficult to understand why the patient may have deteriorated so rapidly. He says that a thorough medical assessment when the patient complained of chest pain may have (emphasis added) identified treatable causes of the pain, e.g., chest infection.

3.17 Wilcock also says that it is possible (emphasis added) that the patient's deterioration was temporary/reversible.

3.18 Wilcock refers to the apparent (emphasis added) inappropriate use of medication.

3.19 There is evidence to show that whilst this patient suffered complications following the hip replacement operation, at the time she was transferred to

Gosport, there is a possibility that she would make a recovery. The experts are not able to explain the rapid deterioration in her condition leading to her death, within 3 days of transfer. The experts are hindered by the lack of documentation. They assume that thorough medical assessments have not taken place. Dr. Barton may disagree with this, but in any event, she will admit that she failed to keep proper notes.

3.20 The police took 41 statements from witnesses of fact. The statements will need to be analysed to identify the key witnesses. For present purposes, assume that approximately 15 witnesses will fall into the key witness category.

Initial Views

3.21 Lack of documentation in this case has made it difficult for the experts to reach any firm conclusions. There is certainly sufficient evidence to bring charges in relation to inadequate note keeping and possibly inadequate assessment of the patient's condition on transfer and after the patient complained of chest pains. On the available evidence, it would be more difficult to pursue charges relating to excessive use of Morphine/Diamorphine.

3.22 Further investigation will need to be undertaken to assess the role of Dr. Lord. It is possible that as the patient was only at Gosport for three days, she was not seen by Dr. Lord and Dr. Lord did not review the medication prescribed by Dr. Barton.

4. **Wilson**

4.1 The patient was 74 when he was admitted to the Hospital in October 1998. He died four days after admission.

4.2 Admitted with a fracture to the left humerus. Before his transfer, whilst he was being cared for at the Queen Alexandra Hospital, he was prescribed Paracetamol and Codeine for pain relief.

4.3 On transfer to Gosport, Dr. Barton prescribed Oramorph despite the fact that the patient had liver and kidney problems **Code A** and these problems made the body more sensitive to the effects of Oramorph.

4.4 Patient deteriorated and was converted to a syringe driver and received Diamorphine. Over the next two days, the dose was increased without obvious indications.

4.5 It appears that Dr. Knapman was the GP who covered for Dr. Barton. In his police statement, he says that the prescriptions written up by Dr. Barton were not excessive.

4.6 In the days immediately preceding the patient's death, on 17 and 18 October, he was seen by Dr. Peters, a Clinical Assistant at the Haslar Hospital. Dr. Peters was covering for Dr. Barton **[the police summary of Dr. Peters' evidence does not say whether he agreed with and/or varied the prescriptions written by Dr. Barton.]**

4.7 Dr. Barton, in his statement, justifies writing up a "pro-active regime" of Diamorphine in the event of the patient's deterioration. She states further that it was her expectation that the nursing staff would endeavour to make contact with her or the duty doctor before starting the patient on Diamorphine at the bottom end of the dose range.

4.8 Dr. Wilcock refers to the patient's multiple medical problems - cirrhosis/liver failure, heart failure and kidney failure. Patient also suffered from dementia and depression.

4.9 Wilcock notes that the pain he experienced following his fracture progressively improved during his stay at the Queen Alexandra Hospital. The doses of Morphine given there were reduced to 3mgs.

4.10 On his transfer to Dryad, he was prescribed 5-10mgs of Morphine, as required for pain relief. He received doses of Morphine despite the general expectation that the pain from the fracture would continue to improve over time.

4.11 Dr. Wilcock refers to a lack of clear note keeping and an inadequate assessment of the patient and he places blame for this on Dr. Barton and Dr. Knapman, the Consultant.

4.12 Dr. Wilcock also refers to doses of Diamorphine being administered - initially 20mgs, subsequently increased to 60mgs. Dr. Wilcock states that the increase in dose is "difficult to justify" as the patient was not reported to be distressed by pain.

4.13 Dr. Wilcock cannot state with any certainty that the doses of Morphine or Diamorphine contributed to the patient's death because of the possibility that heart and/or liver failure caused the death.

4.14 Dr. Black refers to "weaknesses" in the documentation of the patient's condition on admission, when strong Opiate Analgesia was commenced.

4.15 Black says that if clinical examinations were undertaken, they have not been recorded.

4.16 Black refers, in particular, to the prescription of 50mgs of Oramorph on 15 October which he believes was not an appropriate clinical response to Mr. Wilson's pain.

4.17 Further, Black considers that the medication prescribed in the period 15-16 October more than minimally contributed to the patient's death on 19 October. **[Has Dr. Black considered Dr. Peters' involvement on 17 and 18 October and the apparent failure to correct Dr. Barton's inappropriate prescriptions?]**

4.18 Professor Baker has also prepared a report. He says firstly that the Death Certificate inaccurately recorded that Mr. Wilson died of renal failure.

4.19 Professor Baker also believes that the administration of Opiate medicine was an important factor leading to the patient's death. On the evidence available, Baker says that the initial prescribing of Opiate medication was inappropriate and the starting dose was too high.

4.20 Baker refers to the reasons for not using non-opiate drugs for pain relief are not given in the medical notes.

4.21 A further expert report has been obtained from Dr. Marshall, a Gastroenterologist. He describes the administration of high doses of Morphine as "reckless". This is because warnings about using Morphine in the context of liver disease are readily available in the Standard Prescribing Guides.

4.22 Dr. Marshal considers that the impact of regular Morphine administration is likely to have hastened the patient's decline.

4.23 Note that this patient's case was investigated by the police as part of their initial investigation into four other patients. At the earlier stage in the investigation, the police instructed two different experts, Dr. Mundy and Dr. Ford. The former is a Consultant Physician and Geriatrician, the latter is a Professor of Pharmacology.

4.24 Mundy is critical of the standards of care given in this case - in particular, the fact that non-opiate analgesia was not initially considered and the fact that there was large dose range for Diamorphine. However, Mundy does express a view that the palliative care given in this case was appropriate.

4.25 Dr. Ford's conclusions concerning this patient need to be checked.

4.26 The summary of police evidence refers to a statement taken from Dr. Lord, the Consultant Geriatrician. She was on leave between 12 and 23 October. **[Investigate whether there was any locum cover. Experts need to consider whether either Dr. Peters and/or Dr. Knapman are culpable.]**

Initial Views

4.27 We have the benefit of six expert reports in this case. The reports obtained from the two experts at the outset of the police investigation need to be checked.

However, the four reports obtained during the more detailed part of the police investigation, clearly support charges relating to the excessive use of Morphine which hastened the patient's death. For this reason, this is one of the strongest cases and the evidence will support a referral to the FTP Panel.

4.28 The police obtained statements from approximately 40 witnesses of fact and a detailed examination of all the evidence will be required to determine the number of key witnesses. For present purposes, we should assume that there will be at least 20 key witnesses of fact.

5. **Spurgin**

5.1 The patient was aged 92 when she was admitted to the Hospital in March 1999.

5.2 She fractured her hip as a result of a fall, and initially was admitted to the Haslar Hospital. She underwent surgery there to repair the hip.

5.3 There were complications following the surgery and she developed a haematoma.

5.4 She experienced some pain and discomfort following her operation and, as a result of the haematoma. After transfer to Dryad Ward, she was given Oramorph. The pain persisted and it appears that her wound became infected. Dr. Barton prescribed antibiotics.

5.5 There is a suggestion that the hip may have been x-rayed. However, the results of the x-rays have not been found.

5.6 The dosage of Morphine was increased, followed by a decision to use Diamorphine with a syringe driver.

5.7 Dr. Barton prescribed a range of 20-100mgs and the patient was started on 80mgs. Dr. Reid reviewed this and reduced the dose to 40mgs.

5.8 The summary of Dr. Barton's witness statement indicates that the starting dose of 80mgs of Diamorphine was discussed with her before it was administered by the nurses.

5.9 Dr. Wilcock, in his report, is highly critical of Dr. Barton and, to a lesser degree, Dr. Reid, the Supervising Consultant. Dr. Wilcock's criticisms include the following: insufficient assessment and documentation of the patient's pain and treatment; failing to seek an orthopaedic opinion when the pain did not improve over time, but instead increasing the dose of Morphine which is associated with undesirable side effects; the doses of Diamorphine were excessive to the patient's needs.

5.10 Further work needs to be done with the expert to give a more detailed analysis of dates, entries in notes in which Doctor (Barton/Reid) were responsible at a particular time.

5.11 Dr. Black refers to an "apparent" (emphasis added) lack of medical assessment and the lack of documentation relating to this patient.

5.12 Dr. Black is also critical of the use of Oramorph on a regular basis without considering other possible analgesic regimes.

5.13 Black believes that some of the management of the patient's pain was within acceptable practice with the exception of the starting dose of Diamorphine - 80mgs. Black describes it as being "at best poor clinical judgment".

5.14 A further report has been obtained from a Consultant Orthopaedic Surgeon, Dr. Redfern.

5.15 He is very critical of the doctors' failure to investigate the cause of the internal bleeding into the patient's thigh following her operation. Redfern criticises those responsible for her care at Gosport Hospital and at the Haslar Hospital.

Initial View

5.16 The findings of the experts support charges relating to poor note keeping, failure to assess the patient's pain and the use of excessive doses of Diamorphine. There is a complicating factor in that Dr. Reid is also criticised by the experts.

5.17 The police interviewed approximately 20 witnesses of fact. For present purposes, we should assume that the majority of these would be required to give evidence.

6. Devine

6.1 The patient was aged 88 at the time that she was admitted in October 1999. She died 32 days after her admission.

6.2 The summary of the patient's medical history prior to her admission indicates that in the summer of 1999, she was well enough to provide emotional and domestic support to her daughter, who was suffering from Leukaemia. However, by October 1999, she was admitted to Queen Alexandra Hospital where she was reported to be confused and aggressive.

6.3 On 14 October 1999, she was seen by a Dr. Taylor who concluded that it was likely she was suffering from Dementia.

6.4 On 21 October 1999, she was transferred to Dryad Ward for rehabilitation/respite care under Dr. Reid.

6.5 On the day of her admission, Dr. Barton prescribed Morphine to be taken as required.

6.6 Between 25 October and 1 November 1999, she was described as being physically independent and continent although she required supervision. She remained confused and disorientated.

6.7 On 16 November, Dr. Barton referred the patient to Dr. Lusznat due to a deterioration in the patient's renal function.

6.8 On 18 November, Dr. Taylor noted that her mental health had deteriorated and she was becoming increasingly restless and aggressive. Her physical condition, at that stage, was stable.

6.9 On 19 November, Dr. Barton recorded that there had been a marked deterioration and she was then prescribed a combination of Diamorphine (40mgs) and Midazolam. On 19 November 1999, the patient's family were also informed that the patient had suffered kidney failure and was not expected to survive more than 36 hours.

6.10 A police summary records that the Registrar refused to accept the recorded cause of death which resulted in an amendment of the Certificate by Dr. Barton.

6.11 After the patient's death, the family complained about the quality of her care and this resulted in the Health Authority setting up an independent review panel.

6.12 The Panel was asked to review, inter alia, the appropriateness of the clinical response to the patient's medical condition. Oral evidence was heard from various witnesses including Dr. Barton. **[We need to check with the police to see whether they obtained transcripts of the evidence given to the Review Panel.]**

6.13 The Panel found that the dosage of drugs given to the patient was appropriate - including the dose of 40mgs of Diamorphine. The Panel also found that the dosage and devices used to make Ms. Devine comfortable on 19 November were an appropriate and necessary response to an urgent medical situation.

6.14 In her police witness statement, Dr. Barton says that Dr. Lusznat, a Psychiatrist, recorded that the patient was suffering from severe Dementia. Barton says that this was confirmed by a CT scan on 18 November 1999.

6.15 The case was reviewed by three different experts: Dr. Wilcock, Dr. Black and Dr. Dudley, a Consultant Nephrologist.

6.16 Dr. Wilcock is highly critical of the standard of care, in particular, he refers to an inadequate assessment of the patient's condition and the inappropriate

prescribing of medication, including Diamorphine. He describes these as being unjustified and excessive to the patient's needs.

6.17 The list of criticisms made by Dr. Wilcock would form the basis of a strong case. However, the findings of the other two experts are not critical to the same degree.

6.18 Dr. Black refers to a lack of documentation, and the difficulty of deciding whether the level of care was below an acceptable standard.

6.19 He appears to criticise certain aspects of medication regime, but expresses the view that the patient was terminally ill and appeared to receive good palliatation of her symptoms. He is not able to say that Dr. Barton's prescribing had any definite effect on shortening the patient's life in more than a minor fashion.

6.20 Dr. Dudley observes that after a period of stabilisation, the patient's condition worsened and she suffered severe renal failure. He says that although it may have been possible to stabilise her condition, this would not have materially changed the patient's prognosis as death was inevitable.

6.21 Further, Dr. Dudley considers that the patient was treated appropriately in the terminal phase of her illness with strong Opiods to ensure comfort.

Initial View

6.22 It is difficult to reconcile the views expressed by the experts in this case: Dr. Wilcock is highly critical, whereas Doctors Black and Dudley - in particular, Dr. Dudley - are far less critical. Also, the Independent Review Panel findings support Dr. Barton.

6.23 The police took approximately 60 witness statements and, further evidence was given to the Independent Review Panel. It is possible that evidence given by witnesses to the Panel has been recorded and retained.

6.24 Dr. Reid, in his police witness statement, confirms that he saw this patient on three occasions: 25 October and 1 and 15 November 1999. He says that the "as required" Oramorph was prescribed by Dr. Barton on 21 October was reasonable. He also claims that the use of a syringe driver to administer Diamorphine and Midazolam was appropriate in these circumstances.

6.25 The difference in views expressed by the experts in this case and the fact that Diamorphine was used in conjunction with the syringe driver only at the very end of the patient's life, makes this one of the weakest cases.

7. **Service**

7.1 The patient was 99 years old when she was admitted in June 1997.

7.2 The patient died within two days of admission. When she was admitted, she was suffering from various medical problems, including Diabetes, heart failure, confusion and sore skin.

7.3 On transfer, she was placed on sedation via a syringe driver. She became less well the following day and Diamorphine was added to the driver. (She had not required Analgesia other than Paracetamol at the Queen Alexandra Hospital, where she had been before she was transferred.)

7.4 On the day of transfer, Dr. Barton carried out an assessment and noted that the patient was suffering from heart failure, was very unwell and probably dying. In her witness statement, Dr. Barton says that the care of the patient would have been more appropriate at Queen Alexandra Hospital and a transfer by ambulance would not have been in the patient's best interest. Barton claims that Diamorphine and Midazolam were prescribed and administered solely with the intention of relieving the patient's agitation and distress. Diamorphine was also prescribed to treat symptoms of the patient's heart failure.

7.5 Dr. Wilcock casts doubt on whether the patient was dying on the day of her admission, as alleged by Dr. Barton. He refers to blood test results to support his views; however, the summary of his evidence indicates that he is not absolutely sure as to whether or not the patient was dying. He says that if she was not dying, the failure to re-hydrate her and the use of Midazolam and Diamorphine "could" (emphasis added) have contributed more than negligibly to her death.

7.6 If, on the other hand, she was in the process of dying, Dr. Wilcock concludes that it would have been reasonable not to re-hydrate her and to use Midazolam/Diamorphine.

7.7 The police obtained a further opinion from Dr. Petch, a Consultant Cardiologist. He refers to the patient's history of heart disease and states that the patient's terminal decline in 1997 was not unexpected. Further, he says that palliative care with increasing doses of Diamorphine and Midazolam was appropriate - the patient's prognosis was "hopeless". The administration of Diamorphine and Midazolam was reasonable in the circumstances described by Dr. Barton.

7.8 Dr. Black is in no doubt that the patient was entering the terminal phase of her illness. He says that an objective assessment of the patient's clinical status is not possible from the notes made on admission. The notes were below an acceptable standard of good medical practice.

7.9 Further, Dr. Black says that the 20mgs dose of Diamorphine combined with a 40mgs dose of Midazolam was higher than necessary, and "it may have slightly shortened her life".

7.10 Police took statements from 20 witnesses of fact. Without a detailed review of the evidence, it is not possible to say, at this stage, how many of these would be regarded as "key" witnesses.

Initial View

7.11 In the light of the views expressed by the Consultant Cardiologist who considers that the use of Diamorphine and Midazolam was appropriate, there seems little prospect of success in this case.

8. **Cunningham**

8.1 The patient was aged 79 on the date of his admission in September 1998. He died within five days of admission.

8.2 When he was admitted, the patient was suffering from Parkinson's Disease, Dementia, Myelodysplasia. He also had a necrotic pressure sore.

8.3 Dr. Lord, the Supervising Consultant, prescribed Oramorph. Dr. Barton considered that this may not have been sufficient in terms of pain relief and wrote up Diamorphine on a pro-active basis with a dose range of 20-200mgs.

8.4 In her police witness statement, Dr. Barton explains that the levels of pain relief were increased as the patient continued to suffer pain and discomfort.

8.5 Dr. Wilcock is critical of Dr. Barton's practice of prescribing Diamorphine on an "as required" basis within such a large dose range, i.e., up to 200mgs. He says this unnecessarily exposes the patient to a risk of receiving excessive doses of Diamorphine.

8.6 However, in this case, Dr. Wilcock concludes that the patient was dying in an expected way and the use of Diamorphine and Midazolam were justified in view of the patient's chronic pain. The expert also concludes that although the dose range prescribed by Dr. Barton was excessive, in the event Mr. Cunningham did not receive such high doses.

8.7 Wilcock criticised Dr. Barton's lack of clear note keeping and, on the basis of the notes, he also considers that Dr. Barton failed to adequately assess the patient.

8.8 Dr. Black regards this particular case as an example of the complex and challenging problems which arise in Geriatric Medicine. He notes that the patient suffered from multiple chronic diseases and, in Dr. Black's view, the patient was managed appropriately and this included an appropriate decision to start using a syringe driver. Dr. Black has only one concern - the increased dose of Diamorphine just before the patient's death. He says that he is unable to find any justification for the increase in dosage in the nursing or medical notes. He

says that this "may" (emphasis added) have slightly shortened the patient's life, i.e., by a few hours/days.

8.9 The police took 47 statements from witnesses of fact in this case. Without a detailed analysis of the evidence, it is not possible to say how many of these can be regarded as being "key" witnesses.

Initial View

8.10 Whilst Dr. Wilcock, in particular, is critical of the large dose range prescribed by Dr. Barton, he considers that the dosages administered to the patient in this particular case were reasonable. He concludes that the patient was managed appropriately.

8.11 This case has already been referred to the FTP Panel, presumably on the basis of reports from other experts obtained earlier in the police investigation. We will need to review the earlier reports. However, on the basis of the opinions expressed by Dr. Black and Dr. Wilcock, there is no realistic prospect of proving that the doses of Diamorphine administered in this particular case was inappropriate.

9. **Gregory**

9.1 This patient was aged 99 when she was admitted in September 1999.

9.2 [This case is slightly different from the majority of the other cases in that the patient spent nearly 3 months on Dryad Ward until her death. In the other cases, apart from Mrs. Devine who was at the Hospital for about a month before she died, all the other patients died in a period of 2-18 days.]

9.3 Whilst the patient was on Dryad Ward, she was seen on various occasions in September, October and November 1999 by the Supervising Consultant, Dr. Reid. In his police statement, Dr. Reid expressed a view that whilst Dr. Barton's note keeping may have been poor, the patients were managed appropriately by Dr. Barton.

9.4 Dr. Reid, in retrospect, feels that it was inappropriate of Dr. Barton to prescribe Diamorphine as early as 3 September 1999, in the absence of documented pain or distress. However, Dr. Reid believes that it was appropriate for Dr. Barton to prescribe Opiates on 20 November, as the patient was in the terminal stages of her life.

9.5 When the patient was admitted to Dryad Ward, she had recently fractured her femur. She had a history of heart disease. She was regularly reviewed by Dr. Barton and Dr. Reid and was noted to be suffering poor appetite, agitation, variable confusion and no significant improvement in her mobility.

9.6 Between 15 and 18 November, her condition deteriorated following a chest infection. She became distressed and breathless. Dr. Barton was abroad from 12 to 16 November, but on her return on 17 November, she prescribed Oramorph. On 18 November, she prescribed Diamorphine.

9.7 Dr. Wilcock considers that the patient's decline over a number of weeks was in keeping with the natural decline into a terminal phase of her illness. He considers the dose of Diamorphine was unlikely to have been excessive.

9.8 Dr. Black refers to the patient's history of heart failure and lung disease. The patient was very elderly and frail when she fractured her femur. Dr. Black observed that in circumstances there was a very significant risk of mortality and morbidity.

9.9 Dr. Black reports that Dr. Barton failed to record a clinical examination, apart from some brief details concerning the patient's history.

9.10 Dr. Black notes that within a short period of her transfer to Dryad Ward, it is likely that she suffered a small stroke. Essentially, she made no improvement in rehabilitation in the two months that she was in hospital.

9.11 Dr. Black refers to the patient's rapid deterioration on 18 November. He says the prescribing of oral Opiates was an appropriate response to a patient who had an extremely poor prognosis.

9.12 He also considers that a decision to start the patient on Diamorphine was a reasonable decision. He regards the dosages of Diamorphine to have been in the range of acceptable clinical practice.

9.13 He does express a concern about Dr. Barton's practice of prescribing strong Opioid Analgesia in anticipation of a patient's decline. Notwithstanding this, he concludes that no harm came to Mrs. Gregory as a result of this practice.

9.14 Apart from a lack of clinical examination (or possible failure to document such an examination), both on the date of her patient's admission and during the period that her condition deteriorated, Dr. Black appears to be satisfied that the dosages of Diamorphine administered in this case were reasonable. He confirms that the patient died of natural causes.

9.15 The police took 22 witness statements during their investigation relating to this patient.

Initial View

9.16 A case of inappropriate prescribing cannot be made out on the basis of the views expressed by the expert save to the limited extent that one of the experts criticises the practice of "anticipatory" prescribing.

9.17 There are additional concerns raised with regard to lack of note keeping and the possibility that clinical examinations were not carried out. This is one of the weakest cases.

10. **Packman**

10.1 The patient was aged 67 when he was admitted in August 1999. He suffered from gross morbid obesity (in April 1999, he weighed in excess of 23 stone). He was first admitted to the Queen Alexandra Hospital on 6 August 1999, having suffered a fall at his home. On admission to QAH, he was noted to have an abnormal liver function and impaired renal function. He also had leg ulcers and cellulitis (infection of the skin) and pressure sores over his buttocks and thighs.

10.2 It is not clear whether he suffered a gastrointestinal bleed whilst he was at QAH (the experts seem to think that if a bleed occurred, it was not significant or life threatening at that stage).

10.3 On his admission to Dryad Ward on 25 August 1999, he was examined by Dr. Ravindrane, a Registrar working under Dr. Reid, the Consultant.

10.4 On 25 August, he was seen by a Locum GP, Dr. Beasley (it is not clear why Dr. Beasley was involved and Dr. Beasley's name does not appear in the list of witnesses interviewed by the police).

10.5 On 26 August, the patient was seen by Dr. Ravindrane following a report that the patient had been passing blood rectally.

10.6 It appears that the patient's condition deteriorated during the course of the day on 26 August. The experts conclude that a blood test taken on that day revealed a large drop in the patient's haemoglobin, which made a significant gastrointestinal bleed likely.

10.7 In her police statement, Dr. Barton indicated on 26 August, she was concerned that the patient might have suffered a myocardial infarction. In addition, she believed that the patient had suffered a gastrointestinal bleed.

10.8 The experts, in particular, Dr. Wilcock, criticise Dr. Barton for not transferring the patient to an acute ward for treatment for the underlying cause of the bleeding - thought by Dr. Wilcock to be a peptic ulcer.

10.9 In her police statement, Dr. Barton says that the patient was very ill and a transfer to an acute unit would have been inappropriate given the likely further harmful effect on his health. **[Query whether the experts have given this assertion due consideration.]**

10.10 Dr. Barton does not say in her statement why she did not consult anybody - Dr. Ravindrane or Dr. Reid - before taking a decision not to transfer and/or before

prescribing Diamorphine and Midazolam. Note that the police do not appear to have interviewed Dr. Reid in connection with this case, even though Dr. Wilcock, in his report, believes that Dr. Reid, albeit to a lesser degree than Dr. Barton, failed to provide treatment with a reasonable amount of skill and care. It is possible that Dr. Reid only saw the patient on one occasion, i.e., on 9 September, two days before the patient died. Therefore, it may be that Dr. Reid was unaware of the gastrointestinal bleed which occurred on 26 August 1999 - if that is the case, then Dr. Wilcock's criticism of Dr. Reid seems to be limited to the subsequent use of Opioids.

10.11 The police obtained an expert opinion from a Consultant Gastroenterologist, Dr. Marshall. He concludes that a transfer to surgery should have been considered on 26 August when the possibility of a G/I bleed was first considered. He indicates that surgery, in this case, may have resulted in the patient's death because the patient was morbidly obese.

10.12 The police obtained 27 witness statements in this case.

Initial View

10.13 There appears to be at least an arguable case that Dr. Barton should have sought assistance from a Consultant before she made the decision not to transfer the patient to an acute unit following the G/I bleed. Dr. Wilcock, in particular, is critical of this and the decision to prescribe Opiates. His view is that prescribing Opiates contributed "more than minimally" to the patient's death. Dr. Black takes the view that these deficiencies probably made very little difference to the eventual outcome.

10.14 The role of the other practitioners in this case will need to be considered in more detail - i.e., Dr. Beasley, Dr. Ravindrane and Dr. Reid.

10.15 Overall, there is sufficient evidence to refer this case to the Case Examiner.

GENERAL MEDICAL COUNCIL- DR BARTON

Eversheds' RAPID Resolution
Review, Analyse, Plan, Implement, Deliver

Case Outline, Case Analysis and Case Strategy

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The Case Outline, Case Analysis and Case Strategy will be reviewed regularly and adjusted as circumstances change or more information becomes available.

This document has been prepared for the General Medical Council and Eversheds consider no other party to be their client in respect of this dispute. The contents are confidential and must not be disclosed to any third party without Eversheds' prior consent.

Date of preparation/last review : 27 February 2007

Date of next review : 27 March 2007

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Case Outline

This document sets out the background facts to your claim, as we understand them at the present time. If any of the facts in the Case Outline are incorrect or change, then please let us know at once. Changes may have an impact on this Case Outline. Together we will keep this Case Outline up to date as matters unfold and the case progresses.

Details of opponent

Dr Barton's Representative: Ian Barker
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What has happened?

Between 1998 and September 2006 Hampshire Police conducted a series of investigations into allegations of the treatment of elderly patients at Gosport War Memorial Hospital. The investigations resulted from concerns expressed by relatives of deceased patients who believed that patients had died prematurely as a result of receiving strong opiate medication prescribed by Dr Barton.

During their investigation the police referred a number of cases to the GMC and in August 2002, the PPC referred 5 cases to the PCC. These cases have been on hold pending the conclusion of the police investigation.

The police investigation came to an end in December last year when the CPS decided there was insufficient evidence to prosecute Dr Barton.

The police have made available to the GMC a significant body of evidence which they gathered during their investigations. We are currently reviewing the evidence with a view to preparing a case to put before the PCC.

Annex 1 - Detailed Chronology

Background

1. Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed previously by the Fareham and Gosport Primary Care Trust. The hospital came under the control of the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002.

2. The hospital operates on a day-to-day basis with nursing and support staff employed by the PCT. At the relevant time clinical expertise was provided by way of visiting general practitioners and clinical assistants subject to the supervision of consultants.

3. Elderly patients were generally admitted to GWMH by referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

4. Doctor Jane BARTON ("Dr BARTON") is a registered Medical Practitioner who in 1988 took up a part-time position in GWMH as Clinical Assistant in Elderly Medicine. During the period that she worked at GWMH, Dr BARTON also worked on a part-time basis as a partner in general practice.

Police Investigations

5. Hampshire Police conducted a number of investigations, referred to below, into the deaths of elderly patients at GWMH, following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. The investigations also looked at further concerns raised by families of the deceased which indicated that the general standard of care afforded to patients was below an acceptable standard and potentially negligent.

6. Most of the allegations involved Dr BARTON.

7. Two allegations (in respect of patients, SPURGIN and PACKMAN, referred to in more detail below) were investigated by the Police in respect of a consultant Dr Richard REID. Part of Dr REID's responsibilities involved the supervision of Dr BARTON.

8. Of 945 death certificates issues in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Dr. BARTON.

9. The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the

deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

10. The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

The First Police Investigation

11. Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91.

12. Mrs Richards died at the GWMH on Friday 21 August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

13. Following the death of Mrs Richards two of her daughters, Mrs MACKENZIE and Mrs LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs MACKENZIE contacted Gosport Police on 27 September 1998 and alleged that her mother had been unlawfully killed.

14. Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

15. The Reviewing CPS Lawyer determined that on the evidence available a criminal prosecution could not be justified.

16. Mrs MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

17. The complaint made by Mrs MACKENZIE was upheld and a review of the police investigation was carried out.

Second Police Investigation

18. Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17 April 2000.

19. Professor Brian LIVESLEY an elected member of the academy of experts provided a medical opinion in a report dated 9 November 2000 and came to the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs Gladys RICHARDS in a manner as to cause her death."

- "Mr Philip James BEED, Ms Margaret COUCHMAN and Ms Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs RICHARDS was unlawfully killed."

20. A meeting took place on 19 June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

21. Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs RICHARDS had been unlawfully killed were flawed with regard to his understanding of the law.

22. Professor LIVESLEY provided a second report dated 10 July 2001 where he concluded, as follows:

- "It is my opinion that as a result of being given these drugs Mrs RICHARDS death occurred earlier than it would have done from natural causes."

23. In August 2001 the Crown Prosecution Service nevertheless advised that there was insufficient evidence to sustain a realistic prospect of a conviction.

24. Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH and as a result four more cases were randomly selected for review - Arthur CUNNINGHAM, Alice WILKIE, Robert WILSON and Eva PAGE.

25. Expert opinions were sought from a further two medical experts, professors FORD and MUNDY who were each provided with copies of the medical records of the four patients in addition to the medical records of Gladys RICHARDS.

26. The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as the conclusions were similar to the RICHARDS case and that there was insufficient evidence to provide a realistic prospect of conviction. The Police then decided that there would be no further investigations at that time.

27. Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement, for appropriate action.

Intervening Developments between Second and Third Investigations

28. On 22 October 2001 the Commission for Health Improvement (CHI) launched an investigation into the quality of health care at GWMH, interviewing 59 staff in the process.

29. A report of the CHI investigation findings was published in May 2002, concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality of patient care.

30. The CHI further reported that the Trust, post investigation, had adequate policies and guidelines in place that were being adhered to, governing the prescription and administration of pain relieving medicines to older patients.

31. Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

32. On Monday 16 September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

33. The documents were copies of memos, letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including:-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (as per the Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

34. Nurse TUBBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19 September 2002. The following decisions were made:-

- To examine the new documentation and investigate the events of 1991.
- To review existing evidence and new material in order to identify any additional viable lines of enquiry.

- To submit the new material to experts and subsequently to the CPS.

- To examine possible individual and corporate liability.

35. A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

36. On 23 September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients who had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns.

37. In addition, Professor Richard BAKER, during his statistical review of mortality rates at GWMH, identified 16 cases which were of concern to him in terms of pain management.

38. 14 further cases were identified for investigation through ongoing complaints by family members between 2002 and 2006.

39. A total of 92 cases were investigated by police during the third phase of the investigation.

40. A team of medical experts (the key clinical team) were appointed to review the 92 cases, and completed this work between September 2003 and August 2006.

41. The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

42. The terms of reference for the team were to examine patient notes (initially independently) and to assess the quality of care provided to each patient according to the expert's professional discipline.

43. The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine, but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1 - Optimal care.
Category 2 - Sub optimal care.
Category 3 - Negligent care.

44. The cases were screened in batches of twenty and following this process the experts met to discuss findings and reach a consensus.

45. Each expert was instructed to retain and preserve their notes and findings for possible disclosure to interested parties.

46. All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to confirm the key clinical Team's findings.

47. Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly these cases were referred by the police to the General Medical Council and Nursing and Midwifery Council for their information and attention.

48. The fourteen Category 3 cases were referred to the police for further investigation. These included two cases which the police considered as part of their second investigation - WILSON and CUNNINGHAM. Of the fourteen cases, four were potentially negligent in terms of standard of care, but the cause of death was assessed as entirely natural. In the circumstances, the essential element of causation in these four cases was not capable of being proved.

49. Accordingly the following four cases were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR.

50. The final ten cases (referred to below) were subject to a full criminal investigation on the basis that they had been assessed by the key clinical team as being 'negligent care that is today outside the bounds of acceptable clinical practice and where the cause of death is unclear'.

51. The investigation included taking statements from all relevant healthcare staff involved in care of the patients and family members. Medical experts were engaged to provide opinions in terms of causation and standard of care. The police took statements from over 300 witnesses.

52. The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were instructed with guidance from the Crown Prosecution Service to ensure that their reports addressed the relevant legal issues in the context of a criminal investigation.

53. The experts completed their reports following a review of each patient's medical records, all witness statements and transcripts of police interviews with Dr Reid and Dr Barton. They were also provided with the relevant documents required

to put the circumstances of care into 'time context'. The reviews were conducted by the experts independently.

54. Supplementary expert medical evidence was obtained where necessary to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

55. A common denominator in respect of the ten cases was that the clinical assistant in each case was Dr BARTON. She was responsible for the initial and continuing care of the patients, including the prescription and administration of opiates and other drugs using syringe drivers.

56. Dr BARTON was interviewed under caution in respect of the allegations.

57. The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews by submitting prepared statements and exercised her right of silence in respect of questions asked.

58. During a second interview phase (following provision of expert witness reports to the police investigation team) Dr BARTON again exercised her right of silence and refused to answer any questions.

59. Dr REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by the expert witnesses. Dr REID answered all questions put to him.

60. Full files of evidence were submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.
- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

61. Additional evidence was forwarded to the CPS including general healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

62. The ten category three cases were:-

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1. Elsie DEVINE 88 yrs. Admitted to GWMH 21 October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21 November 1999, 32 days after admission. Cause of death recorded as Bronchopneumonia and Glomerulonephritis.

2. Elsie LAVENDER 83 yrs. Admitted to GWMH 22 February 1996 with head injury/ brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6 March 1996, 14 days after admission. Cause of death recorded as Cerebrovascular accident (stroke).

3. Sheila GREGORY 91 yrs. Admitted to GWMH 3 September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22 November 1999, 81 days after admission. Cause of death Bronchopnuemonia.

4. Robert WILSON 74 yrs. Admitted to GWMH 14 October 1998 with fractured left humerus and alcoholic hepatitis. Died 18 October 1998 4 days after admission. Cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26 March 1999 with a fractured neck of the femur. Died 13 April 1999 18 days after admission. Cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18 August 1998 with a fractured neck of the femur, atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21 August 1998 3 days after admission. Cause of death recorded as bronchopneumonia.

7. **Code A** Admitted to GWMH 5 January 1996 with Parkinsons disease. He was physically and mentally frail; immobile, suffering depression. Died 24 January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3 June 1997 with multiple medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5 June 1997 2 days after admission. Cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66 yrs. Admitted to GWMH 23 August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3 September 1999 13 days after admission. Cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21 September 1998 with Parkinson's disease and dementia. Died 26 September 1998 5 days after admission. Cause of death recorded as bronchopneumonia.

63. **Dr David WILCOCK provided extensive evidence in respect of patient care and identified particular themes of concern in respect of the final 10 category ten cases including:-**

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'.*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues including:-*

Enid Spurgin - orthopaedic surgeon, microbiologist
Geoffrey Packman - general physician, gastroenterologist
Helena Service - general physician, cardiologist
Elsie Lavender - haematologist
Sheila Gregory - psychogeriatrician
Code A *- general physician/palliative care physician*
Arthur Cunningham - palliative care physician

64. Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK, and by other experts who were commissioned to review other aspects of the medical care. Full details are contained within their reports.

65. There was however little consensus between the two principal experts Drs BLACK and WILCOCK as to whether the category 3 patients were in irreversible/terminal decline, and little consensus as to whether negligence more than minimally contributed towards the death of patients.

66. As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to the overall expert evidence it

could not be proved that Dr BARTON was negligent to the required criminal standard.

67. Whilst the medical evidence obtained by police was detailed and complex it did not prove that the medication contributed substantially towards death. There is some expert evidence which suggests that in the case of some patients the opiates prescribed and/or administered where excessive to the patient's needs and may have hastened the patient's death by a matter of hours or days.

68. In the view of the CPS there was not sufficient evidence to prove that the doctors were criminally culpable and the CPS concluded that there was no realistic prospect of conviction.

69. Family group members of the deceased and stakeholders were informed of the decision in December 2006. The police investigation was closed.

70. ***IOC Proceedings and Referrals***

71. The IOC considered Dr Barton's case on three occasions; on 21 June 2001 (during the second police investigation); on 21 March 2002 and on 19 September 2002 (a few days prior to the police starting the third investigation).

72. On each occasion the IOC made no Order. On 13 February 2002, approximately one month before the second IOC Hearing, it appears that Dr Barton came to the following agreement with the Isle of Wight, Portsmouth and South East Hampshire Health Authority :

- To cease to provide medical care for adult patients at GWMH
- To stop prescribing opiats and benzodiazepines with immediate effect.

73. On 13 February 2002 it appears that Dr Barton reached a separate agreement with the Portsmouth Health Care NHS Trust, which effectively meant that Dr Barton would no longer work at GWMH.

74. On 29 August 2002, shortly before the second IOC Hearing and one month before the police commenced their third investigation, the Preliminary Proceedings Committee decided to refer to the Professional Conduct Committee the cases referred to in paragraph 24 above, i.e. RICHARDS, CUNNINGHAM, WILKIE, WILSON and PAGE.

75. The allegations which were referred relate to the period between February and October 1998 and include the following :-

> Inappropriate/unprofessional prescribing of opiate and sedative drugs; and prescribing in dosages and combinations which were excessive and potentially hazardous to the condition of the patients.

The cases have been "on hold" pending the conclusion of the Police investigations.

Case Analysis

This document sets out our advice. It contains a summary of our analysis of the evidence gathered to date. This document follows from the Case Outline. If any of the facts in the Case Outline change, then that may have an impact on the contents of this Case Analysis. Together we will keep this Case Analysis up to date as matters unfold and the case progresses.

Legal Analysis

We have prepared the following rough analysis of the strengths and weaknesses of the allegations, based on work carried out to date.

1. **Code A**

1.1 Aged 82 on admission. One of the experts - Black - believes patient was probably terminally ill on admission.

1.2 Patient was assessed by Dr. Lord on the day before his admission - assessed his prognosis as being poor. Chances of survival slim. Unlikely to survive for long.

1.3 On transfer to Dryad Ward, Dr. Tandy, Consultant Geriatrician, had overall medical responsibility. (She worked on the Ward until late 1996.) Her responsibilities included a Ward Round once a fortnight.

1.4 Dr. Tandy saw the patient on 10 January 1996, five days after he was admitted. She prescribed 5mg Oramorph to alleviate pain and distress.

1.5 Dr. Barton, in her witness statement, "<u>believes</u>" (emphasis added) that she reviewed the patient on 15 January 1996 and "believes" that his condition had deteriorated with significant pain and distress.

1.6 It appears that Barton prescribed Diamorphine on 15 January 1996 - it also appears that this was without reference to Dr. Tandy.

1.7 Dr. Tandy, in her witness statement, comments that she would have used a lower dosage of Diamorphine and Midazolam - her practice being to use the lowest dose to achieve the desired outcome, and to reduce adverse effects.

1.8 Nurse Hamblin, the Sister, refers to an increased dosage of Diamorphine on 18 January, six days before the patient died.

1.9 The key clinical team observed that the patient was physically and mentally frail. The team concluded that the patient was probably Opiate toxic, but

notwithstanding this, the dose was not reduced. Cause of death - unclear. Opiates "could" have contributed.

1.10 Two experts have reviewed the case, Dr. Wilcock, expert in Palliative Medicine, Dr. Black, a specialist in Geriatric Medicine.

1.11 As a general observation in this and the other cases, Dr. Wilcock tends to be more bullish in his conclusions compared to Dr. Black who is more circumspect.

1.12 Wilcock refers to Barton's poor medical note keeping. In her witness statement, Barton admits to this, but seeks to explain the deficiency with reference to substantial work place demands. Says that a choice had to be made between detailed note making or spending more time with the patients. Also seeks to explain the policy of "pro-active prescribing" with reference to the demands of work.

1.13 Wilcock says that the patient's pain was not appropriately assessed. We need to check how he reached this conclusion. Is it a case that there was no written assessment? Is there any evidence that a proper assessment was made, but not recorded in the notes?

1.14 Wilcock refers to the inappropriate administration of Opiates to relieve anxiety and agitation.

1.15 Wilcock refers to doses of Diamorphine in the range 40-120mgs as being excessive to the needs of the patient and far in excess of an appropriate starting dose. Says that an appropriate dose would be 10-15mgs.

1.16 Wilcock's overall conclusion is that Barton breached her duty of care to the patient by failing to provide treatment with skill and care, but "it is difficult to exclude completely the possibility that the dose of Diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death".

1.17 Wilcock also believes that the certified cause of death - Bronchopneumonia appears to be the most likely cause of death.

1.18 Dr. Black, in his report, refers to the patient's condition being extremely frail. The patient was at the end of a chronic period of disease spanning more than 20 years. The patient suffered from depression and drug related side effects.

1.19 Black refers to a problem in assessing the standard of care due to a lack of documentation. He agrees with Wilcock in that the lack of notes represents poor clinical practice.

1.20 Black refers to "suboptimal" drug management.

1.21 Black notes that the starting dose of 80mgs of Morphine was approximately three times the dose that is conventionally applied. Black also says that the combination of drugs (Diamorphine and Midazolam/Noizinan) are likely to have caused excessive sedation and may have shortened the patient's life by a short period of time - "hours to days" - "medication likely to have shortened the patient's life, but not beyond all reasonable doubt".

1.22 Other features noted include the following: the patient's own GP, Dr. Brigg, was consulted about the patient on 20 January 1996 - four days before the patient died.

1.23 Police have taken a statement from the patient's daughter, Mrs. Wiles, who is also a retired Registered Mental Nurse. Her understanding is that her father was transferred to Dryad Ward for terminal care. She believes that he died through "self neglect" - he was extremely frail and had lost the will to live. She did not take issue with the fact that her father was prescribed Morphine and she considered this to be appropriate.

Initial View

1.24 There is sufficient evidence to pursue the charges relating to inadequate note keeping, inadequate assessment (possibly) and prescribing/administering medication, including Diamorphine, in excess of the patient's needs. The conclusions of the two experts are not strong enough to sustain a charge that the standard of care resulted in premature death. Further work needs to be done with the experts to particularise the charges and to clarify whether Dr. Tandy is also culpable.

1.25 The police file contains 19 statements taken from witnesses of fact. Approximately ten of these would appear to be "key witnesses".

1.26 Our overall assessment is that this case is possibly suitable for a referral to the Fitness to Practice Panel, but is not one of the strongest cases.

2. **Lavender**

2.1 The patient was aged 83 when she was admitted to Daedelus Ward on 27 February 1996.

2.2 Her son refers to the fact that she was transferred to Daedelus from the Haslar Hospital where she had been recovering from a fall. The son says she was making an excellent recovery and the Occupational Therapist was considering a possible return of the patient to her home. She was coherent and walking with the assistance of a frame. A couple of days after admission to Daedelus Ward, Dr. Barton told the son that his mother had "come here to die". His mother

deteriorated rapidly. The witness was not aware that Diamorphine was being administered by a syringe driver until the day prior to her death.

2.3 The patient was seen by Consultant Geriatrician, Dr. Tandy a few days before she was transferred to Daedelus Ward. The Doctor recorded that the patient had most likely suffered a brain stem stroke leading to the fall. Agreed to transfer of the patient to Daedelus Ward for rehabilitation.

2.4 Barton's statement confirms that she did an assessment on the patient's transfer to Daedelus Ward. It says that the prognosis was not good. The patient was blind, diabetic, had suffered a brain stem stroke and was immobile.

2.5 Morphine was first prescribed on 24 February. The dose was increased on 26 February because the patient's bottom was very sore (pressure sores).

2.6 Barton wrote up a "pro-active prescription" for further pain relief which included Diamorphine. It was "pro-active" on the basis that nursing staff could contact her if necessary and she could authorise dosages as necessary within the dosage range.

2.7 Barton saw the patient again on 29 February and 1 March and noted that her condition was slowly deteriorating.

2.8 On 4 March, the dosage of slow-release Oramorph was increased.

2.9 Barton saw the patient again on 5 March and claims that the pain relief was inadequate. Barton authorised the administration of Diamorphine and Midazolam by syringe driver. Barton claims that the doses were appropriate in view of the uncontrolled pain. The patient died on 6 March. Barton certified death as Cerebrovascular Accident.

2.10 Dr. Black reports that it is likely that the patient was suffering from several serious illnesses and entering the terminal phase of her life when she was admitted. He notes that she was suffering constant pain to her shoulders (in addition, there were serious abnormalities in various blood tests).

2.11 He believes that the patient was mis-diagnosed (presumably both prior to her admission to Daedelus Ward (at the Haslar Hospital) and after her admission). The patient had, in fact, suffered a quadriplegia resulting from a spinal cord injury, secondary to her fall.

2.12 Black says that negligent medical assessments took place both at the Haslar and the Gosport Hospitals. In particular, her medical diagnosis was made to determine the cause of the pain, which he says is consistent with spinal cord fracture.

2.13 Both Black and Wilcock refer to excessive doses of Diamorphine/Midazolam (Wilcock, in addition, thinks that earlier dosages of Morphine may also have been inappropriate/excessive to the type of pain experienced).

2.14 Wilcock says that the excessive doses of Morphine/Midazolam could have contributed towards her death. Black cannot say beyond all reasonable doubt that the patient's life was shortened.

Initial Views

2.15 The probability that the cause of pain was misdiagnosed, not only by Dr. Barton, but by the doctors at Haslar, before the patient was transferred to Gosport, makes this case more difficult to assess.

2.16 Further work needs to be done to determine whether a stronger case can be made relating to Dr. Barton's failure to seek specialist advice in view of the deterioration in the patient's condition leading to increased dosages of Morphine and the use of Diamorphine.

2.17 Both experts agree that at least some of the dosages of Diamorphine/Midazolam were excessive to the patient's needs. The opinions of the experts are not strong enough to sustain a charge that the patient's life was shortened.

2.18 Police took 32 witness statements and approximately 15 witnesses would fall within the category of "key witnesses".

2.19 There is sufficient evidence to refer the case on the basis of the excessive use of Diamorphine/Midazolam and possibly the failure to seek specialist advice, as part of an assessment to diagnose the underlying cause of a patient's pain.

2.20 The inappropriate prescribing of Diamorphine/Midazolam may only relate to one or two particular occasions. There may be other cases where prescribing took place over a longer period and where a stronger case may be made out.

3. **Lake**

3.1 The patient was aged 84 when she was admitted in August 1998. She had suffered a fall and broken a hip. She spent 2-3 weeks at the Haslar Hospital where she received a new hip. She was transferred to Gosport to recuperate and was expected to be discharged at some stage.

3.2 Patient died within 3 days of admission. On the first day at Gosport, she was able to talk to her family. On the second day, she became agitated and distressed. The next day, she was asleep and unable to respond either orally or through hand gestures. During the last two days of her life, she was receiving medication through a syringe driver. Despite these and other ailments, at the time of her fall, she was usually mobile, independent, and self caring. Following

her hip replacement operation, she had problems with vomiting and shortness of breath. Blood tests revealed on-going renal impairment. On 10 August, she was reported to be unwell, drowsy and experiencing vomiting and diarrhoea. Her pulse increased and became irregular.

3.3 An x-ray revealed an infection at the base of the left lung and no heart failure. She was given antibiotics intravenously and started to improve.

3.4 Her improvement continued and on 12 August, antibiotics and intravenous fluids were discontinued. Her post-operative recovery was slow.

3.5 She was assessed by Dr. Lord who recorded "It is difficult to know how much she will improve" and she was referred to Gosport for continuing care. The summary in Dr. Lord's assessment recorded the patient as being "frail and quite unwell" and it uncertain as to "whether there will be a significant improvement".

3.6 Nursing records for 15 August record some pain due to arthritis.

3.7 On 17 August, the medical notes record that she was well, did not have a raised temperature or chest pain, that she was mobilising slowly and awaiting transfer to Gosport.

3.8 Her transfer letter written for staff at Gosport noted that she had made a slow recovery from the operation, exacerbated by bouts of angina and breathlessness.

3.9 Dr. Barton made an entry in the patient's medical notes on the day of transfer. This included reference to her operation, and past medical history including angina and congestive heart failure.

3.10 Nursing notes confirm that Morphine was administered on 18 August (5mgs) and 19 August (10mgs). The reason for the dose of Morphine on 18 August is not apparent. The nursing notes indicate that she had settled quite well and was fairly cheerful. On 19 August, she awoke very distressed and anxious and the nursing notes record that the Oramorph that had been given to her had very little effect.

3.11 The nursing notes on 19 August indicate that she was walking, albeit unsteadily. There is also reference in the notes of the patient being very breathless and complaining of chest pains.

3.12 There are various references to prescriptions for Diamorphine. The dosages ranging between 20mgs and 60mgs.

3.13 Dr. Wilcock and Dr. Black highlight a lack of information recorded in the patient's notes. Black regards this as a major problem in assessing the level of care. Both experts make assumptions that the patient was not adequately assessed by

Dr. Barton, because there is no indication in the records that a proper assessment took place.

3.14 Dr. Wilcock also assumes that a further assessment did not take place when the patient complained of chest pain.

3.15 Both Doctors are critical of the lack of justification given for the prescription of Morphine and the decision to commence the use of a syringe driver.

3.16 Dr. Wilcock states that the lack of documentation makes it difficult to understand why the patient may have deteriorated so rapidly. He says that a thorough medical assessment when the patient complained of chest pain may have (emphasis added) identified treatable causes of the pain, e.g., chest infection.

3.17 Wilcock also says that it is possible (emphasis added) that the patient's deterioration was temporary/reversible.

3.18 Wilcock refers to the apparent (emphasis added) inappropriate use of medication.

3.19 There is evidence to show that whilst this patient suffered complications following the hip replacement operation, at the time she was transferred to Gosport, there is a possibility that she would make a recovery. The experts are not able to explain the rapid deterioration in her condition leading to her death, within 3 days of transfer. The experts are hindered by the lack of documentation. They assume that thorough medical assessments have not taken place. Dr. Barton may disagree with this, but in any event, she will admit that she failed to keep proper notes.

3.20 The police took 41 statements from witnesses of fact. The statements will need to be analysed to identify the key witnesses. For present purposes, assume that approximately 15 witnesses will fall into the key witness category.

Initial Views

3.21 Lack of documentation in this case has made it difficult for the experts to reach any firm conclusions. There is certainly sufficient evidence to bring charges in relation to inadequate note keeping and possibly inadequate assessment of the patient's condition on transfer and after the patient complained of chest pains. On the available evidence, it would be more difficult to pursue charges relating to excessive use of Morphine/Diamorphine.

3.22 Further investigation will need to be undertaken to assess the role of Dr. Lord. It is possible that as the patient was only at Gosport for three days, she was not seen by Dr. Lord and Dr. Lord did not review the medication prescribed by Dr. Barton.

4. **Wilson**

4.1 The patient was 74 when he was admitted to the Hospital in October 1998. He died four days after admission.

4.2 Admitted with a fracture to the left humerus. Before his transfer, whilst he was being cared for at the Queen Alexandra Hospital, he was prescribed Paracetamol and Codeine for pain relief.

4.3 On transfer to Gosport, Dr. Barton prescribed Oramorph despite the fact that the patient had liver and kidney problems **Code A** and these problems made the body more sensitive to the effects of Oramorph.

4.4 Patient deteriorated and was converted to a syringe driver and received Diamorphine. Over the next two days, the dose was increased without obvious indications.

4.5 It appears that Dr. Knapman was the GP who covered for Dr. Barton. In his police statement, he says that the prescriptions written up by Dr. Barton were not excessive.

4.6 In the days immediately preceding the patient's death, on 17 and 18 October, he was seen by Dr. Peters, a Clinical Assistant at the Haslar Hospital. Dr. Peters was covering for Dr. Barton.

4.7 Dr. Barton, in his statement, justifies writing up a "pro-active regime" of Diamorphine in the event of the patient's deterioration. She states further that it was her expectation that the nursing staff would endeavour to make contact with her or the duty doctor before starting the patient on Diamorphine at the bottom end of the dose range.

4.8 Dr. Wilcock refers to the patient's multiple medical problems - cirrhosis/liver failure, heart failure and kidney failure. Patient also suffered from dementia and depression.

4.9 Wilcock notes that the pain he experienced following his fracture progressively improved during his stay at the Queen Alexandra Hospital. The doses of Morphine given there were reduced to 3mgs.

4.10 On his transfer to Dryad, he was prescribed 5-10mgs of Morphine, as required for pain relief. He received doses of Morphine despite the general expectation that the pain from the fracture would continue to improve over time.

4.11 Dr. Wilcock refers to a lack of clear note keeping and an inadequate assessment of the patient and he places blame for this on Dr. Barton and Dr. Knapman, the Consultant.

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4.12 Dr. Wilcock also refers to doses of Diamorphine being administered - initially 20mgs, subsequently increased to 60mgs. Dr. Wilcock states that the increase in dose is "difficult to justify" as the patient was not reported to be distressed by pain.

4.13 Dr. Wilcock cannot state with any certainty that the doses of Morphine or Diamorphine contributed to the patient's death because of the possibility that heart and/or liver failure caused the death.

4.14 Dr. Black refers to "weaknesses" in the documentation of the patient's condition on admission, when strong Opiate Analgesia was commenced.

4.15 Black says that if clinical examinations were undertaken, they have not been recorded.

4.16 Black refers, in particular, to the prescription of 50mgs of Oramorph on 15 October which he believes was not an appropriate clinical response to Mr. Wilson's pain.

4.17 Further, Black considers that the medication prescribed in the period 15-16 October more than minimally contributed to the patient's death on 19 October.

4.18 Professor Baker has also prepared a report. He says firstly that the Death Certificate inaccurately recorded that Mr. Wilson died of renal failure.

4.19 Professor Baker also believes that the administration of Opiate medicine was an important factor leading to the patient's death. On the evidence available, Baker says that the initial prescribing of Opiate medication was inappropriate and the starting dose was too high.

4.20 Baker refers to the reasons for not using non-opiate drugs for pain relief are not given in the medical notes.

4.21 A further expert report has been obtained from Dr. Marshall, a Gastroenterologist. He describes the administration of high doses of Morphine as "reckless". This is because warnings about using Morphine in the context of liver disease are readily available in the Standard Prescribing Guides.

4.22 Dr. Marshal considers that the impact of regular Morphine administration is likely to have hastened the patient's decline.

4.23 Note that this patient's case was investigated by the police as part of their initial investigation into four other patients. At the earlier stage in the investigation, the police instructed two different experts, Dr. Mundy and Dr. Ford. The former is a Consultant Physician and Geriatrician, the latter is a Professor of Pharmacology.

4.24 Mundy is critical of the standards of care given in this case - in particular, the fact that non-opiate analgesia was not initially considered and the fact that there was large dose range for Diamorphine. However, Mundy does express a view that the palliative care given in this case was appropriate.

4.25 Dr. Ford's conclusions concerning this patient need to be checked.

4.26 The summary of police evidence refers to a statement taken from Dr. Lord, the Consultant Geriatrician. She was on leave between 12 and 23 October.

Initial Views

4.27 We have the benefit of six expert reports in this case. The reports obtained from the two experts at the outset of the police investigation need to be checked. However, the four reports obtained during the more detailed part of the police investigation, clearly support charges relating to the excessive use of Morphine which hastened the patient's death. For this reason, this is one of the strongest cases and the evidence will support a referral to the FTP Panel.

4.28 The police obtained statements from approximately 40 witnesses of fact and a detailed examination of all the evidence will be required to determine the number of key witnesses. For present purposes, we should assume that there will be at least 20 key witnesses of fact.

5. **Spurgin**

5.1 The patient was aged 92 when she was admitted to the Hospital in March 1999.

5.2 She fractured her hip as a result of a fall, and initially was admitted to the Haslar Hospital. She underwent surgery there to repair the hip.

5.3 There were complications following the surgery and she developed a haematoma.

5.4 She experienced some pain and discomfort following her operation and, as a result of the haematoma. After transfer to Dryad Ward, she was given Oramorph. The pain persisted and it appears that her wound became infected. Dr. Barton prescribed antibiotics.

5.5 There is a suggestion that the hip may have been x-rayed. However, the results of the x-rays have not been found.

5.6 The dosage of Morphine was increased, followed by a decision to use Diamorphine with a syringe driver.

5.7 Dr. Barton prescribed a range of 20-100mgs and the patient was started on 80mgs. Dr. Reid reviewed this and reduced the dose to 40mgs.

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5.8 The summary of Dr. Barton's witness statement indicates that the starting dose of 80mgs of Diamorphine was discussed with her before it was administered by the nurses.

5.9 Dr. Wilcock, in his report, is highly critical of Dr. Barton and, to a lesser degree, Dr. Reid, the Supervising Consultant. Dr. Wilcock's criticisms include the following: insufficient assessment and documentation of the patient's pain and treatment; failing to seek an orthopaedic opinion when the pain did not improve over time, but instead increasing the dose of Morphine which is associated with undesirable side effects; the doses of Diamorphine were excessive to the patient's needs.

5.10 Further work needs to be done with the expert to give a more detailed analysis of dates, entries in notes in which Doctor (Barton/Reid) were responsible at a particular time.

5.11 Dr. Black refers to an "apparent" (emphasis added) lack of medical assessment and the lack of documentation relating to this patient.

5.12 Dr. Black is also critical of the use of Oramorph on a regular basis without considering other possible analgesic regimes.

5.13 Black believes that some of the management of the patient's pain was within acceptable practice with the exception of the starting dose of Diamorphine - 80mgs. Black describes it as being "at best poor clinical judgment".

5.14 A further report has been obtained from a Consultant Orthopaedic Surgeon, Dr. Redfern.

5.15 He is very critical of the doctors' failure to investigate the cause of the internal bleeding into the patient's thigh following her operation. Redfern criticises those responsible for her care at Gosport Hospital and at the Haslar Hospital.

Initial View

5.16 The findings of the experts support charges relating to poor note keeping, failure to assess the patient's pain and the use of excessive doses of Diamorphine. There is a complicating factor in that Dr. Reid is also criticised by the experts.

5.17 The police interviewed approximately 20 witnesses of fact. For present purposes, we should assume that the majority of these would be required to give evidence.

6. **Devine**

6.1 The patient was aged 88 at the time that she was admitted in October 1999. She died 32 days after her admission.

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6.2 The summary of the patient's medical history prior to her admission indicates that in the summer of 1999, she was well enough to provide emotional and domestic support to her daughter, who was suffering from Leukaemia. However, by October 1999, she was admitted to Queen Alexandra Hospital where she was reported to be confused and aggressive.

6.3 On 14 October 1999, she was seen by a Dr. Taylor who concluded that it was likely she was suffering from Dementia.

6.4 On 21 October 1999, she was transferred to Dryad Ward for rehabilitation/respite care under Dr. Reid.

6.5 On the day of her admission, Dr. Barton prescribed Morphine to be taken as required.

6.6 Between 25 October and 1 November 1999, she was described as being physically independent and continent although she required supervision. She remained confused and disorientated.

6.7 On 16 November, Dr. Barton referred the patient to Dr. Lusznat due to a deterioration in the patient's renal function.

6.8 On 18 November, Dr. Taylor noted that her mental health had deteriorated and she was becoming increasingly restless and aggressive. Her physical condition, at that stage, was stable.

6.9 On 19 November, Dr. Barton recorded that there had been a marked deterioration and she was then prescribed a combination of Diamorphine (40mgs) and Midazolam. On 19 November 1999, the patient's family were also informed that the patient had suffered kidney failure and was not expected to survive more than 36 hours.

6.10 A police summary records that the Registrar refused to accept the recorded cause of death which resulted in an amendment of the Certificate by Dr. Barton.

6.11 After the patient's death, the family complained about the quality of her care and this resulted in the Health Authority setting up an independent review panel.

6.12 The Panel was asked to review, inter alia, the appropriateness of the clinical response to the patient's medical condition. Oral evidence was heard from various witnesses including Dr. Barton.

6.13 The Panel found that the dosage of drugs given to the patient was appropriate - including the dose of 40mgs of Diamorphine. The Panel also found that the dosage and devices used to make Ms. Devine comfortable on 19 November were an appropriate and necessary response to an urgent medical situation.

6.14 In her police witness statement, Dr. Barton says that Dr. Lusznat, a Psychiatrist, recorded that the patient was suffering from severe Dementia. Barton says that this was confirmed by a CT scan on 18 November 1999.

6.15 The case was reviewed by three different experts: Dr. Wilcock, Dr. Black and Dr. Dudley, a Consultant Nephrologist.

6.16 Dr. Wilcock is highly critical of the standard of care, in particular, he refers to an inadequate assessment of the patient's condition and the inappropriate prescribing of medication, including Diamorphine. He describes these as being unjustified and excessive to the patient's needs.

6.17 The list of criticisms made by Dr. Wilcock would form the basis of a strong case. However, the findings of the other two experts are not critical to the same degree.

6.18 Dr. Black refers to a lack of documentation, and the difficulty of deciding whether the level of care was below an acceptable standard.

6.19 He appears to criticise certain aspects of medication regime, but expresses the view that the patient was terminally ill and appeared to receive good palliatation of her symptoms. He is not able to say that Dr. Barton's prescribing had any definite effect on shortening the patient's life in more than a minor fashion.

6.20 Dr. Dudley observes that after a period of stabilisation, the patient's condition worsened and she suffered severe renal failure. He says that although it may have been possible to stabilise her condition, this would not have materially changed the patient's prognosis as death was inevitable.

6.21 Further, Dr. Dudley considers that the patient was treated appropriately in the terminal phase of her illness with strong Opiods to ensure comfort.

Initial View

6.22 It is difficult to reconcile the views expressed by the experts in this case: Dr. Wilcock is highly critical, whereas Doctors Black and Dudley - in particular, Dr. Dudley - are far less critical. Also, the Independent Review Panel findings support Dr. Barton.

6.23 The police took approximately 60 witness statements and, further evidence was given to the Independent Review Panel. It is possible that evidence given by witnesses to the Panel has been recorded and retained.

6.24 Dr. Reid, in his police witness statement, confirms that he saw this patient on three occasions: 25 October and 1 and 15 November 1999. He says that the "as required" Oramorph was prescribed by Dr. Barton on 21 October was

reasonable. He also claims that the use of a syringe driver to administer Diamorphine and Midazolam was appropriate in these circumstances.

6.25 The difference in views expressed by the experts in this case and the fact that Diamorphine was used in conjunction with the syringe driver only at the very end of the patient's life, makes this one of the weakest cases.

7. **Service**

7.1 The patient was 99 years old when she was admitted in June 1997.

7.2 The patient died within two days of admission. When she was admitted, she was suffering from various medical problems, including Diabetes, heart failure, confusion and sore skin.

7.3 On transfer, she was placed on sedation via a syringe driver. She became less well the following day and Diamorphine was added to the driver. (She had not required Analgesia other than Paracetamol at the Queen Alexandra Hospital, where she had been before she was transferred.)

7.4 On the day of transfer, Dr. Barton carried out an assessment and noted that the patient was suffering from heart failure, was very unwell and probably dying. In her witness statement, Dr. Barton says that the care of the patient would have been more appropriate at Queen Alexandra Hospital and a transfer by ambulance would not have been in the patient's best interest. Barton claims that Diamorphine and Midazolam were prescribed and administered solely with the intention of relieving the patient's agitation and distress. Diamorphine was also prescribed to treat symptoms of the patient's heart failure.

7.5 Dr. Wilcock casts doubt on whether the patient was dying on the day of her admission, as alleged by Dr. Barton. He refers to blood test results to support his views; however, the summary of his evidence indicates that he is not absolutely sure as to whether or not the patient was dying. He says that if she was not dying, the failure to re-hydrate her and the use of Midazolam and Diamorphine "could" (emphasis added) have contributed more than negligibly to her death.

7.6 If, on the other hand, she was in the process of dying, Dr. Wilcock concludes that it would have been reasonable not to re-hydrate her and to use Midazolam/Diamorphine.

7.7 The police obtained a further opinion from Dr. Petch, a Consultant Cardiologist. He refers to the patient's history of heart disease and states that the patient's terminal decline in 1997 was not unexpected. Further, he says that palliative care with increasing doses of Diamorphine and Midazolam was appropriate - the

patient's prognosis was "hopeless". The administration of Diamorphine and Midazolam was reasonable in the circumstances described by Dr. Barton.

7.8 Dr. Black is in no doubt that the patient was entering the terminal phase of her illness. He says that an objective assessment of the patient's clinical status is not possible from the notes made on admission. The notes were below an acceptable standard of good medical practice.

7.9 Further, Dr. Black says that the 20mgs dose of Diamorphine combined with a 40mgs dose of Midazolam was higher than necessary, and "it may have slightly shortened her life".

7.10 Police took statements from 20 witnesses of fact. Without a detailed review of the evidence, it is not possible to say, at this stage, how many of these would be regarded as "key" witnesses.

Initial View

7.11 In the light of the views expressed by the Consultant Cardiologist who considers that the use of Diamorphine and Midazolam was appropriate, there seems little prospect of success in this case.

8. **Cunningham**

8.1 The patient was aged 79 on the date of his admission in September 1998. He died within five days of admission.

8.2 When he was admitted, the patient was suffering from Parkinson's Disease, Dementia, Myelodysplasia. He also had a necrotic pressure sore.

8.3 Dr. Lord, the Supervising Consultant, prescribed Oramorph. Dr. Barton considered that this may not have been sufficient in terms of pain relief and wrote up Diamorphine on a pro-active basis with a dose range of 20-200mgs.

8.4 In her police witness statement, Dr. Barton explains that the levels of pain relief were increased as the patient continued to suffer pain and discomfort.

8.5 Dr. Wilcock is critical of Dr. Barton's practice of prescribing Diamorphine on an "as required" basis within such a large dose range, i.e., up to 200mgs. He says this unnecessarily exposes the patient to a risk of receiving excessive doses of Diamorphine.

8.6 However, in this case, Dr. Wilcock concludes that the patient was dying in an expected way and the use of Diamorphine and Midazolam were justified in view of the patient's chronic pain. The expert also concludes that although the dose range prescribed by Dr. Barton was excessive, in the event Mr. Cunningham did not receive such high doses.

8.7 Wilcock criticised Dr. Barton's lack of clear note keeping and, on the basis of the notes, he also considers that Dr. Barton failed to adequately assess the patient.

8.8 Dr. Black regards this particular case as an example of the complex and challenging problems which arise in Geriatric Medicine. He notes that the patient suffered from multiple chronic diseases and, in Dr. Black's view, the patient was managed appropriately and this included an appropriate decision to start using a syringe driver. Dr. Black has only one concern - the increased dose of Diamorphine just before the patient's death. He says that he is unable to find any justification for the increase in dosage in the nursing or medical notes. He says that this "may" (emphasis added) have slightly shortened the patient's life, i.e., by a few hours/days.

8.9 The police took 47 statements from witnesses of fact in this case. Without a detailed analysis of the evidence, it is not possible to say how many of these can be regarded as being "key" witnesses.

Initial View

8.10 Whilst Dr. Wilcock, in particular, is critical of the large dose range prescribed by Dr. Barton, he considers that the dosages administered to the patient in this particular case were reasonable. He concludes that the patient was managed appropriately.

8.11 This case has already been referred to the FTP Panel, presumably on the basis of reports from other experts obtained earlier in the police investigation. We will need to review the earlier reports. However, on the basis of the opinions expressed by Dr. Black and Dr. Wilcock, there is no realistic prospect of proving that the doses of Diamorphine administered in this particular case was inappropriate.

9. **Gregory**

9.1 This patient was aged 99 when she was admitted in September 1999.

9.2 [This case is slightly different from the majority of the other cases in that the patient spent nearly 3 months on Dryad Ward until her death. In the other cases, apart from Mrs. Devine who was at the Hospital for about a month before she died, all the other patients died in a period of 2-18 days.]

9.3 Whilst the patient was on Dryad Ward, she was seen on various occasions in September, October and November 1999 by the Supervising Consultant, Dr. Reid. In his police statement, Dr. Reid expressed a view that whilst Dr. Barton's note keeping may have been poor, the patients were managed appropriately by Dr. Barton.

9.4 Dr. Reid, in retrospect, feels that it was inappropriate of Dr. Barton to prescribe Diamorphine as early as 3 September 1999, in the absence of documented pain or distress. However, Dr. Reid believes that it was appropriate for Dr. Barton to prescribe Opiates on 20 November, as the patient was in the terminal stages of her life.

9.5 When the patient was admitted to Dryad Ward, she had recently fractured her femur. She had a history of heart disease. She was regularly reviewed by Dr. Barton and Dr. Reid and was noted to be suffering poor appetite, agitation, variable confusion and no significant improvement in her mobility.

9.6 Between 15 and 18 November, her condition deteriorated following a chest infection. She became distressed and breathless. Dr. Barton was abroad from 12 to 16 November, but on her return on 17 November, she prescribed Oramorph. On 18 November, she prescribed Diamorphine.

9.7 Dr. Wilcock considers that the patient's decline over a number of weeks was in keeping with the natural decline into a terminal phase of her illness. He considers the dose of Diamorphine was unlikely to have been excessive.

9.8 Dr. Black refers to the patient's history of heart failure and lung disease. The patient was very elderly and frail when she fractured her femur. Dr. Black observed that in circumstances there was a very significant risk of mortality and morbidity.

9.9 Dr. Black reports that Dr. Barton failed to record a clinical examination, apart from some brief details concerning the patient's history.

9.10 Dr. Black notes that within a short period of her transfer to Dryad Ward, it is likely that she suffered a small stroke. Essentially, she made no improvement in rehabilitation in the two months that she was in hospital.

9.11 Dr. Black refers to the patient's rapid deterioration on 18 November. He says the prescribing of oral Opiates was an appropriate response to a patient who had an extremely poor prognosis.

9.12 He also considers that a decision to start the patient on Diamorphine was a reasonable decision. He regards the dosages of Diamorphine to have been in the range of acceptable clinical practice.

9.13 He does express a concern about Dr. Barton's practice of prescribing strong Opioid Analgesia in anticipation of a patient's decline. Notwithstanding this, he concludes that no harm came to Mrs. Gregory as a result of this practice.

9.14 Apart from a lack of clinical examination (or possible failure to document such an examination), both on the date of her patient's admission and during the period

that her condition deteriorated, Dr. Black appears to be satisfied that the dosages of Diamorphine administered in this case were reasonable. He confirms that the patient died of natural causes.

9.15 The police took 22 witness statements during their investigation relating to this patient.

Initial View

9.16 A case of inappropriate prescribing cannot be made out on the basis of the views expressed by the expert save to the limited extent that one of the experts criticises the practice of "anticipatory" prescribing.

9.17 There are additional concerns raised with regard to lack of note keeping and the possibility that clinical examinations were not carried out. This is one of the weakest cases.

10. **Packman**

10.1 The patient was aged 67 when he was admitted in August 1999. He suffered from gross morbid obesity (in April 1999, he weighed in excess of 23 stone). He was first admitted to the Queen Alexandra Hospital on 6 August 1999, having suffered a fall at his home. On admission to QAH, he was noted to have an abnormal liver function and impaired renal function. He also had leg ulcers and cellulitis (infection of the skin) and pressure sores over his buttocks and thighs.

10.2 It is not clear whether he suffered a gastrointestinal bleed whilst he was at QAH (the experts seem to think that if a bleed occurred, it was not significant or life threatening at that stage).

10.3 On his admission to Dryad Ward on 25 August 1999, he was examined by Dr. Ravindrane, a Registrar working under Dr. Reid, the Consultant.

10.4 On 25 August, he was seen by a Locum GP, Dr. Beasley (it is not clear why Dr. Beasley was involved and Dr. Beasley's name does not appear in the list of witnesses interviewed by the police).

10.5 On 26 August, the patient was seen by Dr. Ravindrane following a report that the patient had been passing blood rectally.

10.6 It appears that the patient's condition deteriorated during the course of the day on 26 August. The experts conclude that a blood test taken on that day revealed a large drop in the patient's haemoglobin, which made a significant gastrointestinal bleed likely.

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10.7 In her police statement, Dr. Barton indicated on 26 August, she was concerned that the patient might have suffered a myocardial infarction. In addition, she believed that the patient had suffered a gastrointestinal bleed.

10.8 The experts, in particular, Dr. Wilcock, criticise Dr. Barton for not transferring the patient to an acute ward for treatment for the underlying cause of the bleeding - thought by Dr. Wilcock to be a peptic ulcer.

10.9 In her police statement, Dr. Barton says that the patient was very ill and a transfer to an acute unit would have been inappropriate given the likely further harmful effect on his health.

10.10 Dr. Barton does not say in her statement why she did not consult anybody - Dr. Ravindrane or Dr. Reid - before taking a decision not to transfer and/or before prescribing Diamorphine and Midazolam. Note that the police do not appear to have interviewed Dr. Reid in connection with this case, even though Dr. Wilcock, in his report, believes that Dr. Reid, albeit to a lesser degree than Dr. Barton, failed to provide treatment with a reasonable amount of skill and care. It is possible that Dr. Reid only saw the patient on one occasion, i.e., on 9 September, two days before the patient died. Therefore, it may be that Dr. Reid was unaware of the gastrointestinal bleed which occurred on 26 August 1999 - if that is the case, then Dr. Wilcock's criticism of Dr. Reid seems to be limited to the subsequent use of Opioids.

10.11 The police obtained an expert opinion from a Consultant Gastroenterologist, Dr. Marshall. He concludes that a transfer to surgery should have been considered on 26 August when the possibility of a G/I bleed was first considered. He indicates that surgery, in this case, may have resulted in the patient's death because the patient was morbidly obese.

10.12 The police obtained 27 witness statements in this case.

Initial View

10.13 There appears to be at least an arguable case that Dr. Barton should have sought assistance from a Consultant before she made the decision not to transfer the patient to an acute unit following the G/I bleed. Dr. Wilcock, in particular, is critical of this and the decision to prescribe Opiates. His view is that prescribing Opiates contributed "more than minimally" to the patient's death. Dr. Black takes the view that these deficiencies probably made very little difference to the eventual outcome.

10.14 The role of the other practitioners in this case will need to be considered in more detail - i.e., Dr. Beasley, Dr. Ravindrane and Dr. Reid.

10.15 Overall, there is sufficient evidence to refer this case to the Case Examiner.

Case Strategy

This document sets out in detail the actions that will be required, who will undertake each step and in what timescale. The document also sets out a budget for each step.

This document is our project management tool for the work outlined. We will use it to monitor current tasks, timescales and costs. It will form the basis for our regular update meetings. We will amend it as the case develops.

This document follows from the Case Outline. If the Case Outline changes as the case unfolds, then this will also have an impact on the Case Strategy, which will be updated appropriately.

Summary of Strategy

11. The above Case Analysis has already been forwarded to Paul Hylton.. We have On the basis of what we have read so far, there are three reasonably strong cases - WILSON, SPURGIN and PACKMAN. There are a further two cases which are worthy of more detailed consideration - Code A and LAVENDER. The remaining five cases are relatively weak in view of the conclusions reached by the experts.

12. It is difficult, at this stage, to gauge how many cases are likely to go forward via the case examiner to the Professional Conduct Committee. We need to discuss the selection of cases further with you as part of a Strategy Review. For present purposes, we suggest that it would be prudent to work on the basis that a maximum of ten cases will go forward to the FTP Panel. However, we consider it likely that the number of cases will be reduced with the benefit of further analysis and investigation.

13. We have reported to Paul Hylton that on average the Police have taken between 20 and 50 statements from witnesses in each case. In each case there are also between two and six experts. On the basis of our reading so far, it is likely that we will need to re-interview a significant proportion of the witnesses of fact. More detailed work will be needed to refine the expert evidence and tailor it, where necessary, for use in the FTP proceedings.

14. We estimate that we will need at least six months to gather evidence and a further two months for the experts to consider the additional evidence before draft charges are formulated. The Defence will probably need a similar amount of time to prepare their case.

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Code A

Field Fisher Waterhouse

Case Report
May 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Tomlinson / 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. The police instructed Professor Brian Livesley, Professor Richard Baker and a multidisciplinary team who reported on toxicology, general medicine, palliative care, geriatrics and nursing. 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]. We believe 2 further cases making a total of 15 may require investigation.

Investigations: We have received documents (38 boxes) from Eversheds and have contacted all the family members associated with the 15 cases. We will be shortly contacted the experts who have previously written reports in the Police investigation to find out if they will write modified reports for us. We have also been liaising with the defence and disclosing documents to them as they have requested. 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 our review of the papers supplied by Eversheds, visit witnesses as necessary, production statements from witnesses for their Police statements, approach experts, liaise with Coroner and Police, Stage 1 telephone conference.

Listing time estimate: Our provisional estimate for the hearing is 8 weeks to be held in London as all of the witnesses are on the South Coast. This would probably be in 2008 to enable us to complete our investigation.

Listed: Not yet listed

Prospects of Success: Medium

Field Fisher Waterhouse

Case Report
June 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Tomlinson / 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. The police instructed Professor Brian Livesley, Professor Richard Baker and a multidisciplinary team who reported on toxicology, general medicine, palliative care, geriatrics and nursing. 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.

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Investigations: We have received documents (38 boxes) from Eversheds and have contacted all the family members associated with the 15 cases. We will be shortly contacted the experts who have previously written reports in the Police investigation to find out if they will write modified reports for us. We have also been liaising with the defence and disclosing documents to them as they have requested. 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.

We are liaising with the experts to potentially instruct the same experts and possibly use the same reports for the GMC investigation. We are also in contact with the Police regarding disclosure issues.

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. Stage 1 telephone conference.

Listing time estimate: Our provisional estimate for the hearing is 8 weeks to be held in London as all of the witnesses are on the South Coast. This would probably be in 2008 to enable us to complete our investigation.

Listed: Not yet listed

Prospects of Success: Medium

Field Fisher Waterhouse

Case Report
July 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Tomlinson / 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. We are also in contact with the Police regarding disclosure issues.

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, Stage 1 telephone conference.

Listing time estimate: Our provisional estimate for the hearing is 8 weeks to be held in London as all of the witnesses are on the South Coast. This would probably be in 2008 to enable us to complete our investigation.

Counsel: Code A

Listed: Not yet listed

Prospects of Success: Medium

GMC101302-0085

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: Code A

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

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Field Fisher Waterhouse

Case Report
October 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Juliet St Bernard
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.

[illegible]

Listing time estimate: 8 weeks.

Code A

Listed: 8 September – 31 October 2008

Prospects of Success: Medium

Field Fisher Waterhouse

Case Report
December 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Juliet St Bernard
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.

Code A

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:	Juliet St Bernard
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 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.

Code A

Listed: 8 September – 31 October 2008

Prospects of Success: Medium

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

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: Code A

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.

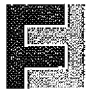
Recommendation: Professor Black to finalise outstanding expert reports, production statements from witnesses for their police statements and visits to witnesses as necessary, liaise with Coroner, police and PCT.

Listing time estimate: 8 weeks.

Counsel: Code A

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
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). In April 2008 we added JS. Counsel has advised that there is not enough evidence to proceed regarding SG, HS and EP.

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

Code A

Code A

Code A

Code A

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Code A

Code A

excessive sub-cutaneous analgesics and who assessed her on admission but failed to note it.

Code A

Instructions to GMC Legal

Name of doctor:	Dr Jane Ann Barton
Type of case (new/review):	New
Date/time of IOP hearing:	Friday 11 July 2008 10.30 The case has been listed for half a day
If review hearing, date of initial Order:	New date
Date referred to IOP:	27 June 2008
Summary of substantive case including any hearing date(s):	**This case has a long history, it has previously been to IOC on four occasions and no order was made, see overview document.** **The MDU have already raised concern that we are being oppressive in submitting Dr Barton to an IOP on a fifth occasion and queried whether a case examiner has jurisdiction to make a referral under to IOP as this is an old rules case.** **This case is High profile**
Do we need to ask the Panel to ask the Registrar to apply to High Court for an extension to order?	No
Order sought:	Suspension
Name and tel. no of Investigation Officer	Code A Code A
Any other matters:	**The hearing bundle has not been anonymised so please ask Counsel NOT to refer to any of**

	the patients by name and request the Panel to do the same. **Also please ask for the minutes to be anonymised.** **Our solicitor for the FTP case is Sarah Ellson from Field Fisherwater House Solicitors.**

Case Report
May 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

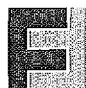
Summary: Dr Barton is a GP. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis at the Gosport War Memorial Hospital. Dr Barton retired from this post in 2000. A number of complaints were made that patients admitted to the GWMH for rehabilitative 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). In April 2008 we added JS. Counsel has advised that there is not enough evidence to proceed regarding SG, HS and EP.

Investigations: Professor Black has now done all his "new" reports including a generic report – he is completing GMC style reports for those he reported on earlier. All patients' families have been updated as to whether their case is to be included. We have had a con with Counsel to review progress and in particular to look at Coroner's announcement of inquests in 10 cases. We have been chasing the final production statements and dealing with the evidence of Mrs McKenzie. We have updated the defence as to progress. We met with the NMC to discuss their case. We are exploring extending the listing to 10 weeks.

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. Sort possible pharmacist expert/witness to discuss drugs charts and medication used. Next protocol call 10 June.

Listing time estimate: 8-10 weeks. **Counsel**: Tom Kark and Ben Fitzgerald

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

 Field Fisher Waterhouse

Case Report
August 2008

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor and Counsel:	Tamsin Hall/Sarah Ellson Tom Kark and Rebecca Harris
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). In April 2008 we added JS. Counsel has advised that there is not enough evidence to proceed regarding SG, HS and EP.

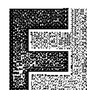
Investigations: As the Hearing has now been postponed pending the outcome of the Inquest we have informed all relevant parties of this decision. There is a Pre-Inquest Meeting on 14 August 2008, Adele will attend to observe.

We will continue finalising outstanding evidence and serving on the defence and liaising with the witnesses and the Coroner.

Recommendation: Chase remaining outstanding witness statements and disclose. Liaise with Police to ensure they have made full disclosure.

Listing time estimate: 10 – 12 weeks

Listed: 8 June 2009 **Prospects of Success:** Medium



Field Fisher Waterhouse

Case Report
October 2008

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor and Counsel:	Tamsin Hall/Sarah Ellson/Adele Watson Tom Kark and Ben Fitzgerald
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). In April 2008 we added JS. Counsel has advised that there is not enough evidence to proceed regarding SG, HS and EP.

Investigations: As the Hearing has now been postponed pending the outcome of the Inquest we have informed all relevant parties of this decision.

We will continue finalising outstanding evidence and serving on the defence and liaising with the witnesses and the Coroner.

Professor Black has indicated that he will not be able to get the time off work to assist with the Hearing in June. We are therefore making enquiries of the other experts who have previously assisted the Police and alternative experts recommended by Professor Black.

Recommendation: Chase remaining outstanding witness statements and expert report.

Listing time estimate: 10–12 weeks

Listed: 8 June 2009 **Prospects of Success:** Medium

Field Fisher Waterhouse

Case Report

December 2008

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor and Counsel:	Tamsin Hall/Sarah Ellson/Adele Watson Tom Kark and Ben Fitzgerald
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). In April 2008 we added JS. Counsel has advised that there is not enough evidence to proceed regarding SG, HS and EP.

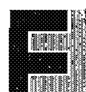
Investigations: Instructions have been sent to Professor Ford in relation to two patients and this will be continued over the next number of weeks to ensure reports are received and disclosed to the defence as quickly as possible.

We have still not been able to speak to Jeffrey Watling despite messages being left with his wife, on his answerphone and further letters being sent to his home address.

Recommendation: To continue sending instructions to Professor Ford. Jeffrey Watling to continue to be chased for outstanding report.

Listing time estimate: 10–12 weeks

Listed: 8 June 2009 **Prospects of Success:** Medium

 Field Fisher Waterhouse

Case Report
January 2009

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor and Counsel:	Sarah Ellson/Adele Watson Tom Kark and Ben Fitzgerald
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). In April 2008 we added JS. Counsel has advised that there is not enough evidence to proceed regarding SG, HS and EP.

Investigations: Instructions have been sent to Professor Ford in relation to five patients and this will be continued over the next number of weeks to ensure reports are received and disclosed to the defence as quickly as possible. We have chased him for his reports and have suggested to Counsel we have a conference once we have some material to consider. We have advised the defence that we plan to use Professor Ford. We have still not been able to speak to Jeffrey Watling (pharmacist) and continue to chase. The Inquest is due to go ahead in relation to 11 patients from 18 March. We have discussed non sitting days in the summer.

Recommendation: To continue sending instructions to Professor Ford. Jeffrey Watling to continue to be chased for outstanding report.

Listing time estimate: 10–12 weeks (LONDON)

Listed: 8 June 2009 **Prospects of Success:** Medium

Dear [ ]

General Medical Council – Dr Barton

I am writing further to your letter dated [ ]/ the telephone conversation on [ ] between [ ].

It may help if I explain that we first received information about Dr Jane Barton in July 2000. The Hampshire Constabulary (the "Police") referred information to us about Dr Barton's treatment of an elderly lady who was a patient at Gosport War Memorial Hospital. At that time, we decided to await the outcome of the ongoing Police investigation before considering the issues further.

In February 2002, the Police referred a further four cases to us. These cases also concerned Dr Barton's treatment of elderly patients at Gosport War Memorial Hospital. We continued to await the outcome of the Police investigation into these additional cases.

Later in 2002, the Police informed us that, in respect of all five cases previously passed to us the Crown Prosecution Service had concluded there was insufficient evidence to provide a realistic prospect of a criminal conviction. The Police also informed us that they would not be conducting any further investigations at that time.

We were then able to resume our own investigations into these five cases. This resulted in a referral to our Preliminary Proceedings Committee (PPC) whose responsibility was to decide whether to refer Dr Barton to a hearing into an allegation of serious professional misconduct. On 29 August 2002, the PPC decided to refer Dr Barton for a hearing by a Fitness to Practise Panel (FtPP).

Then in September 2002 the Police commenced further enquiries into Dr Barton's conduct and treatment of patients at the Gosport War Memorial Hospital. On this occasion, a total of 92 cases were investigated by the Police. During the course of this phase of the Police investigation, a multi-disciplinary team of medical experts (the "Clinical Team") examined patients' medical notes to assess the quality of care provided to each patient. The Clinical Team, using a scoring matrix, filtered each of the 92 cases into one of 3 categories: Category 1 – optimal care, Category 2 – sub-optimal care and Category 3 - negligent care.

The Clinical Team identified 14 cases which fell within Category 3 – negligent care. When the Clinical Team looked in more detail at these 14 cases, they found that the cause of death was entirely natural in 4 cases, even though there was

evidence that these 4 patients did receive negligent care. These 4 cases were released from the Police investigation.

In December 2006, the Crown Prosecution Service concluded that having regard to the overall evidence in relation to the remaining 10 Category 3 cases it could not be proved that Dr Barton was negligent to the required criminal standard. Similarly, in respect of the Category 2 cases, there was evidence of sub-optimal care, however, this was not sufficient to prove to a criminal standard, negligence on the part of Dr Barton. Accordingly, the Police investigation was closed and the Police notified us of this decision.

While this further Police investigation had been ongoing, we awaited its outcome. This was so as to ensure any GMC investigation did not prejudice any criminal prosecution which might have followed.

In early 2007, after the conclusion of the Police investigation, with the assistance of our legal team we carefully considered the information now available. The PPC had referred allegations in respect of five patients; under the statutory Rules if the Solicitor to the Council later adduces grounds for further allegations of similar kind, these can be added to the cases already referred by the PPC. Following initial review of the available evidence, the GMC commissioned an expert to review those cases in Category 3 as these were cases where the Clinical Team had had the most serious concerns. In the light of this expert report, the GMC has taken forward six additional cases from the 10 Category 3 cases. [Two of the five cases referred for hearing in 2002 were also part of the 10 Category 3 cases.]

Also, complaints in relation to two additional patients were brought to our attention in 2007 when the selection process was ongoing. We sought expert opinion in respect of these cases and on the basis of that opinion one of the cases has also been added to the case to be considered by the FtPP.

We had decided the evidential basis of our case of alleged serious professional misconduct before the announcement of the 10 inquests. We awaited the outcome of the inquests in case they revealed evidence, or led to further criminal investigation, such as might impact on the way we could present our case at the FtPP hearing. No such evidence emerged, and it does not appear that any further criminal investigation is contemplated. Our case will involve 8 of the cases for which inquests were held in March/April 2009.

The FTPP hearing is due to take place between 8 June and 21 August 2009 at the GMC's hearing centre in London. The Panel will consider allegations against Dr Barton in respect of her treatment of 12 patients.

Following completion of the hearing we will send you a copy of the Panel's determination.

Instructions to IHLT on IOP Cases

Name of doctor:	Dr Jane Barton
Type of case (new/review):	Review
Date/time of IOP hearing:	3 November 2009 – 10:00
If review hearing, date of initial IOC/IOP Order:	11 July 2008
Date of any previous review hearings:	22 December 2008 1 June 2009
Referral date:	IOP – 30 June 2008 FTPP –
Listing status: (provisional/working listing date?)	FTPP – adjourned 20 August 2009 reconvening 18 January 2009
Has notice of hearing been sent?	Yes for the June 09 hearing
Any significant developments since last IOC/IOP hearing:	Please see item sheet
Do we need to ask the Panel to direct Registrar to apply to High Court for an extension to order?	Yes
Any other specific instructions:	Interim conditions to continue
Name and tel. no of Investigation Officer	Code A

GMC

v

Dr Jane Barton

Advice re:

Code A

Code A

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Code A

Code A

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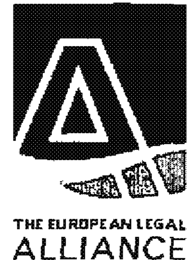
123. There is nothing specific to the care of this patient which justifies criticism of any of the above-named doctors nor is there sufficient evidence upon the basis of which an allegation of impairment could appropriately be made.

124. **Patient L – Jean Stevens.** This patient was admitted to Daedalus Ward on 20th May 1999 and given Oramorph the same day. On the 21st May she was started on a syringe driver and died the following day. There is no evidence that any of the three named consultants had any direct role in this patient's care.

Code A

Code A

FIELD FISHER WATERHOUSE



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

ifficult 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.

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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.

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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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Regulated by the Law Society. A list of the names of the partners of FFW and their professional qualifications is open to inspection at the above office.
The partners are either solicitors or registered foreign lawyers.
The European Legal Alliance is an alliance of independent law firms.

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

GENERAL MEDICAL COUNCIL

-and-

DR JANE BARTON

TRANSCRIPTS

GENERAL MEDICAL COUNCIL

DR BARTON

Index

File 1

1. Transcript Day 2 – Dr Michael Brigg

2. Transcript Day 7 – Margaret Rose Couchman

3. Transcript Day 9 – Philip James Beed

4. Transcript Day 10 – Lynn Joyce Barratt

5. Transcript Day 16 – Dr Richard Reid

File 2

6. Transcript Day 17 – Dr Richard Reid

7. Transcript Day 18:-

   (a) Dr Richard Reid

   (b) Dr Jane Tandy

8. Transcript Day 20 – Professor Gary Ford

9. Transcript Day 21 – Professor Gary Ford

10. Transcript Day 22 – Professor Gary Ford

GENERAL MEDICAL COUNCIL

DR BARTON

Index

File 3

11. Transcript Day 23 – Professor Gary Ford

12. Transcript Day 24 – Professor Gary Ford

13. Transcript Day 16 – Dr Althea Lord

14. Transcript Day 33 – Sister Sheila Joines

15. Transcript Day 34 – Professor Karol Sikora

1

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 9 June 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWO)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T. A Reed & Co Ltd.
Tel No: 01992 465900)

INDEX

MR KARK opened the case on behalf of the General Medical Council (Continued)		1
Submission by MR KARK		14
	MR LANGDALE	16
	MR KARK	19
LEGAL ASSESSOR		20
DECISION		23
Evidence:	LINDA MARION WILES – Statement	25
	DR MICHAEL BRIGG	
	Examined by MR KARK	27
	Cross-examined by MR LANGDALE	35
	Re-examined by MR KARK	41
	Questioned by THE PANEL	42
	Further re-examined by MR KARK	47

A THE CHAIRMAN: Good morning everybody. Mr Kark?

MR KARK: I was about to move on to deal with Patient G, who is Arthur Cunningham. Arthur Cunningham was 79 years old when he was admitted to the hospital, to Dryad Ward, on Monday 21st September 1998 under the care of Dr Lord, the consultant to whom he was known. He had been admitted to the psychiatric ward, Mulberry Ward, some months earlier, on 21st July 1998, when he was depressed and tearful, and since 27th August that year he had

B been living in a local nursing home known as 'The Thalassa'.

He had been seen at the Dolphin Day Care Hospital by Nurse Pamela Gell, where he was found to be very frail, with a large necrotic sacral sore. He was depressed, he suffered from dementia and he was diabetic. Dr Lord decided that he should be admitted to Dryad Ward for treatment of his sacral ulcer, and she wrote on the day before his admission – and in due course when you have these notes you will find it at page 644 – she wrote that he was to be

C admitted to Dryad Ward for treatment of his sacral ulcer; he was to be given a high protein diet, and Oramorph if he was in pain. Dr Lord notes that the nursing home was to keep his bed available for him to return for at least three weeks, but his prognosis was described as being 'poor'.

The day after that note, Dr Barton saw him on the day of his admission, on 21 September, and she made the following note:

D

"Transfer to Dryad Ward. Make comfortable, give adequate analgesia. I am happy for nursing staff to confirm death."

It appears that she prescribed Oramorph 2.5 to 10 mg as required, and diamorphine at a variable dose of between 20 mg and 200 mg, and midazolam between 20mg to 200 mg, and she wrote out that prescription, it would appear, on that very day, even though in fact the

E prescription was undated. Really, it seems, as soon as he arrived at Dryad Ward, or soon thereafter, he was given Oramorph 5 mg at 2.15 in the afternoon, and then 10 mg at 8.15 in the evening.

I say that the prescription was undated, but it has to be presumed to be the 21st because he was in fact also put onto a syringe driver on that same day, at ten minutes past eleven that night, to deliver opiates to him automatically.

F

Dr Barton's explanation for her prescription, to the police, was that she was concerned that the Oramorph might become inadequate in terms of pain relief.

The patient's stepson Charles Stewart-Farthing went to see him on the Monday of his admission, so before the syringe driver had started, and he found him to be cheerful but complaining that "his behind was a bit sore". The patient was started on a syringe driver that

G night at a rate of 20 mg diamorphine and 20 mg midazolam; and according to Nurse Lloyd's notes the other drugs he had been on, co-proxamol and senna, were not given because the patient was being or about to be sedated. The notes reveal that the patient remained agitated until approximately 8.30 in the evening, and they also reveal, frankly, that the patient had been behaving pretty offensively. However, the driver was not commenced, as I say, until ten past eleven that night, and by that time, before the driver was commenced, the patient was described as 'peaceful'. That may well have been as a result of the Oramorph kicking in, as it

H were. So it is hard to glean, at least from the notes what caused the commencement of the

A syringe driver. Nurse Lloyd states that although the patient was peaceful, it was not certain that he would remain that way.

Two days later, on Wednesday 23rd , the medication was increased to 20 mg diamorphine but 60 mg midazolam. A note made by Nurse Hallman records that he was seen by Dr Barton on the 23rd, he had been chesty overnight, and so hyoscine was added to the driver. That note is at page 868 of the records.

B

His stepson, Charles Stewart-Farthing, was informed of a deterioration and he asked if it was due to the commencement of the driver. He was informed that the patient was on a small dosage, which he needed. Charles Stewart Farthing saw his step-father again that day, two days after he had last seen him, when he described him as being cheerful but complaining that his behind was a bit sore, and when he saw him, now on the Wednesday, he found his step-father to be unconscious, and he was shocked by the difference in his condition. He was

C so concerned that he asked for the syringe driver to be stopped so that at least he could have a conversation with his stepfather, but this was denied.

He insisted, apparently, on a meeting with Dr Barton, who informed him that the patient was dying due to his bedsores and that it was too late to interrupt the administration of the drugs. Dr Barton says that she reassessed the patient on a daily basis; but if she did, she failed to make any notes about it, and she refers in her police statement to the doses the patient

D received as "small and necessary".

On the following day, Thursday 24th, the midazolam was increased to 80 mg, and on the following day after that, the 25th, the diamorphine was increased to 60 mg. That followed a further prescription from Dr Barton dated Friday 25th now for a variable dose between 40 mg to 200 mg diamorphine and 20 mg to 200 mg of midazolam, so the lowest dose of the diamorphine had gone up.

E

On each occasion that the dose was increased, Dr Barton claims in her police statement that she "anticipates that the patient's agitation might have been increasing".

The following day, Saturday 26th, the diamorphine was delivered to the patient's body at a rate of 80 mg, and the midazolam at a rate of 100 mg. That of course was well within the variable dose that Dr Barton had prescribed. The patient died at 11.15 that night apparently,

F according to the death certificate, of bronchopneumoniA

The first prescriptions on the day of his admission written out by Dr Barton are described by Professor Ford as "highly inappropriate" and "reckless", particularly in light of Dr Lord's assessment, as you will recall, from Haslar, that he should be prescribed intermittent Oramorph if in pain. There is no doubt that the patient would have been in pain from his sacral sore, but there was no indication prior to him getting to the GWMH that the patient

G have been unable to take any medication. The prescription written by Dr Barton which allowed the nurses to administer the diamorphine and midazolam was undated but, as I say, it must have been written on the day of admission because it was administered that night, and was for a dose range of between 20 mg to 200 mg diamorphine, and 20mg to 80 mg midazolam. It was, according to Professor Ford, poor management to prescribe those drugs to an elderly frail underweight patient – I think the patient at this time weighed about 68 kg – and it created the hazard that the combination of drugs could result in profound respiratory

H

A depression. You will recall the guidance, or course, in the *BNF* about reducing the dosage for elderly patients.

The increases on the 23rd and thereafter are described as inappropriate and dangerous by Professor Ford. He also expresses the concern as to whether the nursing staff would have understood how long it takes for the opiates delivered through a syringe driver to take full effect, which in this case would have been between 15 and 25 hours. So it appears, in fact, in

B the records that they were being increased before they would have the full effect in the original dose.

As his condition worsened, in all likelihood, we submit, as a result of the drugs which were being administered to him, there was apparently no assessment to discover the cause – or at least none that was recorded. Dr Barton admits that she did not seek advice from a consultant, as she could, and we say should, have done.

C

The various dose increases without explanation is described as very poor practice. Even if that was being done independently by the nurses, Dr Barton, we say, had created the situation where that had become a possibility.

The administration of 100 mg midazolam and 80 mg diamorphine would produce respiratory depression and severe depression of the consciousness level.

D

In addition to all of this there is no note that the patient was provided with food or fluid during the period following his admission until his death five days later, and that is despite the note from Dr Lord that the patient was to be provided with a high protein diet. The very opposite seems to have occurred.

The cause of death, given as bronchopneumonia, can occur as a secondary complication to

E opiate-induced respiratory depression.

Let me turn to Patient H, better known as Robert Wilson.

Robert Wilson was 75 years old when he was admitted to Queen Alexandra Hospital on 21 September 1998. He had sustained a fracture of his humerus bone following a fall. Whilst at the Queen Alexandra Hospital he was given relatively small doses of morphine for pain.

F On assessment his Barthel score was 5.

On 7 October it was noted that he did not want to go into care but wanted to return home. He was seen by a Dr Luznat, who was a consultant in old age psychiatry. She noted that he had been a heavy drinker during the previous five years, and she thought he may have developed early dementia.

G The following week, on 13th October, which was a Tuesday, he was assessed by his consultant physician at the Queen Alexandra Hospital, Dr Ravindrane, who found that he needed both nursing and medical care, and that a short spell in a long-term NHS hospital would be appropriate. Dr Ravindrane felt that he would remain at risk of falling until fully mobilised and he thought that the patient's kidney function should be reviewed. He prescribed his patient frusemide, which is a diuretic, and for pain relief he prescribed paracetamol. The patient could, according to the doctor, have stabilised or alternatively he

H could have died quite quickly.

A

The patient was visited on the day of that assessment, 13 October, by his son Iain Wilson, who remembers him on the day before his transfer to the Gosport War Memorial Hospital sitting up in bed and having a joke. On his discharge from the Queen Alexandra Hospital he was taking paracetamol and codeine as required for pain, but he had only required four doses of codeine over the five days prior to his transfer. He was a heavy man, weighing some 93 kg.

B

On Wednesday 14 October, the day after his assessment by Dr Ravindrane, he was transferred to Dryad Ward for continuing care. Dr Barton noted on his admission that he needed help with his daily living activities, his Barthel score was 7, and he lived normally with his wife. He was continent, and the plan was for further mobilisation. She also noted – and this may be significant – that he had alcohol problems. He also had congestive cardiac failure.

C

Professor Ford has noted that there was no record of any symptomatic medical problem at that time. His blood pressure was not taken, nor was there any clinical examination. It is important to note in respect of this patient that he was not admitted for palliative care but for rehabilitation.

His wife, Gillian Kimbley, saw him on the day of his transfer to GWMH, and indeed

D

travelled with him in a minibus which was used for that transfer. She remembers him being lucid that day and being able to hold a conversation.

The nursing note at GWMH on the day of admission recorded that the patient had a long history of drinking and LVF – which is left ventricle failure – and chronic oedematous legs.

On the day of his admission into the GWMH Dr Barton prescribed him Oramorph 10 mg in

E

5 mils, 2.5-5 ml, four–hourly despite the fact that in the days leading up to his transfer he had only been on codeine for pain relief. That prescription for Oramorph was administered twice that day, once in the afternoon at 1445 and again in the evening at a quarter to eleven at night.

The following day, the 15th, he was administered 10 mg every four hours. That was given, according to the nursing notes, because he was complaining of pain in his left arm. Up until the stage of his admission to GWMH his pain had been controlled by codeine and

F

paracetamol, and Professor Ford regards that very first prescription of morphine at that stage to have been inappropriate. His son Iain saw him that day, the 15th, and describes how his father was in "an almost paralysed state".

On Friday 16th the patient was seen by Dr Knapman, who noted that the patient had deteriorated overnight, and he was for active nursing care. His son Iain describes him as being almost in a coma and unable to speak.

G

Later on the 16th, on the Friday – so this is just two days after his admission – it was noted by Nurse Hallman that his chest was very bubbly, and a syringe driver was commenced with 20 mg diamorphine and 400 mcg hyoscine. That was on the basis of a prescription written by Dr Barton which may have been written, according to Dr Barton, on the day of admission. That prescription was for a variable dose of diamorphine, between 20 and 200 mg over a 24-hour period – almost, you may think, the standard dose for Dr Barton. That was,

H

according to her police statement, one of her 'proactive' prescriptions for pain relief.

A

There appears to have been no re-examination by Dr Barton prior to that prescription being administered by the nurses. Indeed, from her police statement it appears that Dr Barton was actually away on the day that the syringe driver was started.

It is quite possible, according to Professor Ford, that the morphine the patient had been receiving via Oramorph that was the cause of his deterioration.

B

The following day was a Saturday, the 17th. His secretions had increased and the hyoscine was increased to deal with them. In the afternoon the dosage of diamorphine was increased to 40 mg, and midazolam was started at 20 mg.

The date of Dr Barton's prescription for midazolam at a variable dose between 20 mg and 80 mg is unclear but it must have been obviously on or before the 17th, the date it was

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administered. There was no record made of the reason for starting the midazolam, and at the time the notes suggest that the patient was in fact, as it is put, "comfortable". Professor Ford views the use of midazolam in these circumstances, together with the diamorphine, to have been highly inappropriate.

No consideration appears to have been given by Dr Barton or by the nursing staff to the real possibility that the reason for the patient's deterioration may well have been the infusion of

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the cocktail of opiates which he was receiving automatically through a syringe driver. The prescription of continuous subcutaneous diamorphine is not an appropriate treatment for a diagnosis of myocardial infarction and heart failure in a patient who is otherwise pain-free.

A particular issue with this patient is one that I have mentioned, and I will come back to, which was his previous chronic alcoholism, which had been noted by staff and appears to have been known to Dr Barton.

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The use of opioids in patients with liver disease as a result of alcoholism has to be very carefully monitored, and preferably not used unless required to deal with severe pain. If he was in severe pain, then a low dose of morphine would have been a more appropriate response.

On the night of Saturday 17th and into the morning of the 18th, that dosage was continued but

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in the afternoon of the Sunday it was increased again, from 40 mg to 60 mg diamorphine and from 20 mg to 40 mg of midazolam. During none of this period was there any note made by either nurses or doctors that the patient was in pain, though there were many notes that the patient was deteriorating.

At 20 to 12 on Sunday night, the 18th, the patient's death was recorded. That was four days after he had entered that ward at Gosport War Memorial Hospital. It was recorded that he

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had died from congestive heart failure. Professor Ford is of the view that the cocktail of drugs is highly likely to have led to respiratory depression and/or bronchopneumoniA

Patient I, better known as Enid Spurgin – Enid Spurgin was 92 when she was admitted to the Royal Haslar Hospital on 19 March 1999, following a fall in which she had broken her hip. Prior to her fall, she had been living at home and caring for herself. According to her medical notes, she had been active and in good health. The fracture was described by an orthopaedic

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A surgeon called Daniel Redfearn, who has examined her notes – he did not treat her but he has looked at this case post these events – as a "relatively complicated" case.

At the Haslar she had initially been given three doses of 5 mg morphine over 20 and 21 March; so in the two days immediately following her fracture. That morphine had resulted in hallucinations; so she plainly had an adverse reaction to morphine – and that is not an uncommon side effect, apparently. A note was therefore made by the anaesthetist, "nil

B further opiates". She was operated upon on the 20th, when a right dynamic hip screw was inserted. The only other analgesic prescribed for her, apart from the morphine, which was stopped on the second day, was paracetamol.

She appears to have had post-operative complications by way of bleeding, and a haematoma developed and she had a painful hip. Dr Reid reviewed her on 23 March and noted that she was still in a lot of pain and that was proving a barrier to mobilisation.

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She was transferred three days later, on Friday 26 March, to Dryad Ward at the Gosport War Memorial Hospital. However, prior to her transfer, when she was still at the Royal Haslar, she had become mobile. She was walking short distances with a zimmer frame and with the assistance of two nurses. She was continent, but not at night, and her only analgesia when she was discharged from the Royal Haslar was paracetamol.

D Dr Barton made a note on her admission, at page 27 of the notes when you get them – "Past medical history, nil of significance; Barthel", and then there is no score; "Not weight-bearing; tissue paper skin; not continent; plan, sort out analgesia". Dr Barton prescribed her Oramorph on the day of her admission – 10mg in 5 ml, 2.5 mg four times a day.

A note by a nurse asserts that the patient had complained of a lot of pain, and oral morphine was administered on 26, 27 and 28 March, and then discontinued because the patient was

E vomiting it. That, you may think, was consistent with her reaction at the Royal Haslar Hospital. She was given co-dydramol as an alternative.

On the 27th, although it was a Saturday, Dr Barton believes that she reassessed the patient, although, if she did, we cannot find a note of that. On the 27th she had increased the Oramorph from 10 ml four times a day to 20 ml four times a day. As I say, the care plan also records that the patient was experiencing pain on movement.

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If pain was uncontrolled by less powerful analgesics, then those prescriptions were appropriate, according to Professor Ford. However, there is no note, as I have said, from Dr Barton recording her assessment or her reason for prescribing as she did. And the patient should not have been in severe pain unless something had gone wrong with the hip repair, which should then have required reassessment.

G The fact that Dr Barton has recorded that the patient was not weight-bearing is not consistent with the notes at the Royal Haslar, and is either inaccurate or indicates that there had been a change in the patient's mobility. That in itself should have triggered a reassessment. A nursing note some days later, on 4 April, records that the wound was oozing serous fluid and blood, and the wound was redressed.

Going back to 31 March, Dr Barton had then prescribed, to replace the Oramorph, 10 mg of

H morphine sulphate to be given twice a day. A week later she was seen by Dr Reid, and he

A suggested that there may have been a problem with the hip screw and said it may be that that was causing the patient's problems. He requested that an X-ray be arranged. Unfortunately that was never actioned.

That day, 6 April, Dr Barton increased the dose of morphine by slow release tablets to 20 mg twice daily. In her police statement she reveals that she would have seen the patient that morning but made no note about it. The review by Dr Reid, therefore, was the first noted B review since that patient's admission on 26 March, 11 days before.

A note by Nurse Shaw of the consultation with Dr Barton reveals that Enid had been incontinent a few times but was insistent about not going into a care home. There was in that note in fact no mention of pain. The prescription issued by Dr Barton for slow-release tables on 6 April was administered until 11 April, which was the Sunday. On the Sunday, the patient was described as being very drowsy but still in pain if moved. She was by then, of C course, effectively on 40 mg of morphine per day.

The following Monday, the 12th, Dr Barton prescribed diamorphine by syringe driver at a variable dose between, as usual, 20 mg to 200 mg over a 24-hour period, as well as 20 mg to 80 mg of midazolam, and there is no note of any further assessment by her.

Those prescriptions are described by Professor Ford as "reckless and inappropriate". The D patient was already described as "very drowsy" and any dose over about 30 mg subcutaneously would be highly likely to produce coma and respiratory depression.

In fact the dose administered by Nurse Shaw, either because of her own calculation or under Dr Barton's direction – we do not know – on 12 April, was 80 mg of diamorphine and 30 mg of midazolam. Those doses that were administered were well within the variable dose that Dr Barton had prescribed, but in fact were much higher than the dose of morphine that the E patient was already receiving and extremely dangerous. The equivalent subcutaneous dose would have been 20 mg of diamorphine, without the midazolam. Nurse Lynne Barrett could not explain why the patient was administered such a large dose and she in fact thought that the dose was only 60 mgs when she was asked about this.

When Dr Reid noticed that the patient was receiving such a high dose of diamorphine, 80 mg, he reduced it. He cut it in half, down to 40 mg, but in fact the patient died the following day. F In Professor Ford's view, the drugs that she was being administered were in fact a direct contributor to this patient's death.

Mr Redfearn, the orthopaedic expert, raises concerns in relation to the lack of response to the patient's pain, which should have prompted the doctors to look for a possible orthopaedic explanation for her symptoms, instead of simply prescribing her ever-increasing amounts of analgesiA No review of that sort was ever done.

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The charges on this occasion therefore reflect specifically the lack of assessment by Dr Barton, given the patient's condition on entry onto the ward. Criticism is also made of her prescription on the 12th and the direction to administer such a high dose on the same day.

I am moving on now to Geoffrey Packman, who is Patient J. Geoffrey Packman was born in Code A and so he was 67 years old when admitted to Dryad Ward on 23 August 1999. He was H very obese; he was suffering in both of his legs from oedema, in other words swelling. He

A also suffered from venous hypertension, atrial fibrillation, and he had poor mobility. He had a low Barthel score and, frankly, he was not a well man.

How he had got to Dryad Ward was because some weeks earlier he had suffered an accident in his bathroom at home. It had taken two ambulance crews to get him out of his bathroom and he was admitted Anne Ward at the Queen Alexandra Hospital on 6 August. On 8 August it was noted that he had very severe sores on his sacral area and the annotation was made in B his notes on two occasions, "not for 555". That apparently meant that he was not to be given resuscitation in the event of a life-threatening event. Eventually, however, according to his wife Betty, he in fact made a good recovery in hospital and he looked better than he had for years.

He was, on 23 August, transferred to Dryad Ward for recuperation and rehabilitation. When he was assessed on Dryad Ward by Dr Ravindrane, the problems recorded were obesity, C arthritis in both knees, pressure sores. His mental test score, however, was good, there being no significant cognitive impairment. His Barthel score was at 6, but Nurse Hallman remembers this patient as having the worst pressure sores she had ever seen.

Dr Barton believes, according to her police statement about this patient, that she must have reviewed him on the morning of the following day, Tuesday 24th, but made no note about it. On 24 August, a drug called Clexane was prescribed, which he received to reduce the risk of D a DVT, as well as temazepam. That Clexane may in fact have caused quite severe problems later on; in particular, a gastrointestinal bleed, from which the patient was to suffer. The following day, on 25 August, he was found to be vomiting and passing fresh blood through his rectum. Again, there is no note of any review by Dr Barton, though she thinks she performed one. Because of the symptom of passing fresh blood through his rectum, Dr Beasley was contacted and directed that Clexane, which was an anti-clotting agent, should be stopped.

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His wife Betty recalls visiting him with friends on or about the 25th or 26th – so the Wednesday or Thursday after his admission on the Monday – and she met Dr Barton for the first time. According to her, Dr Barton took her into a room and told her bluntly that her husband was going to die and that she should look to herself now. Betty was very shocked and surprised.

F On 26 August, Dr Barton made this note: "Called to see. Pale, clammy, unwell. Suggests ?MI" – which I take to be myocardial infarction. "Treat stat diamorph and Oramorph overnight. Alternative possibility GI" – gastrointestinal – "bleed but no haematemesis", which I think is vomiting of blood. "Not well enough to transfer to an acute unit, keep comfortable. I am happy for nursing staff to confirm death". There was no note of pulse, blood pressure, or any other indication of a clinical examination. However, on that day, Thursday 26th, Dr Barton appears to have given a verbal order to give diamorphine G intramuscularly, which was injected that day. She also prescribed Oramorph, 10 mg in 5 ml four times a day, which was administered daily thereafter from the 27th until the syringe driver was commenced three days later, on the 30th. The syringe driver was therefore effectively commenced seven days after his admission.

There is also an undated prescription written by Dr Barton for a variable dose of diamorphine of between 40 mg and 200 mg and midazolam, 20 mg to 80 mg. She said in her police

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A statement that she wrote that prescription out on the 26th and we accept that may well be right; but she says that she had no intention that it should be administered at that time.

The following day after the prescription on the 26th, on the 27th, the patient is noted to be in discomfort, particularly when his dressings were changed. Dr Barton claims that she would have reviewed him, but made no note of it. The syringe driver was commenced on Monday 30 August, which was a bank holiday. It was commenced at the rate of diamorphine 40 mg B and midazolam 20 mg. There is no note from Dr Barton about that and she is not sure if she would have been there, because it was a bank holiday. It therefore seems that the syringe driver may have been started at the discretion of the nurses, and the amount of opiate to be administered was within the range set by Dr Barton and indeed at the lowest dose for diamorphine, because her lowest dose was 40 mg. Dr Barton believes the nurses would have spoken to her before starting it, but there is no note of that recorded.

C Those same doses were administered on Tuesday 31 August, when it was also noted that he had passed a large amount of black faeces, which was an indication of a significant gastrointestinal bleed. The following day, Wednesday 1 September, the diamorphine was increased to 60 mg and the midazolam to 40 mg and then, later the same day, up to 60 mgs; then the following day there were increases again.

On 1 September, Betty visited him and he did not wake up throughout the visit. Geoffrey's D daughter Victoria remembers that her dad deteriorated once he was in the GWMH and that he appeared to be "spaced out". She describes the change as "dramatic". On Thursday, 2 September, diamorphine was increased to 90mg and the midazolam was increased to 80 mg in 24-hour period.

Jeanette Florio, who was a nurse, said that she could not imagine such an increase taking place without the authority of a doctor. Dr Barton says that she would have reviewed the E patient, but made no note about it. She said this in her police statement: "I anticipate again that (the patient) would have been experiencing pain and distress." If that is so, you may think it is very surprising that no note was made about it. The patient's daughter, Victoria, sat in throughout the second and he was unconscious throughout the day. On Friday, 3 September, at ten to two in the afternoon, eleven days after admission to the ward, the patient died.

F In Professor Ford's opinion, the patient's death from a massive gastrointestinal bleed was contributed to by the Clexane he was prescribed, but it was stopped the following day, and it was also contributed to, in his view, possibly by the opiate induced respiratory depression. It is important to note that this patient was not dying, nor expected to die, prior to his deterioration on Dryad Ward from 26 August. He had pressure sores, but those were treatable and he has been transferred or recuperation and rehabilitation. Before deciding that the patient should not be transferred to an acute unit, which Dr Barton did on the 26th, she G should have had further discussion with a senior consultant colleague. That is reflected by the charge which has been admitted.

Her assessment of the patient was, according to Professor Ford, inadequate. Her verbal order to administer diamorphine was inappropriate. There was never Panel order to administer diamorphine, inappropriate. There was no proper explanation for the doses of subcutaneous diamorphine or midazolam. There is no explanation for the dramatic increase in the

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A quantities of those drugs being administered and the dose ranges were inappropriate and hazardous and unjustified by the assessment of the patient's condition.

MR LANGDALE: Sir, may I rise to make one thing clear? I do not think my learned friend meant to put it in quite the way he did. It might have been thought that he was suggested it was admitted that Dr Barton should have consulted a colleague. That is not the way it is put in the charge. It is admitted that she did not; not that she should have. I understand why my
B learned friend put it that way, but I want to make it clear that the admission does not mean an acceptance by us that she should have, in those circumstances.

MR KARK: Can I move to Patient K, better known as Elsie Devine. Elsie Devine was an 88-year-old lady when she was admitted on 9 October 1999 to the Queen Alexandra hospital with an episode of acute confusion. Her problems are summarised by the letter, by Dr Taylor, who is a clinical assistant in old age psychiatry, which you will find at page 29 of
C your bundle. She is described as being confused, disoriented and sometimes aggressive. She had a medical history of treated hyperthyroidism and chronic renal failure. She was independent and was able to wash, but she did tend to her herself lost.

She was transferred from the Queen Alexandra Hospital on Thursday 21 October 1999. There was a referral date, which you will find at page 21, written by Dr Jay, a consultant geriatrician, who had seen her two days earlier and stated that she was alert and could stand,
D but was unsteady on walking. She was increasingly confused and had been aggressive until she got to know the staff.

Dr Barton's note on admission on Thursday 21st stated that she was for continuing care. She needed help with all her daily living needs, but she had a Barthel score of 8. The plan is described as "plan get to know. Assess rehabilitation potential possibly for a rest home in due course."

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On 25 October and 1 November there are further entries by Dr Reid, indicating that the patient was continent, but mildly confused and wandering during the day. She was suffering from renal failure, but was still physically independent, although she needed help in bathing.

Two weeks later, on Monday 15 November, there is a note that she had been aggressive on the ward. She had needed an injection of a drug called Thioridazine to calm her down.
F Lynne Barrett was one of the nurses who helped look after her and she recalls the specific aggressive incident when the patient had grabbed a nurse, would not let go and kicked out at Miss Barrett. Dr Reid saw her on his ward round that day, but that was the last time he saw her. He noted that there was not a single entry on her clinical notes since the last time he had seen her two weeks before. He made a full examination of her. Her heart, chest, bowels and liver were all normal, but her legs were badly swollen. He wanted the patient to be seen by Dr Luznat the psychiatrist, and he made a note to that effect.

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Three days later on Thursday 18 November, the patient was seen by Dr Taylor who was one of Dr Luznat's team. Arrangements were being made to transfer her to an old age psychiatric ward, presumably Mulberry, for assessment and management. However, that same day, when she was seen by Dr Taylor, who was making those arrangements, she was described as confused and aggressive and Dr Barton prescribed a Fentanyl patch for the patient. As I have explained, Fentanyl is an opiate which is applied in this case to the skin by patch. There was
H no indication in the notes as to why Dr Barton thought it appropriate to start the patient on

A opiates. There is no reference anywhere in the notes to this patient being in pain. Dr Barton in her statement to police about the patient stated that the patch was "an attempt to calm her, to make her more comfortable and to enable nursing care."

B The timing may be of some significance. The patch was apparently applied on the 18th at 09.15 in the morning. Those patches can take up to 24 hours to become fully effective, and they remain in the system – the effect of the drugs remain in the system – for between 12 and 24 hours after the patch has been removed.

A note made by Dr Barton the following day on Friday 19th indicates there had been a marked deterioration overnight, the patch of course having been applied 24 hours earlier. Dr Barton wrote on the 19th: "Today further deterioration in general condition. Needs SC [subcut or subcutaneous] analgesia with midazolam. Son aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death."

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Dr Barton prescribed that day diamorphine at a rate of between 40mg to 80mg and midazolam between 40mg to 80mg. In addition, at 8.30 on the 19th, the patient was given injection of Chlorpromazine, 50 mg, prescribed by Dr Barton following an incident in which the patient is suggested to have been aggressive with nurses. Chlorpromazine is a tranquilliser and 50mg is, according to Dr Reid, at the upper end of the normal range of the dose. An hour later a syringe driver was started by the nurses that day, Friday, at 9.25 in the

D morning. It contained, as Dr Barton prescribed at the lowest dose, 40mg of diamorphine and 40mg of midazolam. The fentanyl patch was still on the patient, and it seems it was not removed until about three hours later at about 12.30, according to the notes. There is no record anywhere in the notes that the patient was at any time in pain. At this stage, therefore, on this Friday morning, this patient had in her system Fentanyl, Chlorpromazine, diamorphine and midazolam.

E It is very difficulty to understand why anyone would have thought it appropriate to start this patient on anything less than the minimum dose of midazolam, even if the patient was complaining of pain, which she was not.

The syringe driver was kept replenished for the next two days at those dosages. Dr Barton wrote in her police statement: "This medication (diamorphine and midazolam) was prescribed at 09.25 and was administered with the sole intention of relieving the patient's

F significant distress, anxiety and agitation which were clearly very upsetting for her." Dr Barton again says that she had been making daily weekday reviews of this patient, but accepts that she failed to make a note of any of them, and that she greatly relied on daily reports from the nurses in charge and their nursing note entries. The patient died two days later on Sunday 21 December.

Dealing with the diamorphine and midazolam prescription on the 19th, Professor Ford can

G see no justification for it. Even if the patient had been in pain, for which there is no evidence, the starting doses were excessively high. An appropriate starting dose might have been 10 or 20mg, if the patient was in pain, but not double that and not when coupled with Midazolam. Neither, in Professor Ford's view was the Fentanyl justified. This regime of opiate medication has, according to him, every appearance of being given to keep the patient quiet, which would not be an appropriate use of opiates in this setting. In his view, the drugs administered are very likely to have led to respiratory depression and coma.

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A Patient L is Jean Stevens. Mrs Stevens was 73 years old when admitted to the Royal Haslar Hospital on 26 April 1999, after experiencing chest pains and collapsing. She was found to have suffered a stroke, as a result of a cerebral infarction. She was looked after for several weeks, but she did make a substantial recovery.

On Thursday 20 May – so about a month after her stroke – she was transferred to Daedalus Ward but she was, according to records, in a very poorly condition. She died two days later.
B The criticism by the GMC of Dr Barton's care of this patient hinges around her immediate prescription upon entry on to the ward on the 20th of Oramorphine, diamorphine and midazolam, in the usual variable ranges. This is not a case, the GMC accepts, where this particular unfortunate patient was likely to recover or leave hospital. The only note by Dr Barton was on 20th, on the day of her admission, 20 May. The second note was made by nurse Tubritt, which recovered her death on the 22nd. There was a recorded conversation with her husband on the 21st, noting that he was anxious that medication should not be given
C which might shorten her life.

On the day after her admission a syringe driver was started with 20mg diamorphine and 20mg of midazolam. Dr Barton's entry makes no mention of the patient being in pain and contains no record of any physical examination of the patient. In Professor Ford's expert opinion, there is no evidence that Dr Barton undertook a clinical assessment of the patient, although it is right to say that the patient had previously complained of chronology abdominal
D pain, but treatment, in his view, with opiates would not have been appropriate at that time. In addition, he says, the doses were again far too wide and the dose of midazolam particularly excessively high.

As already indicated, Professor Ford is critical of the quality of Dr Barton's note-making. She failed to note assessments of the patient's condition, if she was making them, she failed to make notes about important decisions relating to treatment and prescribing. She made few,
E if any, notes about why she regularly increased the dosages of her prescriptions. The GMC submit that failing to make appropriate notes in relation to assessments on admission to hospital is particularly serious, because it leaves other treating medical personnel in the dark about what the baseline condition of the patient was upon admission. It left her, Dr Barton, with no notes that she could rely upon to assess properly whether the patient's condition had improved or worsened. In view of the complete lack of notes, it has to be inferred, we would submit, that no assessments were being properly performed before opiates were prescribed.
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The reality in this case, as you will have gleaned from this opening, is that the prescription of very large doses of opiates appears to have become a matter of course at the Gosport War Memorial Hospital for the patients under Dr Barton's care. It is our submission that the patients' best interests were not being served. The prescribing by Dr Barton was, on occasion, we say dangerous, inappropriate and left far too much to the discretion of the nurses, however experienced they were. Patients were overdosed with opiates, so much that
G they became unresponsive.

That is all I say about the background facts to this case. As you will appreciate, this is an old case. So for that reason, we are working under the old rules, which means also the burden of proving the charge is, as usual, upon the General Medical Council, but that the standard of proof in this case is the criminal standard. In other words, before finding any of the heads of charge which have not been admitted proved, the Panel would have to be sure that Dr Barton
H had acted in the way alleged.

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I have given you already the witness schedules, so you know what is planned for those. What we are doing at the moment is working backstage, both last night and this morning, to try and improve on the quality of the notes in the bundles. As you will have seen in Bundle A, the notes are very poor. I can only say that we have been trying for a long time to get the original notes, both from the police and the Trust. Those turned up on Friday of last week, and some more I think are due today. So it is not through lack of effort, as it were, to try and get these things sorted out. We do, however, have a set of notes for Patient A. We have the same pages as you have in your copies, but they are larger and better copies. We will hand those out, if we may. They have been repaginated. We invite you to get rid of the old pages and perform the replacement exercise yourself. We are happy to do it, but you may have marked the notes and it would be inappropriate for us to see those. It may take a little while to do it, and apologies for that.

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We then need to address you in relation to Professor Ford's reports. Both sides have prepared skeleton arguments, and it may be useful if you were to read those skeleton arguments in advance of hearing our various submissions about whether you should or should not receive Professor Ford's reports, and that might be an appropriate moment for a short break.

THE CHAIRMAN: Are we going to do the bundle work prior to the ---

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MR KARK: Yes.

THE CHAIRMAN: How long do you anticipate that will take?

MR KARK: They are being brought in right now. I would have thought it would take you five or ten minutes or so to do it.

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THE CHAIRMAN: Perhaps we will do that before the break, then, and we could perhaps take with us the skeleton arguments and incorporate that into the break so that you have a longer period, rather than us coming backwards and forwards.

MR KARK: Yes. (Documents handed)

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I am sure I do not need to talk you through it. The pages are paginated at the bottom, and they simply replace the pages which I hope you have.

THE CHAIRMAN: They are very much clearer; that is excellent.

MR KARK: We will also hand in our skeletons, then can we leave the room to you?

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THE CHAIRMAN: Once we have the skeletons, you are absolutely free to go. How many pages are the skeletons running to, Mr Kark?

MR KARK: Not very many. Mine is four, and I think Mr Langdale's is rather shorter.

THE CHAIRMAN: Let us say we will resume at ten past eleven, please.

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A MR LANGDALE: May I say that when you receive the skeleton argument on behalf of Dr Barton, there is a typo on the second page. It will be apparent – the third line, it says "... unusual for a GMC Panel to receive an expert's" – and the word "report" has been left out, I am afraid. The reading will make it obvious, I think.

THE CHAIRMAN: Thank you, Mr Langdale.

B (The Panel adjourned for a short time)

THE CHAIRMAN: Mr Kark, Mr Langdale, we have updated our bundles, and we have all read the skeleton arguments.

MR KARK: Thank you very much. Sir, this is our application, so perhaps I should start. I can be very short, because you have seen the reasons why we want to put Professor Ford's
C reports in. Can I just show you what physically that would mean; it is not a lever arch file but it is a fairly full ring binder. What Professor Ford has done is that first of all he made a report to the Hampshire Constabulary back in 2001, and those reports were in relation to five of our patients. He then wrote what I have referred to as a generic report, which is a general introduction to the analgesic ladder and opiate medication, and an explanation of the various drugs which are mentioned in this case and their inter-reactions. Then he has dealt afresh with each of our 12 patients, setting out briefly their history of events, the medication that
D was prescribed to them once they were on Dryad ward, when it was prescribed and when it was administered, and the effect of that administration, and his criticisms. So that is what we are encouraging you to receive.

There is no specific rule that we are aware of either that says that you cannot receive it or that says you can receive it. It is a matter for you, of course, to control your own process. We are not trying to circumvent anything or go behind anything by doing this. Obviously in due
E course you will hear from Professor Ford. If, as a result of evidence during the case, Professor Ford has changed his opinion, you will be in a good position to appreciate that.

Can I deal with the defence skeleton argument briefly. Specific criticism is made by Mr Langdale and Mr Jenkins in the fifth paragraph that Professor Ford's reports which we are encouraging you to receive are based upon various documents which include medical and nursing records, but also statements taken by police officers. Then they say:

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> "Many of the witnesses, from whom statements were taken by the police, had concerns as to the accuracy and completeness of those statements. Many nurses, due to give evidence at this hearing, gave evidence at the inquest hearing ... Their evidence differed ... from the contents of their statements ... It will be obvious that there is a serious risk of prejudice if the panel were to see the reports from Professor Ford based upon partial and inaccurate statements taken by police officers."

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As a result of that criticism I have reviewed Professor Ford's reports this morning. What Professor Ford in fact has done is he has relied – although it is right to say that he has received certain statements, in producing his reports he has actually relied, as far as I can see, and I will be corrected if I am wrong, entirely on the records, which are not challenged. He has relied on the records, and he has relied on the referral letters – in other words everything contained within the patients' medical files. Again I will be corrected if I am wrong, but

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I have not seen a single comment upon, for instance, a nurse's statement or a patient's statement; that is not how he has done his reports at all.

So we would submit first of all that although he may have had other statements, he has written his reports based entirely on the medical records, the accuracy of which is not challenged.

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Being pragmatic, being realistic, there could in fact be no objection if I were to read to you as part of my opening the entirety of Professor Ford's reports. It would probably take me about four hours to do; it would not be produced to you in a very convenient form, although I suppose ultimately you would have the transcripts which you could refer to whenever you wanted to.

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My opening has already been based of course in large part on Professor Ford's reports, so we do not understand on this side of the room what prejudice can actually in truth arise. If Professor Ford makes concessions and changes his view as a result of evidence heard before you, you will be in a very good position to identify that that has happened.

The end of that paragraph, paragraph 5, reads as follows:

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> "There could be no valid objection if Professor Ford gave his opinion based upon the evidence that is actually given during the GMC hearing: but it would be quite wrong for the Panel to consider his opinion based on what he thinks the evidence is going to be."

As we have said, he has based his opinion so far on the notes, so if evidence does change his opinion you will know that. You are not a jury, if I may say so, you are an experienced professional panel, and you should be treated as such. You are well able to ignore what is irrelevant but to take account of that which is relevant.

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This is simply a tool to assist you to follow and understand the evidence that you are going to hear. I will not repeat the complications of the evidence; it is quite apparent from my opening, where I have given you a very light touch, as it were, of some of the evidence that you are going to hear. But there are complications about this case, particularly when we get to the medical staff, who will be dealing with a variety of patients.

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So our submission in essence is that this is simply a tool which will assist you to follow the case, to understand the evidence that you hear, and we do also rely on the point that is made in the skeleton – we do not want to get to the position of having no reports, hearing the patients, hearing the medical staff – the doctors, the consultants, the nurses – then hearing from Professor Ford and saying "Well, I wish I had asked this witness that, because I would have done if I had known that this was referred to in the report". This will give you the advantage of being able to clear up any matters as you wish to, as the evidence proceeds. So in our submission it would be appropriate for you to receive the reports, with the caveat that ultimately it is the expert's opinion as he gives his evidence on oath before you that actually matters.

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THE CHAIRMAN: Thank you very much, Mr Kark. Mr Langdale?

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A MR LANGDALE: Sir, this application is strongly resisted. In our submission it is extremely unusual, if not unique, that the GMC should be able to present to the Panel in advance of any evidence an expert's report which is contentious. It may very well happen that, by agreement between the parties, documents can be placed before the Panel – for example, an expert's report on some matter where there is essentially no dispute. But here these conclusions are disputed.

B May I also make this clear: there is no problem about the Panel having before it a factual history set out in a particular way – chronologically would obviously seem to be the most sensible thing. But what is attempted here or is being attempted is to put before the Panel in advance of any evidence the opinions of Professor Ford – that is the crucial thing. It so happens – and this may be a matter for debate – that the way that Professor Ford sets out the history with regard to individual cases – a narrative of the history without comment – is not actually particularly easy to follow. That is no criticism of Professor Ford; he is entitled to C compile his reports in any way he likes. But, for example, he will have a section dealing chronologically with what the nursing notes say, and he will have another section dealing with what other records say. They do not lie side by side in the sense of slotting in chronologically. So actually in terms of trying to follow the series of events as they happened, Professor Ford's reports may not be in the most helpful format.

But that, with respect to my learned friend's argument, is not the point. I make it absolutely D clear now that if my learned friend and his team wish to put before the Panel a chronological narrative history with regard to each patient, if you like, fleshing out the chronology you already have with regard to prescriptions, then there would be no objection. So that is not the difficulty; that is a matter for my learned friend to decide what he does in terms of presentation of the case, and we are not in any way resisting or seeking to object to anything which assists the Panel in having a useful – to use the word my learned friend used – tool for following the evidence. But that is not the point with regard to Professor Ford. It is his E opinion which is being expressed in this report that is something which should not be in documentary form before the Panel at this stage. It is unique, in my submission.

I have enquired of those who assist me, and they are unable to think of a case in which they have been involved where the Panel has in advance a contentious expert report, and indeed, as I understand it, my learned friend is seriously suggesting to the Panel that Professor Ford's contentious report should be looked at before you get to each individual patient. What in fact F is happening is my learned friend is saying "Here is my case. When you look at Patient A, this is my case expressed by Professor Ford". That is not fair, it is not balanced, and it is completely contrary – I do not think I am putting it too highly – completely contrary to the normal way in which these cases are conducted.

It is unnecessary, too, for the reasons I have already indicated, and it carries with it real risks that the Panel would have in front of it a contentious document which may influence the way G in which the Panel, consciously or unconsciously, approaches the evidence with regard to a witness. The important thing above all – and again I am not putting this too highly – the vital thing in this case is that the Panel decides the case on the evidence.

Professor Ford's report, just like that, is not evidence. What the Panel will be hearing is what he has to say, and there will be no difficulty, since his evidence, apart from anything else, appears at the end of all the factual history you have heard – and you have heard from other H doctors before him. His evidence coming at that stage, this Panel will be very familiar indeed

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with the history with regard to the patients. You will have seen the records, you will have heard the witnesses who dealt with patients having given evidence. It is not a case where you will not be able to follow the evidence if you do not have Professor Ford's report – particularly his opinion.

One has to ask the question rhetorically: why should the Panel have the opinion of one witness before the witness has even given it in evidence in documentary form so it will assist you with regard to the evidence? It is exactly the same as if my learned friend Mr Kark were to say "I've opened the case to you" – his job being in opening the case to you to present the case so that you can comprehend the nature of it, and what it is you are going to have to deal with – "I've opened the case to you, and when we get to each individual patient I am going to make a further speech to the Panel to say what it is our case is with regard to various matters". I do not think my friend would even contemplate making such an application, and I do not think – no disrespect, because it is a matter for the Panel, of course – but I cannot see any Panel conceivably allowing that to happen. That is the reality of what my learned friend is actually seeking to suggest in terms of this procedure.

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The important and critical features, apart from the fact that the case has to be decided on the evidence – I cannot stress that enough, and Professor Ford's report is not evidence – he is the prosecution case. The GMC are inviting you to have in front of you a document, before the witness has said a word in evidence, which sets out their case.

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The objection to this application, if sustained, as I submit it should be, does not shut out from this Panel one single word, one single issue, one single matter in terms of evidence. You will be hearing from Professor Ford in detail when he gives his evidence.

May I turn, sir, briefly to our skeleton argument, and I am not going to read through every word of it. We have set out obviously at paragraph 2 that he is a highly contentious witness. For the members of the Panel to receive his reports would be unnecessary, inappropriate and likely to be highly prejudicial to Dr Barton. We endeavour to support every one of those objections in the skeleton argument, and where a course is being proposed for which there is no particular foundation in the rules, and which is in my submission, unique – or maybe I will call it highly unusual, as we cannot actually establish, I suppose, that it is unique – in such circumstances the Panel would obviously want to give full weight to the objections raised by the defence.

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Paragraph 3 of the skeleton, which was written before my learned friend actually had opened his case, sets out that the fact of the matter is that his opening address, which he has now completed, which was really quite detailed, and must have made it very clear indeed to the Panel what the issues were, or what the matters were that you were going to have to deal with – that having been concluded, there is no need for a further opening speech if there are any deficiencies in what Mr Kark has already said.

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The further point is made in the skeleton – and I think perhaps it is of great importance in considering the nature of this application – the Panel already have in front of them documents to assist them in following the evidence. It may be that further documents can be put in which relate to the narrative or the history which will again assist the Panel. Opinion at this stage is irrelevant, unnecessary in terms of the evidence, and does not assist the Panel to follow the history with regard to individual patients.

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The fourth paragraph – again I am not going to repeat every word of it – makes the point that in criminal proceedings it would be unheard-of for a jury to see an expert's report in circumstances like this. It would be wholly inappropriate for the Panel to see an expert report based, like Professor Ford's, on statements of witnesses due to give evidence. It is quite inappropriate, and we set this out as a basic proposition, for members of the Panel to take an expert report when they retire to consider their findings. What you will be considering is the evidence given by Professor Ford, not any document that he prepared months, if not years, ago.

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May I just say this about the witness statements: it may be that my learned friend is right, that he does not specifically refer to a witness statement. I am not going to trouble with that kind of detail; but what Professor Ford says in relation to each one of the patient cases he is expressing an opinion about, he says – and I will just quote from one of them: "This report is based on my review of the following documents: medical records of Patient A, statement of Dr Barton with regard to Patient A, witness statements of" – and then lists eight or nine witness statements. That is what his report is based on. Whether he cites passages from them or not is, with respect, neither here nor there. But all of those pieces of material that he has relied on go to assist him in forming his view – a view you will be hearing in evidence. That is the important thing. You do not need to have his views in advance of any evidence.

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Apart from anything else on that point, may I say this? Mr Kark, with all due respect to him, has very sensibly, very properly, indicated to you with regard to each patient what it is that Professor Ford criticises. He has set it all out. I do not think that the Panel, even if it does not possess super powers of recall, can have any doubt at all that Professor Ford is saying, "These doses of drugs were inappropriate, were too high and administered at the wrong time". That is basically what it is. We will be able to go into the detail when we hear the evidence further.

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I am not going to repeat the other paragraphs in our skeleton; may I just turn back to the skeleton my learned friend Mr Kark put before the Panel? He set out the position with regard to what the rules say – or really what they do not say – because you will in fact hear all the evidence. I am not going to go through his paragraphs 2, 3, 4, 5, 6 and 7 because none of those apply. I am not criticising him for setting them out, but none of them actually apply to the situation we are now in.

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In relation to his paragraphs 8 and 9, however, when one looks at the reasons that are put forward, may I just say this? "The scale and complexity of the case makes it necessary...." With respect, it does not make it necessary for the Panel to have contentious opinion before it. There is a very sharp division between a part of Professor Ford's report which might assist in terms of being a tool for the Panel to use – that is, pure, uncontentious narrative – and his contentious opinion.

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The issues that will have to be dealt with will have to be dealt with patiently and carefully and will all be clear, as we hear the evidence in the case. The figures, for example, will all be set out before the Panel. They can all be put onto a separate chronology, if necessary, and can all be put into a separate document – without causing the problems that this proposed course envisages or involves.

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"The Panel will be assisted enormously in following the case, understanding the patient notes and the evidence of Professor Ford in reaching its conclusions." With respect, not with

A regard to Professor Ford's opinions. My learned friend Mr Kark has made clear what his case is.

"If the Panel clearly understands the matters subject to criticism by Professor Ford in advance of the other evidence commencing, the Panel can ensure that all potentially relevant evidence is adduced from the witnesses." Again, with respect to my learned friend, it is extremely difficult to see how that makes any sense at all. The Panel will be able to ask witnesses B questions if my learned friend Mr Kark has not presented his case adequately in chief. I am sure that he will not fail in any sense to present his case properly. The Panel will have heard cross-examination in appropriate cases from me or from or from Mr Jenkins. The absence of Professor Ford's report does not prevent the Panel asking any questions it wants to. If, in the unlikely eventuality that a member of the Panel should think "Oh, I wish I'd asked that question", then the witness can be called back or the witness can, by agreement, be asked the question and the information relayed to the Panel. To suggest that that possible problem C warrants taking this wholly unusual, wholly exceptional course, is simply not justified.

Similarly in relation to the last parts of the skeleton. Again, I am not going to go through all the detail because I think the points I have already made cover all of those circumstances. It comes down to this. If the Panel needs a tool to assist in following the evidence, or putting the evidence together comprehensively in terms of its narrative, uncontentious history, then by all means let there be such a document produced. I am sure that we could do it. It can be D done, if necessary, patient by patient, putting the whole thing there in a chronological sequence. Not contentious opinion, which the Panel will decide upon at the proper time – which is when Professor Ford gives his evidence and is cross-examined on it.

Sir, those are my submissions on the point.

THE CHAIRMAN: Thank you. Mr Kark?

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MR KARK: May I reply very briefly? In relation to the last comments that Mr Langdale was making about Panel questions, I have to confess that I have rarely sat down after examining a witness without there being at least one Panel question. That is the nature of these types of inquiries. It does not mean that the barristers have not done their jobs. There are normally Panel questions, because things arise to Panels that would not necessarily arise to the mind of a lawyer.

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I do ask if it is conceded that, at the time that Professor Ford comes to give evidence, the Panel can then receive his reports. My learned friends might think it is unique; it is not unique. Panels very often ask to see the reports. If it is a simple report, I, as a prosecutor, normally resist that; but if it is a complex case, a Panel is often in the position of being presented with a report before the expert gives evidence or at the time that the expert gives evidence, so that they can follow the course of the evidence. If that is right, I simply do not G see why you cannot receive it at an earlier stage.

Finally, this. My learned friend says that I would not dream of reopening my case, as it were, in advance of each patient. That is absolutely right. However, these proceedings are intended to work and, of course, you have the transcript. I think that we have all just received the transcript of my opening. I have little doubt that when we get to Patient D or E, if you have forgotten what the essential case is in relation to that patient, you will take up the H transcript and have a look. There is nothing to prevent your doing that and indeed there is

A every reason why you should do it. If you find that a useful tool, then in a similar way we would say Professor Ford's reports will be a useful tool, with the caveat that we have already indicated. That is my response.

MR LANGDALE: Sir, may I simply deal with that one point which has been raised? It is new in terms of the argument and it will take me only a moment to deal with it.

B If my learned friend wishes to provide the Panel with Professor Ford's report when we get to his evidence, then that is the appropriate time for him to apply and for the argument to be addressed. It may be that circumstances will have changed by then. Who knows? But if that is what he seeks to do – and it may have been done in other cases in those sorts of circumstances – then the proper time is to deal with it then, not before any evidence has been heard.

C THE CHAIRMAN: I will now ask our Legal Assessor for his advice.

THE LEGAL ASSESSOR: Before I give my advice, I wonder whether the Panel might wish to confirm with Mr Kark that it is in no way intended that the reports will go in as evidence; that they are to go in as an aid. I think that is important and perhaps it could be clarified.

MR KARK: Sir, I can confirm that straight away. Yes, they are not intended to be the
D evidence. Professor Ford giving evidence on oath will be the evidence.

THE LEGAL ASSESSOR: This is of course an application that the reports referred to go in at the outset of the case, before any evidence has in fact been heard, and that is all that you have to consider at this stage. You have obviously read the skeleton arguments of counsel in relation to this.

E Mr Kark wishes you to have the reports, as you have just had confirmed, not as evidence but as an aid to assist you with the complexity of the case and so that you can raise with any witness at the appropriate time any relevant issue mentioned in his written reports by Professor Ford. Thereby the GMC no doubt seeks to avoid having to recall witnesses after Professor Ford has given his evidence, and those are the main advantages put forward by the GMC.

F Potential prejudice to the defence of putting the written reports before you is stated by Mr Langdale and Mr Jenkins to be this. The factual basis of an expert's opinion will derive in very large part from what he has read in the formal witness statements or in other material, but any expert, before he gives evidence to you, is likely either to have sat in and heard all the evidence or, more probably, to have read the transcripts of the case so far. This means that, by the time he gives live evidence to you, the expert may have revised or changed entirely his views set out in the written reports. If you had never had the written reports, you might never
G have known this, although you would of course have heard the GMC open the expert evidence in the case. If you do have the written reports before you, you may be tempted, say the defence here, to second-guess the expert and give undue weight to the written views in the report, even though that is not evidence at all and the expert has changed his views anyway.

It can always happen, of course, that the evidence of a witness varies from that in his
H statement, but in this case the defence state that there are particular reasons why you should

A anticipate such variation. First, they say many of the witnesses have expressed concerns about the accuracy and completeness of their witness statements. Secondly, they say evidence has already been given at the inquest earlier this year, and that evidence did, in the case of many nurses, materially differ from the accounts given in their witness statements.

Even if the expert reports are based on medical records rather than witness statements, it is of course possible that the expert would change his conclusions, having heard the actual
B evidence. I hope that is a fair summary of the various arguments.

I advise you as follows. First, on the face of it, rules 50(1) and 50(2) in the old rules – which I think you have before you – might appear to offer some assistance to you. Rule 50(2) has not been directly referred to, of course. My advice is that it does not in fact assist you in this case, because it refers to documents in themselves admissible: maps, and so on, and matters of record. That is not the kind of document that we are looking at here.

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What about rule 50(1), which is set out on the first page of Mr Kark's skeleton? My advice is that you should be careful about concluding that this rule assists you. Why? The reason is this. That rule clearly deals with the admissions of documents as evidence. In fact, the proviso refers to documents being tendered in evidence. Here, of course, the GMC is not seeking to put the reports before you as evidence in the case but as an aid.

D Secondly, I advise you that it can be said that you are a professional Panel, well able to set to one side irrelevant or prejudicial material; but I advise you that, as a matter of good legal practice, such material should not be placed before a Panel if it can be avoided.

Thirdly, as you have heard, if you receive copies of Professor Ford's reports at this stage those reports are not evidence. The only evidence of Professor Ford you can take into account will be his oral evidence. It is important that you remember this and that you
E consider whether your receipt of Professor Ford's written reports at this stage might in fact muddy the waters in this respect, to make it harder for you to come to a reasoned decision. On any view, you would at the end of the evidence have to perform a disentangling exercise, separating in your minds the content of the written reports from what Professor Ford actually said in his oral evidence.

Fourthly, as I have said, the GMC wishes to avoid having to recall witnesses in the light of
F further questions you might have wanted to ask had you had the expert's written reports before you. That is understandable and commendable, but it is of course open to the GMC to set out the views of their expert in their opening to you and, if a particular issue with a particular witness is flagged up in the expert's report, highlight that to you in their opening. You may think that that is what Mr Kark has done. Of course, you will shortly have a full transcript of that opening.

G In addition, when a witness is actually called, both counsel will no doubt ensure that the witness is asked everything that they think is relevant. That really is their – counsels' – responsibility, not yours.

Fifthly, I advise that you should look with care at any analogies, particularly in relation to criminal law, drawn to your attention by Mr Kark. It is of course important that you make up your own minds about the relevance of any analogies, but I do say this. If one looks at
H paragraph 3 of Mr Kark's skeleton, referring to a transcript used by a jury to follow the pre-

A recorded evidence of a witness, bear in mind that that is a situation in which the jury simply has a record of the evidence which is actually being given, at the time that it is being given. In relation to paragraph 4 and the permitting of a witness statement to be exhibited, bear in mind that Mr Kark is not submitting to you at this stage that the reports should be formally exhibited, to show inconsistency or consistency. Indeed he cannot, because the expert evidence has not yet been given.

B In relation to paragraph 6 and the drawing up of schedules and so on, no one doubts that all this can be done by consent, as frequently happens. The issue for you to decide is whether it can be done without the consent of the defence.

Sixthly, my advice to you is that there is no clear and identifiable legal authority for the putting of these reports before you. I advise you that, in criminal proceedings, a report from an expert who is himself going to give evidence would at the outset not go before a jury

C unless the defence consented.

If Mr Langdale and Mr Jenkins were to consent here, of course, it would be a different matter but they object, as they are perfectly entitled to. Because I am unable to point you to any clear and identifiable legal authority for the course proposed by Mr Kark, I am unable to advise you that it is a course open to you to take.

D Even were I wrong about that, and even were you to take the view that the reports are evidence and therefore that rule 50(1) and the discretion do apply, I would not be advising you that your duty of making due inquiry into the case before you makes its reception desirable. You would in any event have to consider whether the admission of the evidence would have such an adverse effect on the fairness of the proceedings that you ought not to admit it.

E This is clearly an important matter and the Panel should consider its decision in camera and should also consider whether to provide written reasons for its ruling. That is my advice to the Panel, Mr Chairman.

THE CHAIRMAN: Mr Kark, do you have any observations on the advice just proffered?

MR KARK: Only this in relation to rule 50. We accept that rule 50 refers to material

F tendered as evidence. As we have said all along, we are not tendering this as evidence; we are tendering this as a tool in order to assist you. We therefore accept it may well be that rule 50 does not come into play.

THE CHAIRMAN: Mr Langdale?

MR LANGDALE: I have nothing to say, thank you.

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THE CHAIRMAN: We will now go into camera to consider our decision. I would not anticipate at this stage that we would have anything for you before the luncheon break. At this stage, therefore, I will say not before two o'clock, and we will attempt to update you on our progress.

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STRANGERS WITHDREW BY DIRECTION FROM THE CHAIR
AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

DECISION

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THE CHAIRMAN: Mr Kark, the Panel has heard submissions, supported by written skeleton argument, from both yourself and Mr Langdale in connection with your application for the Panel to receive reports prepared by the GMC's expert witness, Professor Ford, before it hears evidence from witnesses and before Professor Ford himself is called to give evidence. You have submitted that it is not your intention for the reports to be received as evidence at this stage of the proceedings, rather that the reports be regarded as a tool to assist the Panel when hearing the evidence of other witnesses.

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Mr Langdale strongly resists your application on Dr Barton's behalf. He submitted that it is unnecessary for the Panel to receive contentious reports prior to hearing the evidence of the author, and that if the Panel were to receive the reports at this stage there would be a real risk of the panel being influenced by the opinions expressed in Professor Ford's reports which were of necessity written before any oral evidence has been heard.

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The Legal Assessor advised the Panel that:

- Rule 50(1) of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules of 1988 does not apply, as that rule refers to documents as being "tendered in evidence." Your application seeks to put the reports before the Panel not as evidence in the case, but as an aid.
- The Panel is a professional Panel, well able to put to one side irrelevant or prejudicial material, but that, as a matter legal principle, such material should not be placed before a Panel if it can be avoided.
- The copies of Professor Ford's reports are not evidence. The only evidence of Professor Ford that the Panel can take into account will be his oral evidence, and the Panel should consider whether Professor Ford's written reports might muddy the waters and make it harder for it to come to a reasoned decision. The Legal Assessor cautioned that at the end of the evidence the Panel would have to perform a

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disentangling exercise, separating the content of the written reports from what Professor Ford actually said in his oral evidence.

- There is no clear and identifiable legal authority for putting these reports before the Panel. In criminal proceedings a report from an expert who is himself going to give evidence would, at the outset, not go before a jury unless the defence consented, which in this case they have not.

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- Were the Panel nonetheless to conclude that the reports are evidence and that it had discretion to receive them under rule 50(1) of the Procedure Rules, the Panel should then consider whether its duty of making due inquiry into the case makes reception of the evidence desirable. Further, if the Panel considered that the admission of the evidence would have an adverse effect on the fairness of the proceedings, it ought not to admit it.

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While the Panel might have found some value in the early reception of the reports, and while it is well able to put to one side irrelevant or prejudicial material, the Panel nonetheless accepts in its entirety the advice of the Legal Assessor. The Panel has concluded that in the absence of consent from Mr Langdale on behalf of Dr Barton, it would not be appropriate to receive the reports at this stage. The Panel therefore rejects your application.

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The Panel would, however, welcome an agreed fuller chronology in relation to each patient which incorporates the specific criticisms which are made by the GMC in respect of Dr Barton and the Panel will allow you time to prepare such a document, should you wished to do so.

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MR KARK: Thank you for that indication. I am not going to ask for time now. As the case proceeds we will consider how best we can flesh out the chronology that you have.

Can we then start by calling evidence? If you go to your witness list, the first witness is Linda Wiles, who is the daughter of Mr Leslie Pittock. That witness is not available to attend, but I am told by Mr Langdale that there is no objection to her being read. I wanted to clarify whether the agreement is to her being read as agreed evidence, or whether it is agreed that she can be read because she is unwell and therefore falls within one of the categories of section 166 of the Criminal Justice Act.

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MR LANGDALE: May I assist on that point? It seems to me, in the circumstances, there is no difficulty with treating her evidence as agreed evidence. The Panel will also hear that this lady attended the inquest. It refers to another witness and not this lady. It does not affect what I am saying. My respectful submission is that the Panel treat this as agreed evidence.

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THE CHAIRMAN: That is most hopeful. Before you read her, Mr Kark, one thing that the Panel feel would assist it is for us to, at this stage, invite you to withdraw for a few moments while we all read that part of your opening in the transcript that relates specifically to Patient A We would do that on each occasion that there is a movement towards a new witness. We have already identified the pages concerned. Some of us have already embarked on the process but we will need probably another five to 10 minutes to achieve that.

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MR KARK: As a matter of housekeeping, I know that Panels sometimes request the statements of witnesses who are being read to them, and we could certainly do that in this case. Can I suggest this? Because you are going to be getting a full transcript of the proceedings and we are happy (certainly towards the end of the GMC's case) to provide you with a full index of every day, you will be getting an index for every day, but we can provide you with a cumulative index, rather than having two bundles to refer to rather than one, we suggest you stick to the transcript. It also means that if there is any editing to be done with witness statements, you do not need to trouble about that; you simply hear the relevant evidence being read to you. We are in your hands. We can provide you with statements if you wish, but in the circumstances perhaps you may feel it is unnecessary. Perhaps at some stage you could indicate.

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THE CHAIRMAN: The Panel have indicated that they are quite happy to proceed on that basis, Mr Kark.

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(After a short break)

THE CHAIRMAN: While we are waiting, Mr Kark, if I can tell you and Mr Langdale that the Panel have refreshed our memory of the opening in respect of Patient A. We will follow this course, if we may, throughout the procedure. So you will never go straight from one patient to another; we will always need a break to read up again.

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This is the statement of Linda Marion Wiles. Her statement to the GMC was made on 3 June of this year. She exhibits a police statement, and that is how most of these witnesses will be giving evidence. She simply says in her GMC statement that she exhibits a copy of a witness statement dated 8 November 2004. She confirms that she has been given the opportunity to add or amend to it, but she does not wish to. Her statement, dated 8 November 2004, reads as follow:

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"I am the daughter of Lesley Charles Pittock, born Code A, who died in the Gosport War Memorial Hospital on 24 January 1996.

My Father was born in Hemel Hempstead. He had two sisters; one who died as a result of an ectopic pregnancy whilst in her twenties to thirties, and the other who died of cancer in her late fifties.

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My father was a submariner in the Royal Navy. Whilst in Canada he met and married my mother Audrey. They had my brother Paul and the family came to England in 1947. My parents had three children. Paul is the eldest and I have a young sister Virginia Cresdee.

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My father suffered from severe depression for a great deal of his life. He made

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several attempts to end his life and had to be admitted to hospital for treatment. He was admitted to Knowle Hospital, Wickham, on a number of occasions through the Sixties, Seventies and Eighties and received ECT treatment.

My father was physically a very strong man, and it was mainly due to his strong constitution that his attempts to end his life failed.

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My father retired from the Navy after 22 years' service and worked as an instructor at the Nautical Training School, on Training Ship Mercury on the river Hamble. My father loved sailing and he enjoyed his job, but when the Training School closed he seemed to lose his purpose in life and withdrew into himself.

Some time around 1993 to 1994, my Father was admitted to Alverstoke Ward at Knowle Hospital. He was very depressed and had no motivation. My mother had been caring for him at home and the strain this placed on her was giving concern to my father's psychiatric nurse, John Allen, and his social worker, Jackie (whose surname escapes me). Because of this, a decision was made that my father would be discharged to a rest home.

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My Father left Knowle and went directly to Hazeldene Rest Home where he lived until he was admitted to Mulberry Ward at the Gosport War Memorial Hospital.

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My father became progressively worse whilst at the nursing home. He would not socialise with any of the other residents, who were predominantly women, remained in his home and rarely spoke to anyone. He was not rude; he just would not initiate any conversation. He would be the same when the family visited. He stopped eating and drinking properly and was eventually admitted to Mulberry Ward, which is a psychiatric ward at the Gosport War Memorial Hospital.

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My father continued to deteriorate mentally and physically. He did not respond to treatment. He seemed to have given up. The nursing staff on the ward were excellent and took great care of my father. The family visited regularly. Virginia and I would take it in turns to take my mother in to visit my father.

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After a period of time, Dr Vicky Banks told us my father had a chest infection. She informed us that the clinical team had considered and rejected treating my father with ECT (electro convulsive therapy) because of his physical condition. She told us that there was nothing more that could be done on Mulberry Ward, and that he was going to be moved to Dryad Ward. I knew that my father was not eating or drinking. He would lie in bed all of the time and ignore everyone. He believed that he had Parkinson's Disease. I understood that my father was going to Dryad Ward for terminal care. This was never actually said to me, but my knowledge of the type of patient that Dryad took led me to believe this.

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I visited my father regularly with my mother and as a family we watched as my father died through what I would describe as self-neglect. He had become extremely frail and just seemed to have lost the will to live. I remember asking the nurses if he was in any pain and if he had any pressure sores because he was immobile. The nurse told me that my father's skin was breaking down and that he cried out when the nurses turned him. I remember that morphine was mentioned to me for pain relief, but I

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A

cannot recall if I was told that my father was already receiving it or was going to receive it. I knew that his body systems were breaking down and that he would have been uncomfortable. I was not alarmed by the thought that my father was being given morphine. I considered it to be appropriate care. The nurse turned him regularly and I recall that he had a blister on his ear. My mother was spoken to about the use of a drip and was kept informed about my father's condition and how grave it was. I have no recollection of ever seeing a drip used in relation to my father, so I assume that my mother was referring to a syringe driver. The family acknowledged that invasive or aggressive treatment would be inappropriate in my father's case. By this I mean to force-feed him or use ECT to try and lift his mood. I remember that it seemed to take my father a long time to die. I expected him to die as he was in a dehabilitated state, was not eating or drinking and had a chest infection.

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C

My father died on 24 January 1996. His death was certified by Dr Jane Barton and his cause of death was given as bronchopneumoniA He was cremated at the Porchester Crematorium on 30 January 1996.

I have been asked if I ever spoke to a doctor during the time my father was in Dryad Ward. I did not speak to a doctor as I was kept fully informed of my father's condition by the nursing staff. Had I felt that I needed to speak to the doctor, I would have taken the necessary steps in order to do so. My father's GP was Dr Asbridge who had a very good understanding of my father's condition and was very supportive of my mother.

D

I think it is pertinent to mention that I am a retired qualified mental nurse, having nursed the elderly mentally ill for most of my career. The time of my father's admission to Mulberry Ward and subsequently Dryad Ward I was the G Grade clinical manager of the Phoenix Day Hospital within the Gosport War Memorial Hospital."

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That concludes her statement.

THE CHAIRMAN: Thank you, Mr Kark.

MR KARK: The next witness is one who I will now call, Dr Michael Brigg. You may wish to get Patient A's files available to you.

F

MICHAEL BRIGG, Affirmed
Examined by MR KARK

(Following introductions by the Chairman)

G

Q Is it Dr Michael Brigg?
A That is correct, yes, sir.

Q Can you bring the microphone a bit further towards you?
A Yes.

Q Are you a self-employed GP?
A I am, sir, yes.

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A

Q Your practice I think is the Forton Medical Centre, Whites Place in Gosport, is that correct?
A Yes.

Q Does that mean in fact that you practise with Dr Barton?
A Yes, I have been practising with Dr Barton for the last 15 years, since 1993.

B

Q You must keep your voice up. This is a very big room and we have air-conditioning.
A I have been in practice with Dr Barton and her former partners and present partners since I joined the practice in 1993.

Q Can we take it that she was there before you?
A Yes, she was.

C

Q I am not going to ask you a great deal about your medical training. I think you registered with the GMC in August 1982; I think in 1985-1986 you took a post as senior house officer, domiciliary care of the terminally ill, at a hospice, is that right?
A That was a domiciliary care job with St Joseph's hospice in Hackney. The consultant was Dr Robert Pugsley, and subsequently whilst I was seeking a practice after completing my general practice training, I returned there over the course of a year to work as a locum quite frequently, both in domiciliary care and in hospice care, with in-patients at the hospice, in 1992.

D

Q I want to ask you particularly, please, about your involvement with a patient whom we know as Leslie Pittock. I can see that you have brought a file in with you. Have you marked up a file for your own purposes or are you happy to use an unmarked file?
A I have marked some of my statements where I can see question marks that are relevant to my memory of the case.

E

Q Right, I understand that. Do not worry about that for a moment. In relation to the bundle of patient notes, have you marked one up or are you happy to use the clean bundle, which is to your left?
A I am happy to use the clean bundle on the left.

F

Q Could I ask you to take that up, please, and I was going to ask you to turn to page 189 and I will then ask you some questions about it. Before we examine the entries on that page, we know, just to fill you in with the background, that this patient was admitted to Dryad Ward on 5 January 1996 – yes?
A Yes.

G

Q We also know that he was prescribed various drugs by Dr Barton, and I am not going to ask you in relation to those. We know that on 15 January he was started on a syringe driver, and that appears to have contained diamorphine – and is it hyoscine?
A Yes.

Q And midazolam. Then I think we get to 20 January, where we see a note in relation to Nozinan. Can I just ask you this: up to 20 January 1996 had you had any dealings with this patient, as far as you know?

H

A No.

A

Q So presuming for a moment that you did do something in relation to the patient on 20 January, this would have been your first contact with him?
A I may have known that the patient was there from doing ward rounds when I was on duty prior to that time, but if the patient had not had any medical problems at the time, I would not have been required to make entries into the notes at that time.

B

Q When you talk about doing ward rounds when you were on duty, what duties did you have in relation to the Gosport War Memorial Hospital?
A As a partner in the practice, the practice had an agreement with Dr Barton that when Dr Barton was not on call for the practice, that the GP on call for the practice would take on the responsibility for care of the patients at the Gosport War Memorial Hospital.

Q So if she was unavailable you would come, as it were?

C

A In effect Dr Barton, I suppose, subcontracted her responsibilities to the War Memorial to the practice, and the practice subcontracted that responsibility to whoever was the duty doctor at the time, and that doctor might in turn subcontract that to a deputising service if they were on duty.

Q All right. Let us deal with how you came to be telephoned, I think, on 20 January. What role were you performing on that day when you were telephoned by, I think, a nurse at the hospital?

D

A 20 January was a Saturday, a weekend, and I would always undertake my own on-call duties at weekends and at night, so I was effectively duty doctor for the practice and covering patients at the War Memorial Hospital.

Q Right. Could we have a look, please, at what happened on 20 January? Do you have a recollection now of these events? It is a very long time ago.

E

A I have a reasonably clear memory of the clinical questions that were being raised, although I do not have very much memory for the patient himself.

Q You may want to keep a finger in page 189 but also go for these purposes to page 198, which is a record I think made by a nurse and then by you; but perhaps you can help us. At page 198 do you see an entry on 20 January, first of all?
A Yes, I do. That is my writing – that is my signature. The writing above that is

F

Dr Barton's writing, dated 18 January 1996.

Q Just dealing with 20 January, you say "my writing and my signature". There is no signature under 20 January, is there?
A There does not appear to be so, no.

Q But that is your writing?

G

A That is my writing, yes.

Q How did you come to make that note?
A I had been called by the staff nurse to come and see the patient, to arrange for an alteration in the medication. The staff nurse, which was Staff Nurse Douglas, I think, was concerned that Mr Pittock had become more agitated and very restless, and she was concerned that there was a paradoxical side effect with haloperidol which at high doses could

H

A cause significant agitation to develop in certain patients. She wanted me to review the dosage of haloperidol or consider other medication that could be used.

Q Is that, may I ask, an effect of haloperidol on its own or is it the effect of haloperidol when mixed with other drugs?
A The side effect with haloperidol is listed in the palliative care book that we have reference to, as specific to haloperidol.

B

Q So your first contact would have been what – a telephone call from Nurse Douglas?
A That is correct. Nurse Douglas I think would have been recharging the syringe driver at about 3.45 that afternoon, which is when the driver was always being recharged, and that is when it would have been noted that Mr Pittock's symptom control was not so good.

Q Can I then take you back, please, to page 189, and ask you to assist the Panel. As we

C work through this case we will probably get more adept at reading these and understanding them, but perhaps you would be able to assist us at this stage. We can see first of all that there is a prescription under the heading "As required prescription" for – is it Nozinan 50 mg?
A Yes, that is Nozinan 50 mg to be given in a subcutaneous syringe driver over a 24-hour period, the starting date on 18 January 1996, which correlates to Dr Barton's note on 18 January 1996 on page 198 noting a further deterioration in Mr Pittock's condition and

D symptoms. So that would have been added – she has written there "Try Nozinan". It says "Further deterioration, analgesia" ---

Q "SC", I think.
A "Subcutaneous analgesia", I think, I cannot read that word. "Difficulty controlling symptoms. Try Nozinan".

E Q Just going back to page 189, you told us it was "SC" and you are right, but I just wanted to make sure we all understand why. We can see under the word "Drug (approved name)", "Nozinan 50 mg", and then underneath that on the left we see "Route", and is that "SC"?
A Yes, it is. It is subcutaneous in 24 hours.

Q So that is the indication, as it were, that it is to be delivered by way of a syringe

F driver?
A That is correct.

Q Then to the right of that we can see the date, 18 January 1996; then is that Dr Barton's signature underneath?
A Where it says "Signature", you have "J A Barton" underneath, just above the space saying "Special directions". The timing of the dose being given is signed by the

G administrating nurse.

Q Can we just look at the timing then. If we look to the right of "50 mg" we can see a number of columns. The heading for the first is "Date", and then we see "Time", then we see "Dose" and then we see "Given", and then it repeats itself a number of times across the page. So the date on this occasion, two days before you came into the picture, as it were, is 18 January 1996.

H A Yes.

A

Q The time is 15.15.
A Yes.

Q The dose is 50 mg.
A Yes.

B

Q Then there is an initial.
A There is, yes.

Q Is that likely to be a nurse?
A That would be a nurse's initial.

C

Q Right. So is that an indication that on 18 January at a quarter past three in the afternoon a nurse would have loaded up a syringe driver with 50 mg of Nozinan among the other drugs that she was using?
A Yes, it is.

Q That is very helpful. Thank you. Then if we look below that we can see another date, which I think is 19 January. Again, 1500.
A Yes. The date is a little obscure, because the milligrams bit of Nozinan covers the "19", and it does not show; but it would have been in different coloured inks, I think. So that is 19 January 1996.

D

Q That is another 50 mg of Nozinan being put into a syringe driver at 1500 hours?
A Yes.

E

Q So these are 24-hour drivers, are they?
A They are, yes.

Q We can see that on the 18th Nozinan is put in, as it is on the 19th, at about the same time of day.
A Yes.

F

Q Then we move to the 20th. If that dose of 50 mg of Nozinan had just continued, would we simply see further date entries below that?
A Yes.

Q Tell us then, please, what happened on the 20th.
A I was called to see the patient, and I was advised that he was becoming agitated, that it might perhaps be the haloperidol that was causing the increased agitation. I agreed with Staff Nurse Douglas that that seemed quite likely; and in view of the fact that Mr Pittock was already being prescribed Nozinan and haloperidol, which do have a broad overlap in their therapeutic effect, I felt it would be reasonable to reduce the number of different medications in the syringe driver in order to firstly avoid any problems in the mixing of drugs; and secondly, to consolidate the prescription into a more simple form.

G

Q So what did you do?
A I suggested that the haloperidol should be stopped, and that the Nozinan should be increased from 50 to 100 mg, bearing in mind that the sedative effect of haloperidol would

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A have been removed from the driver, and so any sedative effect of Nozinan 50 would have to be increased to compensate for that change.

Q What was the purpose of the Nozinan in this mix?
A The purpose of the Nozinan from Dr Barton's note is simply to control symptoms of agitation and distress, that it was felt Mr Pittock was suffering at the time. Nozinan, to my knowledge, has mainly used as an anti-emetic, to counteract a side effect of diamorphine
B which acts on the emetic centre of the brain; but it also has broad sedative properties which have a calming influence of patients who are distressed by their symptoms.

Q Anti-emetic meaning stopping a patient feeling sick?
A Prevention of sickness and vomiting.

Q It may be helpful then to look at page 190, to see what other drugs this patient was
C receiving.
A This is part of the same prescription chart. Diamorphine and midazolam would both have some sedative influence, in addition to pain relief and allowing muscle relaxation.

Q Did you go in and see the patient on this day? We can see the words "verbal order". What does that indicate to us?
A I went in to see the patient because I would have had to see the patient in order to
D countersign my prescription, which was written by the nurse.

Q When we see on page 189 the words "verbal orders", does that mean you would have given the order over the telephone first and then gone in to see the patient?
A That is correct.

Q Why would you need to go in to countersign?
E A It is standard or proper practice that, where a verbal order is given, the nursing staff are allowed to take the verbal order and carry out the order, on the understanding that the doctor, having been called, will come and see the patient. This would particularly apply if, for example, orders were made to change CD drugs.

Q Controlled drugs.
A Controlled drugs.

F

Q Because if you are authorising the prescription of a controlled drug, that has to be written out by the prescribing doctor, I think.
A I believe that, with controlled drugs, unless the drug is actually written on the chart by the doctor, the nurse cannot give it and cannot take a verbal order for that. So in order for verbal orders to be administered, the prescription for a controlled drug might well need to be pre-written into the chart, if it is anticipated that changes in medication might be necessary
G when the doctor is not in the hospital.

Q How long, may I ask you, did it take you to get from your practice into the hospital? What is the geography of it?
A On a Saturday I would be covering, at that time, a range of patients between Lee-on-Solent and Gosport and, going north, up as far as Fareham.

H

A

Q I just want to stick at the moment to the distance between your practice and the hospital. Not on this particular day that you had to go in, because you may have been all over the area, I suppose.
A Yes.

Q But to get from your practice to the hospital would take you how long?
A By car, with no traffic, I would think it would take about ten minutes.

B

Q In terms of mileage, what does that mean?
A It is about two miles.

Q Going back to page 189, you have explained why you gave this prescription of 100 mg. Did you stop the haloperidol at the same time?
A Yes, I did.

C

Q At the time that you did this did you believe that Nozinan had been continuously administered to the patient?
A Yes, I did. I think there is actually an error in my statement in this respect, which I have reviewed. My statement indicates that, after looking at the prescription with DC Greenall, I had noted that Nozinan 50 had not been placed in the syringe driver on 20 January, and that it was therefore my belief perhaps that Nozinan was not in the mixture when Mr Pittock was showing greater agitation. But in fact he would of course have been on the Nozinan that had been placed in the mixture on the 19th, because it would have been continuing through until 1545 on the 20th, when the syringe driver was recharged.

D

Q Let us just pause about that. It may not matter but, just to be absolutely accurate about it. If we go to page 190, it looks on the 20th – and please tell us what the true picture is – as if the syringe driver was not actually re-loaded until, is it 1800 hours?
A This shows that the syringe driver was re-loaded initially on the 20th at 1800.

E

Q So that is rather after the 24-hour period has expired from the previous syringe driver?
A There is a crossed-out bit just above 1800, actually, at 1530. I am sorry. If you look on the 20th, there is a re-loading noted at 1530, where diamorphine, midazolam, hyoscine and haloperidol are all re-loaded into the syringe driver. But, yes, the Nozinan was not re-loaded at that time. So there would have been a period, I suppose, of an hour perhaps after that. I am not entirely certain the exact time when I was called to see the patient after the re-loading, or whether it was at the time of re-loading. I would be uncertain exactly at what point I would have been called.

F

Q What does the crossing-through of the entry at 1530 signify?
A That signifies that the syringe driver that was running at that time has been taken down and disposed of, and then re-loaded at what looks to be six o'clock. I think six o'clock would have been the time when it was re-loaded with Nozinan 100 mg, which, if we look at the prescription detail on page 189, was commenced at six o'clock in the evening.

G

Q And it would not have troubled you that there was a few hours' break, if that is what it was?
A I am not certain whether there was a few hours' break there or not. I cannot remember whether I was called at three o'clock or whether I was called perhaps at

H

A five o'clock, but it is possible that there might have been an hour or two when Mr Pittock did not have the Nozinan 50 mg in his driver.

Q I just want to understand this. Again, I am not seeking to make any point about it but I just want to understand it. These are 24-hour drivers. Are they exactly 24 hours or are they approximate?
A No, there is always a certain amount of overage available. If an emergency arises and

B it is not possible for one reason or another to change the driver at the exact 24-hour period, there would be three or four hours of additional available drug to continue running.

Q So even though we see that the last time Nozinan was put into the driver was at 1515, that actually would continue unless that driver is stopped?
A It would, yes.

C Q If we go over to the 20th, we see that at 1530 a new driver was actually started.
A It was, yes.

Q And then crossed through.
A Yes.

Q When that new driver was started, it appears that Nozinan was not included.

D A It does, yes.

Q So there would be a period – it may not matter – when Nozinan was not being injected into the patient's body.
A There would, yes. I am uncertain how long that would have been.

Q I totally understand that. How many syringe drivers, from your understanding of

E these notes, were in fact working with this patient?
A When I first spoke with the nurse, I was concerned that it might have been just one; but, reviewing the notes, I have seen from a nursing Kardex note that there were two drivers running, and this would have been proper practice because they would normally not place more than three drugs in one syringe driver, in order to avoid any interaction or precipitation problems.

F Q But you cannot tell from this, the notes that we are looking at, how many syringe drivers there are?
A No.

Q Could I then take you to page 198? We have looked at your note briefly on 20 January as being "unsettled" on haloperidol and syringe driver. You took that from the nurse – yes?

G A Yes.

Q "Discontinue and change to higher dose Nozinan, increase Nozinan 50 mg to 100 mg in 24 hours (verbal order)" and then, underneath that, do we see your writing again? "Much more settled" – this is on 21 January.
A Yes.

H Q What is the note? "Quiet breathing"?

A A It says, "Quiet breathing, respiratory rate 6 per minute, not distressed; continue".

Q At any stage, either on 20 January or 21 January – when you must have seen the patient to make that note, presumably?
A Yes.

Q Was the patient awake, as far as you know?
B A No. The patient was not awake on either of those because, when I went in on 20 January, the changes to the syringe driver would already have been made on my verbal order and, by the time I came in to see the patient, the effect of those changes would have already taken place.

Q And the effect would be?
A Would have been to settle the patient, who was distressed prior to the change and, it
C would appear from my note, became un-distressed and was able to sleep or relax.

Q I understand that, but the effect of the drugs that this patient was being administered would be that he was asleep at the time that you saw him.
A Yes.

Q On both occasions.
D A Yes.

Q And I do not think that you had any other dealings with this patient.
A No, I did not.

Cross-examined by MR LANGDALE

E Q Dr Brigg, as you will realise, I am asking questions on behalf of Dr Barton. Just in relation to what you were saying about your note with regard to 21 January and the respiratory rate of 6 per minute – that is what I want to ask you about.
A Yes.

Q That is slow, but you would have borne in mind at the time that he was under the influence of diamorphine which was being administered?
F A That is correct.

Q And therefore that would have been expected.
A That is correct.

Q But you would also have noted whether his skin colour suggested excessive respiratory depression?
G A Yes.

Q You have not noted that; so we can take it that that was not present.
A That was what I stated to the police in the original inquiry: that whilst I had made a brief note about the respiratory rate, the fact that I have noted the respiratory rate indicates that I did have a concern as to whether he might be over-sedated or overdosed with medication, and the fact that I have not written anything to that effect would indicate that I
H was happy that he was not inappropriately dosed at the time.

A

Q I was going to add that, of course, from your note we can see that you have said, "continue" at the end of your note for 21 January, on page 198.
A Yes.

Q Meaning that you were happy with the regime he was under at that time in terms of the medication and that it should continue.
B
A My concern for Mr Pittock was that he had been admitted with distress and agitation, and that the purpose of treatment was to relieve his distress; that he appeared to be comfortable and not in distress but at the same time he was not in any physiological stress either.

Q Had you been unhappy with any other aspect of the medication he was receiving, you would have pointed that out and done something about it?
C
A I would have made further changes to his medication regime and then reviewed him again at a later stage.

Q The senior nurse whose name you have mentioned, senior nurse Douglas, was somebody who in your view had extensive personal experience of palliative care, including a knowledge of different drugs and their specific side effects?
A Yes.

D

Q Would it be right to say that that was your view as to the knowledge and experience of other senior nurses in that hospital?
A Yes, it was.

Q In general terms, Dr Brigg, is it right you felt that the nurses in Gosport War Memorial Hospital were doing their job well and had particular experience and expertise?
E
A I did, yes.

Q Would it also be right to view the situation as being this in terms of reliance on nursing staff: that when you came in to see a patient, maybe on call or somebody whose case you did not necessarily already know very well, you would find yourself naturally very reliant on what was said to you by the nursing staff as to what they observed of the patient's condition?
F
A Many of the patients would be unfamiliar to me, as would be their history. Many of them, because of their medical condition, would have extensive, very large sets of notes, and these notes would require enormous amounts of time to go through to gain an accurate impression of what the patient's condition and treatment plan was; so nursing staff could be relied upon to fill me in on a lot of that detail.

Q Would it also be the case, with your trust as a result of your own experience in the
G
nursing staff, that you would take note of *their* view as to the condition of the patient?
A That has been my practice in all areas of medicine where I work with nursing staff.

Q It may be just a matter of common sense, because you may be seeing a patient just by way of seeing them in a snapshot way at the time you have to come in to try to deal with whatever the problem is, whereas the nurses, of course – not every nurse is there 24 hours – but the nursing staff in general are seeing the patient for hours each day and are observing a
H
whole series of things which the snapshot approach cannot observe.

A

A Yes, that is correct.

Q That is putting it very broad brush, but just so we can have the picture. In general terms, did you find that if you were called in to deal with or treat a patient with whose case you were not already yourself familiar – in those cases did you find that the notes that you did have available to you were sufficient for you to make a judgment about what was appropriate?

B

A I never had any difficulty with judging the situation with patients.

Q You would have not only the notes if you needed to look at them, any clinical assessment that might have been made, but you also had the assistance of the nursing staff and what they could tell you.

A There is access to nursing Kardex notes, medical doctors' notes, other medical letters in the notes and, in general, where a lot of these patients were in for quite long periods of time, very often the notes would relate to crisis intervention. On days when the patient was in a stable state, there may not be a note but that would usually just involve a line, for example "in status quo" or "continue with treatment".

C

Q Because in effect there was nothing to note specifically?

A There would be nothing to add to the patient's needs at the time.

D

Q You have told us about your own out-of-hours cover, just so we can get the general picture – and I am afraid you are the first medical witness we have heard so far, so I am using you to cover a bit of background information – you were doing your own out-of-hours cover and that would mean, would it, in general terms at this time, that you were on call one night a week – something like that?

A Something like that. There were six partners in the practice at that time, and myself and Dr Peters would cover our own on-call commitments. The other partners in the practice were in the habit of contracting a deputising service, usually between the hours of ten and seven each night when they were on duty.

E

Q In terms of your cover in this aspect, something like one weekend in five would you be on call?

A About that, yes.

F

Q Just very roughly.

A Yes.

Q You yourself had done some palliative care, had you not, in your training?

A Yes, I had.

Q Is that specifically the hospital in Hackney you were mentioning?

G

A Yes, it was. But palliative care is an aspect of most areas of medical practice, both in hospital and in general practice.

Q Yes, I was going on the way it was put in your statement. I think that you have probably already covered it. You said that you were at St Joseph's Hospital in Hackney as a senior house officer/registrar in palliative care.

A Yes.

H

A

Q That, I think you told us, was 1992.

A In 1992 I had completed my general practice training and was seeking a job in general practice. It took about a year to find a suitable job and during that year I was taking on various locum posts in the area in which I was living at the time. I lived at that stage in the East End of London. Having previously worked at St Joseph's Hospice they knew I was there and would contact me when they needed assistance.

B

Q May I just ask you a little bit about Dr Barton? Somebody, I think you can confirm, who worked very hard?

A Yes, indeed. Very hard. When I first came to look at the practice in Gosport, I was shown round the Gosport War Memorial Hospital by Dr Barton, who showed me the wards, the wards where she worked, and indicated the nature of the work that was involved and asked me if I was happy to take on that kind of work. I stated that I would be very happy to take on that kind of work. It was the kind of general practice hospital which I would value the opportunity to work in.

C

Q Would it be right, in terms of the practice generally to regard her as the most experienced practitioner in terms of palliative care generally?

A Very much so, yes.

D

Q You would also, no doubt, have become very familiar with her practice in terms of palliative care.

A Yes, I was.

Q Obviously, if you were on call and were required to attend the hospital, you would see records that she had made and you would also see what her prescribing practice was.

A I was fully aware of her prescribing practice.

E

Q I want to ask you about one aspect of it. It may be that in the course of this hearing different people will use different expressions. I am going to use the expression for the moment 'anticipatory prescribing'.. I think that is something you touched upon earlier on. You were aware obviously that Dr Barton practised that in terms of patients at Gosport War Memorial Hospital.

A Yes, I was. I regarded it as a very necessary practice.

F

Q I would like you to flesh that out. What is the difficulty and what justifies doing that?

A Well, when a patient requires a CD drug to be given, nursing staff are not allowed to dispense or administer that drug unless the drug is actually written up in the notes by the doctor themselves. They are not allowed to give or to write in a verbal order for a CD drug into the notes. It is allowed, to write in non-controlled drugs, but diamorphine and morphine in particular, they cannot write this. So if you have a patient who is in great distress, or who develops acute symptoms, who requires reasonably urgent administration or initiation of pain relief or other medication to relieve their distress, that drug needs to be written up and ready in the ward, so that it can be given. This is a particular problem if, for example, a patient becomes unwell at a time when you are already engaged in seeing another patient elsewhere out in the community; in which case, there might well be a delay of an hour or two perhaps before you can actually go in to see and deal with that patient. So I regarded it as an essential practice to allow the adequate care of patients in the wards, and I did not see any problem with that.

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Q Putting it very broad brush, to prevent them suffering unnecessarily whilst waiting for a doctor to arrive to actually prescribe something.
A I think that is an essential part of this type of practice.

Q Did that also mean that such anticipatory prescribing might on occasion justify a dose range?
A Yes, it does.

B

Q As opposed to a specific dose. Can you explain the purpose and point of that? Why a range, as opposed to a specific amount?
A Some of these patients might, for example, already be on oral morphine products, and therefore would not be naive to the effects of morphine and would need to initiate on higher doses of morphine in the syringe driver. So if a patient, for example, was taking oral morphine, 10mg, five or six times a day, you might well need to start that patient on maybe 80mg or so diamorphine in the pump. Otherwise it would not be sufficient to cover their symptoms, if you started at a lower dose. In fact, in general practice, where we have patients self-administering drugs, it is absolutely standard practice to instruct patients about how they can adjust and use their medication.

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Q So they are given a range themselves.
A Patients may be advised on ranges of drugs they may take in order to reduce symptoms, if they need them. These are untrained persons, and it would be seem natural to me that trained staff, such as nurses, can be trusted to help administer appropriate doses of drugs, with the direction of a doctor, if they wished to consult of that matter.

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Q Again, it comes back to that being something which you would approve and which you would practice, as long as you could trust your nursing staff.
A Yes.

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Q We may be going into this other topic that I am about to ask you about in more detail with other witnesses, but it may help, if you can give us part of the picture. As time went on – because you are starting in 1993, if I remember correctly?
A Yes.

Q As time went on through the Nineties, would it be right to say that in terms of patients at the Gosport War Memorial Hospital there was an increase in workload?
A Yes, there was.

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Q What was the cause of that, as far as you judged it at the time?

Q I think it was seen that the War Memorial Hospital provided a very good service for management of patients who were at a stage of end-of-life care where, through general physical deterioration and decline, these patients had reached a point where it could be anticipated that they would never be capable of rehabilitating back to an ability care for themselves; where they were suffering distressing symptoms, or were unable to express their needs. And in those circumstances, a facility was necessary to offer what was, in effect, a hospice management for these patients.

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Q Obviously in the District General Hospital, whatever category of hospital we are talking about apart from the Gosport War Memorial Hospital in this sense, there was a pressure on bed. It is inevitable, yes?
A Yes.

Q And a perfectly understandable desire perhaps that patients who had been treated, let us say, in Queen Alexandra Hospital (by way of example), as soon as it was possible for them to be transferred, because the hospital did not see itself as needing to provide immediate care as a result of an operation, say, they would be looking to transfer patients as early as possible.
A I think that certainly happens. When you have pressure on beds, you develop wards which specialise in different areas of care, and it might be felt perhaps that the management of a patient who is beyond medical or surgical treatment is not best managed on a ward where the psychology of the ward is geared towards producing an improvement or a cure. In those circumstances, the quality of care of the patient it is felt might be improved by moving to a ward where there is a philosophy of palliative care rather than intervention.

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Q Did that sometimes mean that patients were discharged – and I just take Queen Alexandra Hospital as an example – from such a hospital? Some patients might be discharged before, in an ideal world, they were quite ready?
A I think in terms of before the patient or their relatives were ready to accept the nature of their condition perhaps, yes. I personally feel that occasionally patients would be arriving at Gosport War Memorial having been, or their relatives having been, given the expectation of rehabilitation rather than continuing care. And those expectations may have been partly driven by staff at outlying hospitals who were unfamiliar with the exact nature of the type of conditions and physical conditions, that we were actually dealing with at the War Memorial.

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Q So in some cases, leading to rather higher expectations of what was realistic than was actually the case?
A This is partly complicated, because there were also long-term rehabilitation wards based at the War Memorial. Sometimes it would be unclear to staff at the Queen Alexandra Hospital whether the patient was going to a rehabilitation ward or a long-stay ward.

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Q Would you help, in relation to the Gosport War Memorial Hospital, when you talk about rehabilitation ward or wards, what names do we think of as applying, because we will be hearing of different names?
A Daedalus Ward was what I would regard as a ward where the emphasis was perhaps towards some rehabilitation work. I think Dryad Ward tended to have patients who had a more severe degree of disability.

F

Q We will be hearing about patients who came to Gosport War Memorial Hospital for slow stream rehabilitation, or something of that kind. They would be likely to go to Daedalus, would they?
A I think so. I think it would very often be a fairly broad mixture, because it would depend on where the bed availability was between the two wards.

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Q It might also turn out to be the case that a patient who was transferred with a hope of progress with regard to rehabilitation might turn out, on arrival or shortly thereafter, to be a case where rehabilitation, realistically speaking, was not on.

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A That would certainly be the case quite often. Assessment of the patient would often show – or the patient, for that matter, would take a turn for the worse. And in those circumstances, one would have to actually change the direction or emphasis of treatment.

Q Thank you for that by way of background and context. Lastly, may I ask you this about Dr Barton. Was she somebody who, in your view and your experience of her, who was wholly committed to the best interests of her patients?

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A I have never had any doubt of that.

Q Thank you. That is all I need to ask.

Re-examination by MR KARK

Q Just a couple of matters. You spoke about patients being written up in advance, as it were; prescriptions being written in advance for patients.

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A Yes.

Q Are you saying that happened for every patient who entered Dryad of Daedalus Ward?

A I do not think it would happen to every patient, but I think that any patient where it could be anticipated to be a need, then there would be an advance prescription perhaps written up.

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Q You spoke about patients who might already be on morphine.

A Yes.

Q Let us deal with those first of all. So this is patients who are on morphine, but taking it orally, is it?

A It may be administered orally or through a patch or something of that nature, but not by a syringe driver at the time.

E

Q Were you aware of the difference in the amounts that should be provided, administered, subcutaneously; in other words, the conversion rate?

A I would be aware of that. There would be a chart for that purpose. The issue there though is that very often, when a patient moves from oral medication to needing syringe driver medication, it is very often due to a deterioration in their condition. And often that deterioration might require an incremental increase in the dose in the first place.

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Q I understand.

A So the conversion might not necessarily apply. You might deliberately go to a higher dose equivalent.

Q The conversion rate presumably still applies, but you have to bear that in mind when you are seeking to deal with the patient's distress.

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A Yes.

Q You are not saying you ignore the conversion rate and treat it, as it were, one for one, are you?

A No, I would not treat it as one for one, because they are different drugs.

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Q If a patient is opiate naive, would the range have to reflect that?

A I think it probably would, depending on how severe their symptoms were.

Q You told Mr Langdale that in general terms you had never had any difficulty with the notes that you came across on the Ward. Is that right?
A Yes.

Q Can I take it, or would you tell us, have you reviewed any of the notes for any of the other patients that we are dealing with in this case? I think broadly you are aware of them?
A I have not reviewed other patients' notes. I was not involved in any of the specific care of any them that I am aware of.

Q You also said this. You would be very reliant on the information provided to you by the nurses. "Many of the patients would be unfamiliar to me." Yes?
A Yes.

Q You also spoke, or I think perhaps these words were used by Mr Langdale, that really you would be getting a snapshot of the patients on the occasions when you went into the ward.
A I would, but where I felt that that was not adequate for me to make a clinical judgment I, could make reference to the patients' notes, where I needed to.

Q I understand that, but you were not there, as it were, as Dr Barton was, on a day-to-day basis.
A No.

Q In relation to the patients on Daedalus and Dryad Ward, although the patients might be unfamiliar to you, whose patients would you regard them to be?
A I would regard them to be patients of the consultant in charge, which would be Dr Lord and I think Dr Tandy at times. Dr Barton would have knowledge of them, as being the clinical assistant who would deal with many of the day-to-day affairs of their medical needs.

Q Thank you very much.

THE CHAIRMAN: Doctor, as I had indicated, after Mr Kark had asked questions of you it would be open to members of the Panel to do so, so I am looking now to see. Mr William Payne, over to your left, is a lay member of the Panel.

Questioned by THE PANEL

MR PAYNE: Good afternoon, doctor. I am hoping you can help me with some clarification of the questions just asked by Mr Kark. You said that you have not reviewed the other patients' details, so you have only concentrated on this one, because this particular patient you were involved in.
A This particular patient I was involved with the care, and the police in the course of their investigations of the Gosport War Memorial Hospital asked me to review the notes of Mr Pittock in detail, because I had had some clinical involvement with his care.

Q Just this one?
A Just this one.

A

Q I think you have just said that you only attended perhaps once a week, or once every other week, or ---
A When I was on duty during the week I would really just be on-call for out of hours, which meant that if there was no request to see a patient I would not go into the hospital. When I was on duty at weekends I would conduct a ward round of the Daedalus and Dryad wards on the Saturday morning to review any medical needs or requests from the staff nurses – the nurses in charge – and I would usually make a telephone enquiry on the Sunday of any needs and go in on the Sunday also to write up any specific needs.

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Q I think you have given me the picture of your input into the hospital. Can I just ask you to turn to pages 189 and 190, please?
A Yes.

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Q These are administrative records for this patient.
A Yes.

Q You would have seen these administrative records, this record, for this patient, because you actually increased the dosage of one of the drugs?
A Yes.

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Q So you would have had access to the other pages and the drugs that had been prescribed prior to that.
A This is actually the third drug charge of this patient during the course of this admission. When he was on Phoenix ward under the care of the elderly mental health team, he would have had a drug chart written up for Phoenix ward. When he was transferred to Dryad ward, the entire chart would have been rewritten as part of that transfer, with all his drugs transferred to the new chart, and his previous drugs would not be included in that. Then subsequently when the number of available spaces for writing in different drugs ran out on that chart, it was rewritten again on 17 January, and the previous chart would have been put away in the notes – filed away in his notes.

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Q But you would have seen this? You would have seen page 190?
A I would have seen 189 and 190, because you can see that I have actually signed for the drug, and that indicates that I have looked at the chart.

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Q Thank you for that. If you looked at page 190 – and I am not familiar with this chart, so I am trying to read it to the best of my ability – the top reference is diamorphine?
A Yes.

Q And that has been administered on the 17th, with 120 mg?
A Yes.

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Q The 18th with 120 mg, and the 19th with 120 – am I reading this correctly?
A Yes, you are.

Q The one below it is midazolam, and that is administered 80 mg on the 17th, 80 on the 18th and 80 – I am reading this correctly?
A Yes.

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Q So when you went into the hospital you saw this. What was your reaction to these figures, to these amounts of drugs?
A They are quite large doses, but I was aware that in spite of those large doses the patient remained agitated and unsettled, and these are drugs which I have used with what I would call a high ceiling, in that if the patient requires a greater dose response – if the patient requires a higher dose, a higher dose may be given.

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Q Right.
A I am aware that prior to this chart, the diamorphine had been written up at 80 mg, so this was increased from 80, which had been the original starting dose, after he had been given oral morphine prior to that.

Q What I am trying to ask you – and it is my fault, I am not putting it well – but I am wanting to know if you saw those, and if those figures alarmed you, or were they the sort of

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figures that you would have been met with at regular visits to the hospital?
A The dose would have alarmed me if Mr Pittock had been showing signs of respiratory depression and physiological stress as a result of that.

Q I understand, I am listening to you; I am trying to take a note of what you are saying.
A Patients develop tolerance to opiates, and if they develop a tolerance to those opiates then large doses may be necessary to produce a therapeutic effect. So I would presume that if

D

he was still agitated and unsettled on these higher doses, that it would indicate that he had a degree of tolerance to those drugs, which meant that the higher dose was safe to administer.

Q Right. Just bear with me for a second. Can you give me some indication – and I would assume that all patients are different – but can you give me some indication of how long it would take for someone who was an old man – I think he was 80 – for his body to develop a tolerance?

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A Assuming that his clinical condition and his need for pain relief was stable, I would anticipate quite a rapid initial development of tolerance over a period of about one to two weeks. So starting from a starting dose of morphine orally until this point in time, anything between seven to 14 days.

MR PAYNE: Thank you very much for your help.

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THE CHAIRMAN: Dr Roger Smith, to Mr Payne's left, is a medical member of the Panel.

DR SMITH: Could you turn to page 198 again, please? Just remind me again – it has probably slipped my absolute memory here. When you attended this patient he was unconscious, is that correct?
A When I was consulted about him he was agitated. I asked for changes to his medication to be made, and when I subsequently attended at a later stage, his agitation had

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settled and he was peaceful.

Q Was he unconscious?
A I do not think he was in a coma, no.

Q Was he conscious?
A No, he was not conscious.

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Q Thank you. You said to Mr Kark that it was clear from Dr Barton's entry on 18 January 1996 that the Nozinan was to control symptoms. I wonder if you can just take me through that entry and explain what you mean by that. Rather this: tell me what you understand precisely from that note, bearing in mind that you did not know the patient. And if you can – and this is difficult – if you can divorce your mind from the fact that you have since reviewed all the notes of this patient, what was in your mind on the day when you saw him? How does that note impact upon you? What does it tell you, precisely, that helps you manage the patient?

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A It states "Further deterioration". The nursing staff had advised me that Mr Pittock had become agitated and unsettled. I interpreted that to mean that he was in distress. I did have the habit of reading the notes of patients that I was asked to see, and particularly to read the admission note, which would give information as to why the patient was being treated in the War Memorial, and Mr Pittock's condition noted here was that he had progressive deterioration of his mobility, that he had become completely unable to leave the bed; he had become incontinent, he was unable to move easily without assistance, and he had developed bedsores of the sacral area, the buttock area, and these would have been causing him pain. He also had a long history of agitated depression, and a degree of not suicidal but wishing to end his life, wishing his life would end, over a long period of time, and had developed a very aggressive affect with people who cared for him, indicating that he was in a very distressed and unhappy state. So I would have interpreted him as suffering greatly from the inevitable deterioration as a consequence of his age. So "further deterioration" here would indicate to me that Mr Pittock was suffering gravely, and that he required increased medication to relieve that suffering.

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Q I am sorry, this might seem pedantic, but I am just trying to get to the nub of what notes mean in general here. What symptoms does deterioration in this case refer to, and how do you know that?

A My experience of patients ---

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Q No, sorry, not your experience – this patient, from this note, or from these notes that were available to you on that day.

A It does not specifically state which deterioration we are talking about, whether it relates to pain or cardiac condition or abdominal condition, no.

Q I think you have already alluded to this, that there is a context of care.

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A Yes.

Q And you have alluded to the fact that there are different categories of patient – rehabilitation patient, long-term patient, end-of-life patient. From these notes, as you come in on the Saturday, what can you tell about the category in which this patient lies?

A I would say that this patient lay in the category of end-of-life care. In fact the note prior to this indicates "TLC", which means that the philosophy of care for this patient was to relieve distress and suffering.

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Q Thank you. So in a nutshell, TLC, would you say, is a commonly accepted synonym of end-of-life care?

A Yes.

THE CHAIRMAN: Thank you, doctor. Ms Mansell is a lay member of the Panel.

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MS MANSELL: Doctor, can you just explain to me, in your evidence, after talking about end-of-life care, you actually said what you see as the essentials of hospice management. Can you tell me what you actually see as the essentials of this hospice management?

A Hospice management is about preserving patient dignity, respecting the patient's needs, respecting the patient's wishes, and reducing the distressing effects of their medical or physical condition and their mental condition also. I think that if a patient is expressing distress, then they should be given the medication they request to deal with that distress. To continue, for example, to feed a patient who has expressed a desire not to be resuscitated would be in my opinion tantamount to force feeding, which is an area of medication which we would not condone under any circumstances. So it is about respecting the patient's needs and wishes.

B

Q Just clarifying with you, in relation to your responses to Dr Smith I understood you to say that this person, through the range of drugs that the person had been given, that he actually was unconscious, when you actually went to see him?

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A Often, when you see a patient who is in distress, if they are awake they are in distress, and often when you see patients who are suffering from pain they may be on morphine and they may be awake from time to time, and the only memory they have of that time period is of being in pain. So if you have a patient who is in great pain or distress, you have to prevent them from becoming aware of that distress. Otherwise, that is the only memory they have.

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Q What can be the other side effects of the range of drugs that this patient was actually on?

A One of the side effects of haloperidol which we discussed was that the patient might become more agitated, more restless, and this might be an idiosyncratic reaction relating to haloperidol and that particular patient.

Q What was your assessment as to how much the haloperidol was contributing to the patient's agitation?

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A My feeling was that, if the patient was agitated, we need to give him medication that did not give him agitation; and if we withdrew the haloperidol, the therapeutic effect of haloperidol would have to be replaced by something else – bearing in mind that, although it has side effects, it also has therapeutic effects.

Q I am just trying to clarify here in my own mind, because it seems to me that what you are saying to us is that you had to give the patient this type of drugs because the patient was agitated, but at the same time the cocktail of the drugs could have been contributing to that agitation.

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A That is a reasonable speculation, but you can also speculate that, without the haloperidol, the patient will also suffer distress because the therapeutic effect of the haloperidol will be withdrawn. So you have to make a decision based on a best guess in those circumstances, and my best guess here was that the patient would be more comfortable without the haloperidol and with an increase in Nozinan; so it was a therapeutic decision, based on personal opinion and experience.

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THE CHAIRMAN: Doctor, which came first? Can you tell from the record? Was it the agitation or the haloperidol?

A I have no doubt it was the agitation. There is extensive reference to aggressive, agitated and distressed behaviour from Mr Pittock in the run-up prior to this event. He was

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initiated on oral morphine for that reason, amongst others, because he was in pain from his bed sores when he first arrived on the ward.

Q Would it be fair, in your opinion and experience, to say that the combination of drugs prescribed at the time that you were involved with the care of this patient ran a high risk of producing respiratory depression and potentially coma?
A When I saw the patient he was taking the medication and he did not have respiratory depression at that time; so although there would be a risk with a patient being given these doses straight in – yes, there would be a risk of respiratory depression – but his dose had been escalated steadily as his symptom control required. If medication such as morphine is used to relieve distress, it is likely, if needed in a high dose, that it will probably shorten life, but that is a side effect of the necessity to relieve the distress.

B

Q My question was would this combination of drugs present a high risk? You have accepted clearly that it is a risk. Would you go so far as to say that it is a high risk of producing respiratory depression and potentially coma?
A I would think there would be a risk of that. I think that is ---

C

Q What? There is a risk of a high risk? I am sorry, I do not want to be ---
A I am trying to find a way to answer the question in a way that puts it in context. If you take a patient off the street and you give him these doses, there would be a high risk that that patient would develop respiratory depression and would be endangered by that. This patient is already in a situation where they are at high risk of dying because of their medical condition, because of their deteriorating medical condition. In that context, one has to use high-risk management in order to control their symptoms.

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Q Was this high-risk management?
A There is a high risk that their life will be shortened by it, yes.

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Q In your view, was that a justified risk?
A It was.

THE CHAIRMAN: Are there any questions, Mr Kark, first of all, arising out of those of the Panel?

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MR KARK: It should be Mr Langdale first of all, sir.

THE CHAIRMAN: I beg your pardon, yes. Mr Langdale, any questions arising out of those of the Panel?

MR KARK: Very kind of Mr Kark, but no, thank you.

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THE CHAIRMAN: Mr Kark?

<u>Further re-examined by MR KARK</u>

Q In relation to your last answer to the Chair, what medical condition do you say was going to kill this patient?
A He had bed sores. He had extreme immobility, which would place him at risk of orthostatic pneumonia. He had extreme mental distress, which was well documented through

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A his admission in Phoenix Ward. But I think the main risk to him of death would be through immobility.

Q Not being able to move?
A His being unable to move, which pre-existed any use of morphine. In fact, I believe his death certificate shows bronchopneumonia, which would have been of an orthostatic type.

B Q You interpreted from the notes "further deterioration" as meaning that the patient was agitated, is that right?
A Distressed.

Q Distressed. But at the time that you come into the picture, do you know the cause of his distress?
A At the time I would not be able to know precisely that. I would have to judge that on
C the basis of his clinical history.

Q You spoke about how a prescriber would have to be aware of the possibility that a patient had developed a tolerance to opiates – yes?
A Yes.

Q You spoke about how a tolerance might develop over, I think you said, seven to
D 14 days. Is that right?
A I would expect tolerance to develop initially very quickly and then gradually to reduce in speed. So one would initially quite quickly become tolerant to a dose of opiate, and the speed with which you develop that tolerance might slow down.

Q I want to understand what you mean by becoming tolerant and what you mean by "quite quickly".
E A Tolerance of opiates occurs, as I understand it, because when your body receives opiates the receptor for the opiate is then blocked, so the body then develops an increasing number of receptors. So the longer for which you are actually on morphine, the more receptors you have; and the more receptors you have, the more morphine you need to cover those receptors, to gain a therapeutic effect. The speed with which you develop those receptors is induced by the morphine; so also, if you need to have a relatively high dose of morphine, you would develop tolerance at a faster rate.
F

Q Do you stick to your original evidence that tolerance might develop over a seven to 14-day period?
A I do not have chapter and verse to that, and that is a purely personal, subjective opinion. I think that the degree of tolerance of the patient is partly determined by the patient's response to the dose. So one's judgment of tolerance is based on how well a patient tolerates a dose. If a patient develops respiratory depression at a dose of 50 mg of morphine,
G then you would stick at that dose. If they do not have respiratory depression at that level, one would be able to go to a higher dose without feeling there was a danger.

Q Yes, I understand that, but the starting point is not the respiratory depression; the starting point presumably is whether the patient is in pain or not.
A The starting point is symptom control, yes.

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Q And the reason – just coming back to the questions, I think asked by Mrs Mansell – you stopped the haloperidol was because of signs of agitation, signs of distress.
A It was because it was felt the haloperidol might be contributing to that.

Q Quite apart from the patient's symptoms. It could have been the drugs.
A A combination is possible, yes.

B

THE CHAIRMAN: Thank you very much indeed, doctor. That brings us to the end of your testimony. We are most grateful to you for coming to assist us with this matter today, and you are free to go.

(The witness withdrew)

MR KARK: Sir, we are about to move on to Patient B. It would plainly be a convenient moment to adjourn, if you are going to take the time to read my short opening in relation to that patient.

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THE CHAIRMAN: Yes.

MR KARK: May I mention in passing that we all know there will be a Tube strike starting this evening. I know that counsel can get here on time, but I wonder whether we are proposing to start on time?

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THE CHAIRMAN: We are proposing to try to start on time. Some of us are staying up in town; some of us live up here already; but there are others who do require to come in by train. They are anticipating a long walk, on the basis that taxis will be like hens' teeth and bus queues will be enormous. I am told that they are bringing in sensible shoes and will get here as soon as they can. They are aware of the difficulties so presumably they will be leaving that much earlier. We cannot be sure what will happen but we will attempt a 9.30 start.

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(The Panel adjourned until Wednesday 10 June 2009 at 9.30 a.m.)

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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 16 June 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY SEVEN)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

INDEX

Page No.

MARGARET ROSE COUCHMAN, Sworn

Examined by MR KARK	1
Cross-examined by MR LANGDALE	35
Re-examined by MR KARK	55
Questioned by THE PANEL	58
Further cross-examined by MR LANGDALE	76
Further re-examined by MR KARK	79

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THE CHAIRMAN: Good morning everybody welcome back. Mr Kark?

MR KARK: I have provided to the Panel and to my learned friends a revised witness order. We are now on Day 7 and it was hoped to have called Dr Ewenda Peters first because she deals, albeit briefly, with the patient, Robert Wilson, who we were dealing with yesterday. I gather Dr Peters has not yet arrived.

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THE CHAIRMAN: Is anybody in contact with her.

MR KARK: We have left a message for her on her mobile, but she has not responded. The other witness we have for you today is Margaret Couchman. She is here, so I am in the hands of the Panel as to whether you want to give, say, 15 minutes to see if Dr Peters arrives and we can then deal with the end of the evidence in relation to Mr Wilson or whether you are prepared to embark on a fresh witness.

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THE CHAIRMAN: I have a suggestion. Given that Nurse Couchman is apparently to be dealing in particular with Patients E and B, what the Panel could do at this time is re-read your opening in respect of those patients. If by the time we have finished the Doctor, Ewenda Peters is still not here, we would go straight on with Nurse Couchman.

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MR KARK: Can I also mention that we thought we would have something of a legal argument in relation to the statement of Carl Jewel. I am glad to say that we have resolved our differences. There were not many differences and we are going to be able to read that to you by agreement. We will have a relatively short day today, depending I suppose on how much my learned friends have for the two witnesses.

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THE CHAIRMAN: That makes it all the easier to give the extra time now. We will take 15 minutes to re-read your opening in respect of Patients E and B and assess the situation at the end of that time.

(The Panel adjourned for a short time)

MARGARET ROSE COUCHMAN, sworn

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(Following introductions by the Chairman)

Examined by MR KARK

Q Is it Margaret Rose Couchman?
A Yes.

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Q I think you are a nurse. Can you tell us a little about your background. How long have you been a nurse?
A I trained in the 70s at Portsmouth School of Nursing and I worked at the Royal Portsmouth until it was demolished. We moved to Queen Alexander Hospital and I worked for a length of time. I left the hospital at one point and worked for the Hampshire Autistic Society in Alverstoke for two years and then in 1983 I took a job at the Gosport War Memorial on the Children's Ward.

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Q I will ask you about the Gosport War Memorial Hospital in a moment. Have you come along today with a nurse representative?
A I have, our RCN representative.

Q Is that Miss Betty Woodlands who is also a nurse at the Gosport War Memorial Hospital?
A Yes.

B

Q Is that the lady sitting at the back with Dr Barton's husband?
A Yes, it is.

Q The Gosport War Memorial Hospital has a number of wards and it has changed through the years. We have heard about something called the Redcliff Annex and, at the time of the events that we are going to be dealing with, I think the Redcliff Annex had closed. Did you ever work at the Redcliff Annex?

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A No.

Q You told us that when you started you worked on the Children's Ward at Gosport War Memorial Hospital?
A Yes, I did.

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Q How many wards did the hospital have?
A When I started there were three wards. There was the Male Ward, the Female Ward and the Children's Ward -- oh, and a theatre.

Q In our bundle 1, behind tab 11, we have the most enormous plan of the hospital and I am going to suggest that you put that to one side and I will hand out one which is more manageable. I tried to open the plan that you have and it will subsume you all. Could I hand out a smaller version of small same thing. I am going to ask Nurse Couchman to give us some assistance about where the various wards were.

E

THE CHAIRMAN: Mr Kark, do you wish us to discard---

MR KARK: I suggest you get rid of the one behind tab 11 and replace it with the one I am handing out now, if the defence are content with that. At the moment you might want to keep this plan out, it is easier to keep it where it is. I am not going to give it an exhibit number, it can just go into our file. You will get one of these in a moment. I am holding it so the Dryad and Daedalus are on the right-hand side of the page, which is upside down. I think someone has written the words the wrong way to which the plan is meant to work. Dryad and Daedalus are on the right-hand side. This, I think, shows us the whole of the ground floor plan of the hospital. Since you are the first nurse witness that we are calling, I am going to ask you to try and help us. I am going to give you a moment to see if you can understand the plan. The part which is outlined and, I expect, coloured in on the original, is Dryad Ward, or meant to be Dryad Ward. Does that make sense to you or not?

F

G

A What date is this?

Q It is 2000.
A I was thinking of the old hospital previous to this.

H

Q No. Is this the hospital as it was in 1996, 1997 and 1998?

A It changed, did it not?

Q It did change, but when did it change. Can you help us?
A I do not think I can help you.

Q You cannot ask Dr Barton (Witness turning towards Dr Barton). Can you help us as to when it changed of your own knowledge?
A No, ten years perhaps.

Q Did the position of Dryad and Daedalus Ward change. Did they continue to exist after the change?
A Yes, the Children's Ward disappeared.

Q Can you see where Daedalus Ward is marked on the plan?
A Yes, I can.

Q Does that seem right to you at the time that we are going to be discussing, which is 1996 through to 1999?
A I cannot really make a lot of sense of it.

MR LANGDALE: If it assists, I do not mind if my learned friend leads and puts what his case is because I am trying to manage with the larger one which helps in the sense it has colour coding. I do not know if my learned friend wants to put to the witness what the location is or not.

MR KARK: I cannot at the moment, no, but thank you for the invitation.
A I can tell you the general layout.

Q That would be excellent. Would you do that for us?
A If you came in through the main doors, the doors where A&E were, you walked up a long corridor and Dryad Ward was off to the left of the corridor. At the top of the corridor you actually turned right and then sharp left again into Daedalus Ward. On that floor also was physio and a Mental Health Day Ward to the left.

Q That is not Mulberry?
A Mulberry was upstairs and another ward.

Q How many wards did you have on the ground floor. Can you remember?
A Two on the ground floor.

Q Was that Daedalus and Dryad?
A Yes.

Q Were they inter-linked?
A No.

Q At the time we are discussing, was there any Accident & Emergency there?
A Yes.

Q Where was that?

A

A That was at the entrance, the front entrance.

Q You told us that in 1983 you, I think, started working on the Children's Ward?
A Yes, I did.

Q Did there come a time when you found yourself working on Daedalus Ward?
A Yes, when the whole hospital was changed and we no longer had a theatre and Children's Ward, then I worked on Daedalus Ward.

B

Q So there came a time, did there, when there were no operations being conducted?
A That is right, yes.

Q Did that mean the closure of the Accident & Emergency as well?
A No.

C

Q The Accident & Emergency kept going throughout, did it?
A Yes.

Q What was Daedalus Ward used for?
A Daedalus Ward, I think at the time we are talking about, was partly stroke and partly long stay.

D

Q How many beds did it have?
A It had 24 beds.

Q What about Dryad Ward?
A I do not think it had so many. I think perhaps it was 20, possibly 22.

E

Q What was that used for?
A I think it was mostly, then mostly long stay patients.

Q Did you ever work on Dryad Ward?
A No.

Q Were you a permanent member of staff?
A Yes, I was.

F

Q What was your seniority as a nurse?
A E-grade.

Q Can you help us what the grades are?
A Managers G-grade. The manager of the ward is G-grade, then there is a senior staff nurse who would be F-grade and then I think we have two E-grades.

G

Q You were one of those?
A Yes.

Q Does that denote a certain level of seniority?
A Yes.

H

A

Q Meaning you had been doing...
A A small amount.

Q ... the job for a while and you were experienced?
A Yes.

Q You know and knew Dr Barton?
B
A Yes, I worked with Dr Barton.

Q For how many years did you work with Dr Barton?
A A long time, ten, maybe more, years.

Q I want to deal with her role as clinical assistant as you saw it. We know that there were consultants who did rounds on the two wards---
C
A Every week.

Q Who did rounds on the two wards, Daedalus and Dryad?
A Yes.

Q You said "every week", I am not sure what that refers to?
A I think it was one day a week that we had a round, a ward round.

D

Q You cannot turn to Dr Barton, I am afraid, for assistance.
A I know, I did not mean to, I am sorry.

Q You think once a week a consultant would be doing a ward round on each ward?
A Yes.

E
Q Or on one of the wards?
A Yes.

Q Which is it?
A I think it is once a week on each ward.

Q Do you remember who the consultants were?
F
A Yes, the consultant was Dr Lord.

Q Anyone else you can remember?
A I cannot. We did have a male and I cannot remember his name.

Q Does Dr Reid mean anything to you?
A Yes, I remember Dr Reid.

G

Q What about Dr Tandy?
A Yes, I did not see them very often.

Q So it was mainly Dr Lord?
A Yes.

H
Q Did you ever go on one of the ward rounds with one of the consultants?

A

A Yes.

Q How often would Dr Barton come into the hospital?
A She would come every morning.

Q At about what time?
A About eight to half past.

B

Q How long would she remain at the hospital?
A Every morning she would remain, I would say, about half an hour.

Q Can you remember, did she divide her time equally between the two wards for which she was responsible?
A I should imagine so, but as I was working on Daedalus, I do not know what went on.

C

Q You just saw her on Daedalus?
A Yes.

Q Apart from every morning coming in between eight and 8.30, are you saying she came in at eight and left at 8.30, or you saying she arrived ---
A I am saying roughly. Possibly she was there three quarters of an hour some mornings depending on the work she actually had to do.

D

Q Always arriving at about eight?
A Yes.

Q Did you go round with her when she visited patients?
A It depended. If I was in charge of the ward that morning, then, yes.

E

Q Tell us what role Dr Lord played. You tell us she was a consultant. She visited once a week you think?
A She did, the ward round once a week.

Q That would mean what?
A That would mean that she would see each patient, she would see each patient as to any problems they had, she would look at their notes, she would look at their treatment card and prescribe any further treatment she wanted for the patient. If she had asked for x-rays or blood tests previously she would look at the results you.

F

Q You told us that on Daedalus there were approximately 24 beds?
A Yes.

G

Q Is it quite a busy ward?
A Yes.

Q Would Dr Barton visit some of the patients each morning?
A She would see the patients who had had problems, basically.

Q When you said she would see the patients who had problems, either, presumably, when they came into the ward or if they were getting worse or better?

H

A

A If they had problems overnight.

Q Who would attend these ward rounds with her? Let us take it from your own experience.
A It would be the consultant, Dr Barton, the nurse in charge, so I did not do the round every week.

B

Q You say "the consultant" but you tell us the consultant comes round once a week, so I want to concentrate on a ward round that Dr Barton is doing on her own?
A The daily?

Q The daily ward round?
A It would be the nurse in charge.

C

Q So it would be Dr Barton and the nurse in charge?
A Yes.

Q Where were the patient notes kept?
A They were kept in the office; in a filing cabinet in the office.

Q How would the notes be made available to Dr Barton?

D

A The nurse in charge would take them out for her, or she would go and help herself.

Q Was there a trolley or something like that?
A Yes.

Q Would all the patient notes for all of the patients on the ward come out with the nurse, or just for specific patients?

E

A It would depend. If it were a weekly ward round, all the notes would go round. If it were in the morning, when Dr Barton was seeing the patients with problems, it would be their notes which would be out.

Q But who would be directing Dr Barton to the patients with problems?
A The nurse in charge.

F

Q Who had authority to write out prescriptions?
A Dr Barton and the consultant.

Q Who had the authority to administer the prescriptions as written out by Dr Barton?
A The nurse on the drug round.

Q Tell us about the drug round.

G

A They were certain times of the day: in the morning; lunchtime; in the evening; and a night-time round.

Q That would mean what? Just imagine we have never been to a hospital before and there are no nurses or medical people on the Panel. Just imagine that for a moment. It is not quite right, but imagine that for a moment. We want to know what actually happened. What happens on a drug round?

H

A The nurse in charge or one of the senior nurses will go round with the drug trolley to each patient, would check the treatment card, check the patients – patients all have a wrist band with their name on – check the treatment card and administer the drug for that time.

Q Where would the treatment card be?
A Probably at the end of the bed.

Q So each patient would have a treatment card at the end of the bed, which would be checked by the nurse on the drug round.
A Yes.

Q Were you able to do drug rounds?
A I did.

Q So you were able to administer drugs.
A Yes.

Q Would that include controlled drugs?
A Controlled drugs requires two trained nurse. They are in a locked cupboard in a locked cupboard, and we have a controlled drug register.

Q Tell us a bit about the administration of controlled drugs, please. You would be able to administer controlled drugs, with another nurse?
A With another registered nurse.

Q Before you issued controlled drugs to a patient, what sort of authority would you need to have?
A I do not understand.

Q You would need a prescription presumably?
A Yes, of course, written by a doctor. It would have to be the right date and the right time, et cetera.

Q As I am sure you know, we have heard quite a lot already in this case about variable doses. You know about variable doses, do you not?
A I have heard about it, yes.

Q If a variable dose has been written out, just tell us how you would decide what to give.
A I would give the lowest amount.

Q What does that mean?
A Supposing it said 5 to 10 mg, I would probably give the patient 5 mg, if that were suitable.

Q And if it says 80 to 200 mg, you would give 80?
A Say that again.

Q If it says 80 to 200 mg ---
A I would give 80, yes.

A

Q Are you allowed to give less than the minimum dose on a variable dosage?
A It is not normal, no.

Q Would you ever have done that?
A Probably not, no.

B

Q What about increasing within a variable dose? Say you have started off at the minimum dose, how and why would you make a decision to increase that dose, or would you need any special authority for that to happen?
A I would probably talk to the manager about it.

Q The manager at the time – was that Philip Beed?
A Yes. It is not something that I can recall doing.

C

Q You cannot remember increasing a dose?
A No.

Q Nurse Hamblin we are going to be hearing a bit about. What was her role?
A She was a sister, I believe.

D

Q You believe?
A She was a sister.

Q Does that put her a grade, in the pecking order, above you?
A Yes.

Q Would that mean she was an F or a G?

E

A G.

Q So she actually is a manager grade?
A Yes.

Q If you were thinking about increasing drugs for a patient, would Nurse Hamblin have the authority to allow an increase in the dose – provided it is within the variable range?

F

A Probably.

Q Can you help us? "Probably" does not help us a lot. If you cannot remember, you cannot remember.
A I can remember, yes, but I have told you that – that I did not have to increase any drug dose.

G

Q How long were you on ---
A Quite some time.

Q ...Daedalus Ward.
A (*Correcting pronunciation*) It is Daedalus Ward.

Q Daedalus, all right! How long were you on Daedalus Ward?

H

A Over ten years.

A

Q During that period, can you ever remember increasing a dose?
A No.

Q I think you made a statement to the police about a patient called Elsie Lavender. Do you remember that?
A Yes, I can remember the statement.

B

Q Do you remember the patient at all?
A No.

Q What I am going to do is try to direct your attention to some of the entries that I think you made in the patient notes. One of the difficulties we have had is reading people's writing, and even more difficulty reading signatures; so if you see an entry that you have made that I do not point out to you, would you please just tell us? Do not sit quiet and let it pass by. All right? I am going to ask you to take up the notes. To your left you will see a row of files and I am going to ask you to take up file B, please.

C

Just to bring this patient back to mind for everybody, she had a fall on 5 February 1996. You will find a chronology right at the beginning of that file. I understand that you cannot personally remember her, but it may just help us all if we very briefly recap. She had a fall and she was admitted to the Royal Hospital Haslar. How far away was the Royal Hospital Haslar from Gosport War Memorial?
A About ten minutes in a car.

D

Q She was looked after by, among other people, Dr Tandy. Then she was transferred to Daedalus Ward on 22 February, where she was reviewed. In the notes, which you now have, you will find some nursing records towards the back of the bundle. I am going to take you to the beginning of those first of all. If you go to page 1001 first of all, and then I will take you to an entry you made on 1022 – but I want to use you, if you would not mind, to introduce us to these notes. The document you are looking at on page 1001 – do you recognise that? That sort of document?
A Yes.

E

Q I do not think that has got your writing on anywhere, has it?
A I cannot see it, no.

F

Q Is this an admission form, effectively, for this patient?
A Yes.

Q We can see that there is a brief summary of the patient's condition. We can see that she is coming from A4 Ward, under the care of her GP, I think. It shows Dr Peters. Is that right? Do you see just above the words "From A4 Ward"?
A Yes.

G

Q Then we can see on the right-hand side of the page, "To Daedalus Ward, GWM" and then the next of kin is set out. We can see "Nursing requirements: needs minimal assistance with feeding; needs full assistance with hygiene needs; ulcers to both legs dressed every other day with dry…" – is it Kalbstat?
A Yes.

H

A

Q And then, something "padding". What is the word before "padding"? Can you read it?
A I cannot quite read it.

Q Is it "conforming bandages"?
A Yes.

B

Q "Toe to knee; all pressure areas intact although buttocks are very red but not broken; blood sugars are quite erratic so" – is it 7 BMs?
A Yes, have been recorded.

Q BMs?
A Yes.

C

Q What are BMs? Blood…?
A It is a way of measuring the sugar in the blood.

Q And "she is unable to inject herself". Then we can see that the drugs that she is on at that time are set out below.
A Yes.

D

Q Over the page, page 1002, that is signed by – do you recognise that signature?
A No. It is "RGN", but ---

Q All right. Then we can see that there is a nursing care plan, but there seem to be a number of different sheets as we leaf through the following pages. The first one starts on 29 February, but then we go to 24 February and 22 February after that. We can get the original records in here if we want, but how did these nursing care plan documents work?

E

A They are actually designed so that a strange nurse can come on to the ward and read the nursing care plans, and she is supposed to be able to see exactly how to treat the patient and what has been done for the patient.

Q These seem to be individual sheets rather than a running record.
A Yes.

F

Q Is that because each nurse ---
A They were at the time – individual sheets.

Q How did it work? Each nurse would fill in their own?
A Yes. At the end of each shift she is supposed to fill in the care plan and sign it.

G

Q If we go, for instance, to page 1007 – I just want to try and understand these records – do we see on 5 March 1996, is that your signature?
A Yes, it is. That says, "Dressing remains in place"; so I did not change the dressing.

Q As I say, if we go back to 1005, could you shout out where you see an entry by you? I do not need you to deal with everything perhaps, but it is just to get an idea of how these are working. So at 1005 do we see your signature?

H

A Yes, on 24th of the second I say the catheter is draining.

A

Q And also 1 March?
A On 1 March, "Catheter draining satisfactorily".

Q And 5 March?
A And 5 March, yes.

B

Q Why are you making notes on this document? This all seems to be to do with a catheter.
A Yes.

Q So is this a document that is particular to show how the catheter is working?
A Yes.

C

Q Then if we go back to page 1007, is that a document particularly dealing with the ulcer on the legs?
A On the right leg, or on the left leg, yes.

Q I think both of them, in fact; and over the page is the same. Then if we go to page 1009, we can see this is all about bathing the patient and washing the patient.
A Yes.

D

Q We can see your signature again on that.
A Yes.

Q You, I expect, have no recollection of doing this at all?
A No.

E

Q For that reason I am not going to ask you about each entry, but it is just so that you can help the Panel and give us an idea of how these worked. Page 1010 is still a nursing care plan.
A Yes.

Q But this now has a named nurse shown at the top of that.
A Yes, Yvonne Astridge.

F

Q That is 22 February.
A Yes.

Q Can we go to page 1013? This seems to be to do with analgesia.
A Yes.

G

Q Can you just talk us through this, please?
A On the 1st of the third I say, "Complaining of pain in shoulder on movement"; then I see on the 4th of the third she had physio.

Q Can we start at the top? 27 February 1996, "Analgesia administered". This is not your entry, is it?
A No. "Fairly effective; able to help when dressing this morning."

H

A

Q Whose signature is that?
A Chris Carraher. She was also an E grade.

Q I am sorry? Chris...?
A Carraher – C-a-r-r-a-h-e-r.

Q Then we can see under that, "Right arm less painful, able to lift it above head height, and left arm..." – is it "less improved"?

B

A Yes.

Q Then on 29 February, "Able to move arms for washing and dressing"; and then your entry on 1 March, "Complaining of pain in shoulders on movement". Would you try and grade the pain at all? We can see you have not here. Did you use a pain scale at the hospital?
A We did have a pain scale, yes, for analgesia.

C

Q But you have not recorded the level of the pain here.
A No.

Q Underneath that we can see, the following day, "Slight pain in shoulders when moved".
A Yes.

D

Q That is somebody else. Then we can see on 4 March, as you mentioned, she was having analgesia.
A Yes, and physio.

Q Then: "Elsie needs---" ?
A "--- reminding."

E

Q Means what?
A "Reminding".

Q I appreciate it is not your note. "... needs reminding." Does that have any particular meaning to you?
A No. Unless she had been asked to do...

F

Q It follows from the note about physio – exercises, so I do not want to speculate too much, but it might be a note to say, "Remind Elsie to do her exercises".
A Umm.

Q Then we can see "analgesia increased". Then we have your note on 5 March: "Pain uncontrolled, patient distressed, syringe driver commenced."

G

A Yes. I think... I do not if we have a plan for the night, but I think I remember from the interview that I was told by the night staff how distressed she was. Here is a one here.

Q Page?
A Not recorded, perhaps.

Q Sorry, page what is the night plan?

H

A 1017.

A

Q Just have a look at that.
A But it does not seem to be recorded anyway on here.

Q If we go back to page 1015. How do you tell when it is a night plan? Sorry to ask you.
A Actually, I was looking for that. It did actually say, "Requires assistance to settle for night." I think that is probably the night plan. That was 1016.

B

Q At 1015 we can see that the patient had been given an enema on 2 March and then a further one on 3 March, and the unfortunate patient was leaking faecal fluid.
A Yes.

Q There is no note there of pain.
A No.

C

Q So your note on 1013, "Pain uncontrolled, patient distressed" would be based on what you were told by somebody else?
A Yes.

Q Would you have spoken to the patient?
A I am not sure the patient could speak. I cannot really remember her.

D

Q If you had spoken to the patient, would you have made a note about it?
A Yes.

Q If the patient had complained to you directly about pain, is that something you would have noted or not?
A Probably, yes. Yes.

E

Q And so it was your decision, was it, on 5 March to begin a syringe driver?
A Yes.

Q Just give me a moment.
A It would not have been mine alone because two nurses would start the driver anyway.

F

Q If we go ---
A It would not be mine alone.

Q No. If we go back to 975 – and this is not your note but it may assist.
A Which one?

G

Q There are loads of numbers, I am afraid, at the bottom of these pages but would you look for the number with two lines either side of it. In this case I think it is circled as well – 975.
A Is it a written number, or printed?

Q It is a written number, handwritten. Shall I hold it up to you? Can you see from there or not?
A No. (The witness was shown the correct page)

H

A

Q We were looked at 5 March and your note "Pain uncontrolled, patient distressed, syringe driver commenced 09:30 hours" and here, on 5 March, we can see a note – is that Dr Barton? Nurse Couchman, do you know Dr Barton's writing or not?
A No, I do not remember it.

MR LANGDALE: It is.

B

MR KARK: Thank you. But you do not remember it?
A No.

Q "Has deteriorated over last few days." I am afraid I cannot read the next line.
A "Not eating or ---"

C

Q "Not eating"?
A "--- or drinking. In some ---"

Q "In some pain."
A Yes.

Q "Therefore", I think it is "start subcutaneous analgesia."

D

A "Let family know."

Q Yes. Does that help you as to how you came to make your note at page 1013?
A Yes.

Q Tell us. How did it work?
A Well, Dr Barton would have come in and I would have told her how distressed the

E

patient was and how much in pain she was. She would have seen her.

Q So you would have been revealing to Dr Barton what you were told ---
A What I was told.

Q --- by the night staff who did not make a note. Right. Then she would have done what?

F

A She would have examined the patient and decided what she was going to do.

Q We know that the syringe driver – I can take you to the drug chart if you like. Have a look at page 990 and page 991. In fact, I think perhaps we are going to see your initials. Do you have 991?
A Yes.

G

Q It is very difficult to read, I am afraid, but these are the best copies we can get and I think they are legible.
A Yes, it is my initials.

Q I thought it was. Do we see at the top, "Diamorphine" – a variable dose between 100 and 200 mg?
A Yes.

H

A

Q Had you administered that dose?
A Yes.

Q At what rate?
A 100.

Q 100 mg?

B

A Over 24 hours.

Q Yes. I know it is obvious, but why would you have started at 100 mg of diamorphine?
A Why?

Q Yes.

C

A Because in my opinion that was enough medication.

Q So who chose the dose? I mean ---
A Not myself alone. Whoever was doing it with me. I think it was Mr Beed, Mr Philip Beed. We decided we would do the 100.

Q You decided you would do the 100. And how did you calculate that? How did you

D

decide? I know it is the lowest dose.
A We decided to give the lowest dose.

Q Okay. Did you form any independent judgment about whether it was write to give the patient 100 mg of diamorphine in a syringe driver?
A No.

E

Q We have heard quite a lot about syringe drivers. Can you just tell us a little bit about the process of charging them and what you would actually do?
A Two of us would go to the drug cupboard and take out the dose required and fill in the book, okay?

Q That is the drugs book?
A The drugs book. The old drugs book.

F

Q So that would show that you are withdrawing a controlled drug?
A That is right. And two RGN nurses would sign the book.

Q Right. And if you are going to administer a dose of 100 mg of diamorphine, and in fact in this case I think you also administered a dose of midazolam?
A 40 mg of midazolam/

G

Q And who decided? I know what you are going to say, but who decided 40 mg of midazolam?
A The two of us would have said, "How much midazolam shall we put in" and we would say we would put 40, because it is the lowest dose.

Q Again, would you have questioned the conjunction of those two drugs, putting both in

H

at the same time?

A	We were used to using those two together.

Q	Right. That was the practice?
A	When we were talking about the drugs rounds and the rounds the consultant used to do, we did not tell you but every week the pharmacist would come from QA. We had the same pharmacist from QA who would look at these treatment cards every week to see what each patient was taking, whether the drugs were the right drugs, whether the doses were correct. If she felt they were not, then she would leave a note for Dr Barton.

Q	How could the pharmacist know if the dose was correct. Because a dose –
A	That is her job.

Q	Yes, but the dose... You told us that you would decide the dose depending on the pain and the patient?
A	Yes.

Q	How does the pharmacist ---
A	If the patient cannot tell you exactly how much pain they are in, the safest method is to give them the lowest dose.

Q	Right.
A	And then assess the patient to see if that is correct.

Q	I understand. I understand. When you talk about "the lowest dose", you are talking about the lowest dose as prescribed?
A	Yes.

Q	By Dr Barton?
A	Yes.

Q	Because you could have a much lower dose than 100 mg, presumably?
A	Yes.

Q	Tell us about how the drugs came. Are they in bottles? Are they in ---?
A	They are in little vials.

Q	Little vials?
A	It is powder.

Q	And would there be a 100 mg vial?
A	I believe so. I have not worked for some years now, as you appreciate.

Q	If you saw that the prescription was for 100 mg of diamorphine, you would get a 100 mg vial, if there was such a thing?
A	Yes.

Q	And you would get, are they, 40 mg vials of midazolam. Can you remember?
A	I think that was in 10s, I think.

A

Q Again, just imagine we have never seen a syringe drive in our lives. How do you get this drug ---
A It looks like a syringe.

Q So do you use the needle of the syringe to draw up the amount of the drug?
A Yes, yes.

B

Q And is there a mixing process? Do you shake the syringe or does it all go in and get mixed up?
A It is all mixed anyway.

Q How do you connect that to the patient?
A You have a little needle connected to a tiny tube. The needle just goes under the skin of the patient with a---

C

Q You are pointing to your wrist?
A Yes. I am talking about the skin, not necessarily the wrist. It does not have to be the wrist.

Q No. Where would you normally ---?
A If the patient was restless, then it would be quite a good idea to just put the syringe driver, the needle, in here.

D

Q And you are pointing when you say "here" to your shoulder?
A To your shoulder, to the little pad of flesh there.

Q Not the bony part, the fleshy part.
A Up there. The little fleshy part.

E

Q Yes?
A And then that little tube connects to the driver.

Q Again, why would you do that if the patient was restless? Why would you put it in there?
A So that it would remain in place.

F

Q So they could not dislodge it?
A So it would not dislodge.

Q Then do you put of some sort of tape over it?
A Yes, yes.

G

Q Then where does the syringe driver itself lie?
A Probably then it sits in a little case, a little cotton case, under the pillow.

Q Presumably this is an electrical device?
A It has a battery.

Q And so how would you actually start the machine going?

H

A There is a button to press, and a light will come on to show that it is actually working.

A

Q So on the basis of the prescription that you are given by Dr Barton you withdraw the drugs from the controlled drugs cabinet with your colleague nurse; you draw the drugs up into the syringe; you would insert a small needle very often into the patient's shoulder and that would then be connected by a very small tube to the syringe driver itself?
A The tube can be varying lengths. It might be longer.

B

Q And that would like under the patient's pillow. And that gradually injects the drugs into the patient's system?
A Yes.

Q And it is designed to last – we have heard – a bit longer, in fact, than 24 hours?
A Yes.

C

Q Just in case somebody does not renew it in time.
A Umm.

Q All right. Can we just go back, please, to your original note. I just want to make sure you have not made any other notes that we may be missing. Can we go back to page 1022, please? We just dealt with the note of the 5 March. Then we can see at the bottom of the page: "Son contacted by telephone, situation explained." That is your signature next to that, so you would have called the son?

D

A Yes.

Q And you would have explained what to him?
A I would have explained how poorly his mother was and asked his permission to set up the syringe driver.

E

Q Could we just look at the entry prior to yours on 4 March? Can you read this:

"Patient complaining of pain and having extra analgesia PRN"

PRN means "as required" does it not?
A Yes.

F

Q "Oromorph sustained release tablets dose increased to 30 mg" – I think that means "BD", twice daily, does it not?
A It does.

Q Yes?
A Yes.

G

Q The nurse there is?
A Chris Carraher.

Q That is Chris Carraher again. Is that a male Chris or a female Chris?
A She is female.

Q That would seem to indicate, would it not, that the patient was on 60 mg of effectively

H

Oromorph which is a form of morphine, is it not? Are you all right?

A Yes.

Q Okay. The patient was on 60 mg of oral morphine a day - yes?
A 60 a day, yes.

Q Sorry – 60. Yes, 60 mg a day. And then the next day you commence her, on instruction, I understand, on 100 mg diamorphine and 40 mg of midazolam. Were you ever taught anything about conversion rates?
A Yes, we were.

Q You were?
A Yes.

Q When were you... When did you have that ---
A I cannot remember them now. I have not worked for four years.

Q Tell us what you know about conversion rates?
A I know there is a conversion rate.

Q That is a good start. Can you tell us any more than the fact that there is a conversion rate. Can you tell us what the conversion rate is between oral morphine ---
A I cannot. I am sure Philip will tell you when he comes over.

Q We will look forward to that. Can you say whether, when you start with oral morphine, you should go up and down if you are transferring to a subcutaneous dose?
A That, I do not know.

Q Would you have known at the time?
A I would have known at the time, yes.

Q This change, presumably, did not trouble you. Would you have done something about it if you had been?
A Yes, if I had felt that that was incorrect – do not forget there were two of us doing it, not just me – and if we felt it was incorrect, we would have rung Dr Barton and asked for clarification.

Q Do you remember ever ringing Dr Barton?
A No, I never needed to.

Q In ten years working on this ward, you say you never needed to call Dr Barton?
A No, well, yes, I called her on certain occasions when it was necessary.

Q What would have triggered it, what would have made it necessary?
A What made me call her?

Q Yes?
A I remember calling her because somebody's blood sugar was something like 20 and I wondered what to do about it; that is rather high.

Q Specifically about the sort of doses of diamorphine?

A

A No, I did not question her on any doses.

Q You did not ever question her on any doses?
A No, I do not think any of us did.

Q Can I ask why not, did it never arise?
A It just did not arise and at the time that was the dose that was given.

B

Q If we turn over the page to 1023, you can see that the patient died the following evening. Can I ask you to look at the top entry. I am sorry to use you as a sounding board. The day after the syringe driver starts and the day that this patient died:

> "Seen by Dr Barton medication other than through syringe driver discontinued as patient unrousable."

C

Two things to ask about that. Patients becoming unrousable as a result of the injections of diamorphine, did that ever give you cause for concern or is that part of the norm; how did it work?
A I think it was just normal.

Q So when you started a syringe driver with diamorphine, you felt it was normal for the patient to become unconscious?

D

A No, not all patients became unconscious when they had a driver.

Q Would it concern you at all if a patient was unrousable, meaning, presumably, if you shook them they would not wake up. Would that have caused you any concern, or not?
A I do not know.

E

Q The second thing I wanted to ask you was that "medication other than through syringe driver discontinued", and again it may be obvious from what you just said, but the other medication, presumably, would be oral medication, would it?
A Yes.

Q Would there be times when a patient was on a drip for fluids and things like that?
A Yes.

F

Q What was the practice once diamorphine started. Were drips continued, discontinued, was there any regularity as to what happened?
A I think if the patient was on an IV drip, then that would continue.

Q Even though a syringe driver was started?
A Yes.

G

MR KARK: I do not think you made any other notes about this patient. I am now going to move on to another patient. Sir, I do not know if you feel that the witness should have a break.

THE CHAIRMAN: She has been on the stand for an hour and 15 minutes. We are going to give you a break now and we will all take a break. It will be about 15 minutes and you will

H

A

be taken to a room where you can get some refreshment. Please do not discuss the case with anyone in the interim.

MR KARK: Can I repeat it and reinforce it. (To the witness) This is not directed at you particularly at all, but for all nurse witnesses, and I know your representative will know the rules. You must not discuss with any other nurse, nor indeed with the nurse representative, the evidence that you have given.

B

THE CHAIRMAN: Fifteen minutes please.

(The Panel adjourned for a short while)

THE CHAIRMAN: Mr Kark.

C

MR KARK: Nurse Couchman, you have made a note in relation to the various patients that we have here and I am going to ask you about a patient called Gladys Richards. I think you were interviewed by the police in relation to her?
A Yes.

Q I was not going to take you through every other patient that we have, we have 12 patients, unless you have specific recollections of any of them?

D

A I do not.

Q I am going to ask you about Gladys Richards, our Patient E. You may want to take up her file, which you will find if you put away the file on your desk and take up Patient E. Right at the beginning of that you will find a chronology. I mention in passing that we are all in discussion about the chronologies. I have spoken to Mr Jenkins this morning, Mr Fitzgerald has been working on them and we have not forgotten about it. They are quite

E

lengthy documents, so it will take a while to get them together. We are still working on the chronology that we have. To remind ourselves about this patient. For you, Nurse Couchman, to remind yourself as well, she was taken, as we can see on the second page of the chronology – do you have a chronology right at the beginning of that, the document on its side?
A Yes.

F

Q On 29 July she was taken into the Royal Hospital Haslar after a fall at a nursing home for a fractured right neck of femur. You told us that the Gosport War Memorial Hospital had an Accident & Emergency Department. Did it have an Accident & Emergency Department in 1998?
A I think so.

Q Did it have a ward to look after patients, or were they transferred if they needed

G

ongoing care?
A Yes.

THE CHAIRMAN: Sorry, Mr Kark, could I ask the witness to turn her microphone on.

MR KARK: This patient was taken to the Royal Hospital Haslar. She underwent an operation on 30 July and then we can see that she was transferred on 11 August to Daedalus

H

Ward. We know that on 13 August she had another accident in the sense that, having had her

A hip repaired, she was found on the floor at 1.30 lunch time and it seems she dislocated her hip again. She then headed back to the Royal Hospital Haslar. She was operated on again and then on 17 August she came back to Daedalus Ward. Do you have a recollection of this patient?

A I did not meet her until she came back to the ward. I was on leave when she was first admitted.

B Q I think for the period from 11 August you were away.

A I was on leave, yes.

Q You cannot comment on any of that?

A No.

Q You were there...

C A I met her when she came back from the Haslar.

Q ... on 17 August when she came back?

A Yes.

Q Would you turn to page 51, we can see a note, under the Nursing Care Plan – and I am only going to ask you about 17 August onwards – that the patient was readmitted on

D 17 August. On 17 August she was given Oramorph 10mgs in 5mls and Oramorph we have heard a lot about. Is that a liquid morphine?

A Yes.

Q Is it taken on a spoon or a little cup. How would the patient actually take that drug?

A Possibly on a spoon, yes, teaspoon perhaps.

E Q That would indicate, obviously, if a patient is on oral morphine that they must be able to swallow?

A Yes.

Q Did you find that patients sometimes reacted badly to Oramorph, or did you not have that experience?

A No, I did not find that.

F

Q It was always all right, was it?

A It seemed to be.

Q If we go to the back of the bundle and we go to page 294, I think the last note we are looking at, would that be a note from the Royal Haslar?

A On page 294?

G

Q Yes.

A This looks like Haslar's.

Q Would you have access to the Royal Haslar notes?

A No.

H Q What would you get at the Gosport War Memorial Hospital?

A We would probably get a letter with the patient.

Q If we turn right back to page 8 – I do not think we have managed to find a better copy of this – is that the sort of letter you are talking about?
A Yes, something like that. I could not read this one.

Q It is dated 17 August and it gives a brief description of what has happened to her. In the second paragraph I think it talks about a knee splint – no, a canvas---
A "Knee immobilising splint to discourage any further dislocation".

MR KARK: Would be your understanding of that be? Sorry, reading on, I think it is suggesting that she should stay for four weeks.

THE CHAIRMAN: You may say "this should stay in situ".

MR KARK: I am grateful, thank you. "This should stay in situ for four weeks".
A It is like a triangular cushion which goes between the tops of her legs to keep her legs straight.

Q "When in bed it is advisable to encourage..." is it "abduction"?
A Yes, that is what I am talking about.

Q "By using pillows or…"?
A "Abduction wedge" I think that might be.

Q "She can however mobilise", and then at the bottom "fully weight bearing". At your hospital you would have got a transfer letter like this, would you?
A Yes.

Q This one, presumably, for this patient?
A Yes.

Q If we turn to page 58 of these notes and then 59, the ones with the two lines either side, we can see there seems to be an entry at the bottom on 18 August?
A Yes.

Q "Complete bed bath given". That is not your note I do not think?
A That is not my writing.

Q Over the page, also 18 August, is that, "Night oral care given frequently"?
A Yes.

Q Let me ask you about your dealings with this patient. She was transferred back from the Haslar on the 17th. Do you remember there being a problem with her transfer?
A Yes, I remember her transfer.

Q Tell us about that.
A I came back from coffee and I could hear this patient screaming as I came back down the ward. She was obviously in a lot of pain and a lot of distress. The two support workers who were on the ward came to tell me that this patient had been transferred. She was

A transferred on a sheet and not the normal canvas. The canvas is quite taut and thick and they felt that she was not lying correctly in the bed, which she was not, and they were not happy with her transfer.

Q What would be the effect, as far as you are concerned, of not transferring the patient on a canvas sheet?

A She would not be lying correctly. As they said, she had to have her legs in abduction and she probably was not because she was wobbling around on a sheet. She was in a lot of

B pain and we did have her x-rayed and she had a large haematoma on this hip where she had had the operation.

Q Haematoma being a---

A Being a large collection of blood where the two pieces of bone had been rubbing together.

C Q Can that cause a patient pain?

A Causing the patient a lot of pain, a lot of distress, yes.

Q Do you remember meeting the patient's daughter at any stage?

A Yes, I do.

Q Was she there on the 17th?

D A They were both there, both daughters were there. The younger of the two was telling me that she was an ex-nursing officer and, because there was just myself on the ward, she helped me re-position her mother and put her legs in the correct position.

Q When this care assistant ---

A Make her more comfortable.

E Q When this care assistant came to find you, is that the first you realised the patient was in pain?

A Yes, she was transferred whilst I was off the ward.

Q Do you know how long the patient had been screaming for?

A I do not, but I was only gone for about 20 minutes, so it was during that time she was transferred.

F

Q So you helped the daughter to level the patient out, as it were, so that she was more comfortable?

A Yes, she helped put her in a correct position.

Q Did that help her?

A That did help her.

G

Q Could you go to page 47? I am sorry to dot around this bundle. We can see there is a contact record at page 47.

A Yes.

Q Do you have a recollection of this?

A Yes, I do.

H

A

Q It is your writing, I think?
A Yes. I did ask the daughter if I could give her mother some Oramorph and she said yes, and I gave her 2.5 mg in 5 ml. They told me that she must be transferred back to Haslar if she dislocated again, and that is why Dr Barton ordered the X-ray and that is how we knew she had a haematoma.

B

Q That Oramorph that you gave, of course you would not have been able to give it – and I am not saying there was anything wrong with it – but you would not have been able to give it unless there had been a prescription from Dr Barton.
A Yes.

Q Or from a doctor who was allowed to prescribe controlled drugs.
A Yes.

C

Q Keep your finger in page 47, please, and also turn up page 63. We are beginning to get a bit more used to reading these charts and we can see that the first entry under "As required prescription" is Oramorph 10 mg in 5 ml. It is a bit difficult to read but I think we can make an educated guess that that is the prescription. Do you accept that?
A Yes, I do.

D

Q Then, to the right of that, we can see in the first four columns that it is given first of all back on 11 August, when you were away on leave, at 2.15 in the afternoon – no, I am wrong, I am sorry – 11.15, I think it is, in the morning, 10 mg. Is that Philip Beed? Whose is that initial? It is a pure assumption on my part because it looks like "PB", but it might not be.
A It is Philip Beed.

Q Then other nurses have made their entries below.
A Yes.

E

Q There is a gap obviously between 14 August and 17 August, when she has been off at the Haslar having her hip fixed. Then on 17 August do we see another entry?
A Yes.

Q Tell us about that, please? Who is that?
A The first one is the one that I gave, isn't it, at 13:00 it says in here? My actual time I have put is 13:05. That is the on I gave.

F

Q Whose initial is that next to it?
A That is Philip Beed. That is because the two of us drew the – as I was saying, two trained nurses do each controlled drug.

Q But only one of you has to ---
A Either of us could sign this, and he actually signed it.

G

Q You would have given that to the patient, presumably on a spoon or in a little cup?
A Yes, but you can see that I did ask the daughter first if I could give it to her mother and she agreed.

Q Absolutely, and the patient was clearly in pain?
A Yes.

H

A

Q Then we can see that it is given again, I think. It is a bit difficult to read the time. Let us just see if Mr Fitzgerald... (reviews document) No, I do not think he could read the time either.
A I cannot read that. Maybe Philip can.

Q It seems to be given again on 17 August and then, in total, there are four doses given of 2.5 ml for the first three and then, in the evening at 8.30, is 5 ml given? If you look to the right-hand side ---
A Yes.

B

Q 17 August, 20:30, 5 ml. That is not you, I do not think?
A No, that looks like Philip again.

C

Q That obviously would have been a dose given hopefully before the patient went to sleep. Was it your practice that you remembered to give a higher dose at night, to ensure the patient rested through the night, or can you not remember?
A I cannot answer for him, if Philip gave that one. I do not remember. I do not recall giving it myself.

Q That is why I asked you about *your* practice. Was it your practice?
A Possibly if you had given those tiny doses and they were not helping, then he decided to give the 5 ml then.

D

Q Keep that page open but go back to page 47, and just go back to your note – to link all of this up. 13:05, "In pain and distress; agreed with daughter to give her mother Oramorph 2.5 mg in 5 ml; daughter reports surgeon to say he..." ---
A "...her mother must not be left in pain."

E

Q "...to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an X-ray." Then we see in the afternoon, "X-ray at 15:45; film seen by Dr Peters."
A It is to go to radiologist. That is for reading.

Q Then, "For pain control overnight and review by Dr Barton in the morning."
A In the morning, yes.

F

Q Then the following day, "Reviewed by Dr Barton". Whose writing is this?
A It is Philip's.

Q We can ask him about it, but I think we can see that the treatment was discussed and Philip has noted, "They agreed to use of syringe driver to control pain to allow nursing care to be given". Are you able to interpret that or not?
A Yes, I can read it.

G

Q Then tell us.
A It is practice on the ward, before giving Oramorph or before giving a syringe driver, to discuss what we were going to do with the relatives and to discuss the treatment.

H

A

Q If you were giving, first of all, Oramorph, would you expect the patient to remain rousable or not?
A Yes.

Q I want to ask you about a drug called midazolam, because I think this patient was given midazolam together with her diamorphine. Before we turn to that, I want to ask you about your understanding of midazolam and what it was used for.

B

A This patient had dementia, Alzheimer's. That is one of her diagnoses. So she was quite restless and distressed as well as in pain, and midazolam was given as a sedative.

Q So it was a drug with a sedating effect.
A Yes.

Q If we go to page 63, which is the drug chart, can we concentrate on midazolam first of

C

all? Can you recall what part you played in the administration of the midazolam?
A I can see that I drew it here on the 20th of the eighth, when I renewed the syringe driver.

Q It seems to have been started before you, though. Is that right?
A Yes.

D

Q Again by Philip Beed?
A Yes.

Q Midazolam, would that be being administered by way of syringe driver?
A Yes.

Q If we go two pages on, to page 65, we can see diamorphine was also being given.

E

Yes?
A Yes.

Q If you look – just to help you – two entries up from the bottom, does that appear to be Dr Barton's prescription for a variable dose of between 40 and 200 mg of diamorphine?
A Yes.

F

Q Starting on 18 August?
A Yes.

Q So this is the day after this patient has come back from the Haslar and has been transferred on her sheet?
A Yes.

G

Q Can you help us as to your recollection of the decision to use midazolam as well as diamorphine with this patient?
A To make her more comfortable, I think.

Q The diamorphine was started at what dose?
A Forty. She only actually had 40; over 24 hours she had 40.

H

A

Q Prior to that, she had been on Oramorph. If we go back to page 63, to try to follow this through, she had been on Oramorph on 17 August and I think she had had – but I will be corrected – about 25 mg, effectively, of morphine; because it is 10 mg in 5 ml, is it not?
A Yes.

Q And she, on that day, is given 7.5 ml in total during the day and then 5 ml at night. Yes?

B

A Yes.

Q The day after that she is started on 40 mg of diamorphine.

MR LANGDALE: The early morning of the 18th.

MR KARK: Yes, I am grateful. (To the witness) Going back to page 63, we can also see she is given two doses of Oramorph ---

C

A During the night.

Q Is that just after midnight and the second at four o'clock in the morning?
A Yes.

Q So she has had ---

D

A Twenty.

Q 20 mg cumulatively in those two 5 ml. Then the next day, or that day rather, she is started on diamorphine, and the lowest dose prescribed would appear to be 40. Does that seem to be right?
A Yes.

E

Q Can I just ask you this, and I appreciate you did not start this patient on 40 mg and, even if you had, it would not have been your decision. You have spoken about your knowledge about the conversion rate. Did you have any understanding of a thing called the "analgesic ladder"?
A Of course, yes.

Q I did not mean that to sound rude, but we need to know what your state of mind was.

F

What was your understanding of what the analgesic ladder was all about?
A It is all about starting on the lowest analgesia, paracetamol, and rising up the ladder.

Q As it is necessary.
A However, you have to remember that possibly she could not swallow. I cannot remember. We are talking about 13 years ago, aren't we?

G

Q I understand.
A So if she could not swallow the tablets....

Q When it comes to increasing a dose, if the patient remains in pain, you are working through the analgesic ladder; but say you have a patient to the point where you have to use morphine in one form or another – Oramorph, diamorphine, an opiate – what was your understanding at the time of the rate of increase?

H

A We did not increase it very often.

A

Q Right. I did not ask you that, though. What was your understanding of how it was meant to work? Of the rate of increase? If you felt that a patient was still in pain ---
A We would probably ask for guidance before we did increase it any further.

Q From whom?
A From probably Dr Barton or the consultant, if she was around.

B

Q We can see from the drug chart that on 18 August the patient was started on 40 mg of diamorphine ---
A Over 24 hours.

Q Yes, that is a given. I accept that. And 20 mg of midazolam, in the syringe driver. When we see your signature, as we do on page 63, does that indicate that you were starting a fresh syringe driver?
A Yes. Every 24 hours it would have to be changed. It would be empty.

C

Q Of course, the needle presumably remains in place.
A Yes, probably. Although, no – thinking about it, I think we did change the needle as well every 24 hours.

D

Q And a completely fresh syringe would be used?
A Yes.

Q Would you use an old syringe or would you use a completely fresh syringe?
A No, there is one special one. It is called a Graseby syringe driver.

Q And new drugs would be drawn up according to what you decided to administer.
A Yes.

E

Q There is something I meant to ask you. Would you ever put a syringe driver in when the patient was asleep?
A No, I should not think so.

Q An answer like that, "I should not think so" – I am not sure how much it helps us. Can you remember ever doing it?
A No. I will say "no" then.

F

Q With the last patient that we were looking at, Elsie Lavender – I do not want to go back through it – but when you inserted the needle into her, and you thought you might have done it into the fleshy part of the back, would she have been awake or asleep?
A Awake.

G

Q So she would have been able to talk to you?
A I honestly cannot remember. We are talking about a long time ago. I think the last patient was nine years.

Q Let us just look at the other drugs, please, on page 63. You have dealt with the Oramorph, which was stopped on 18 August at 04:20. We can see that the diamorphine

H

A which was in fact prescribed on 11 August by Dr Barton – and that was a variable dose between 20 and 200 mg? The second one down?

A Yes.

Q Is that right?

A Yes.

B Q But that does not ever appear to have been given.

A No.

Q Then hyoscine, the next one down – are we still on the same page, page 63?

A Yes. I see them.

Q What is causing you concern?

C A No. I am just.... No.

Q What are you looking for?

A I am not.

Q I see. Page 63, hyoscine, 200-800. Is that a drug to deal with secretions?

A Yes.

D

Q Can you recall now whether secretions were an issue for people on diamorphine?

A Secretions sometimes are an issue, yes. I can see that Mrs Richards did not have very much.

Q Very much what?

A Hyoscine. She probably did not need it.

E

Q She probably did not need it? Does your initial appear?

A Yes, in the middle, on 20th of the 8th I used it.

Q Why would you have used it?

A Presumably she needed it then, so I used it, but like I am saying, it is not just me that used it. Two of us would be doing this together.

F

Q Okay. Then we have dealt with the midazolam and then, over the page, at page 65 at the top is that lactulose?

A Lactulose, yes; that was her bowels.

Q And when we see a cross?

A That means it was not given.

G

Q It was not given. So it was not given on the 18th and it was not given on the 21st?

A Umm.

Q But when we see the initial "B", this seems to have been given on the 17th?

A Yes.

H Q Haloperidol. What are the effects of that drug?

A

A Again, that is used for restlessness and agitation.

Q Does that have a sedatory effect?
A I can see that she had that. When she was given that, I was not actually on the ward, so I cannot say the effect it had on her.

Q No, but what is the purpose? Had you ever administer haloperidol before?

B

A For restlessness and agitation.

Q Does it have a sedating effect?
A Yes.

Q Then underneath that we can see Oramorph has been crossed out. I am sorry – Oramorph is there, but that particular prescription of Oramorph has not been given. That is

C

10 mg in 5 ml from 12 August. Then there is another prescription for Oramorph underneath that and then there is the prescription for diamorphine and haloperidol. Can you help us with this? None of these prescriptions seem to have been crossed through. If we go back to the two pages before, does that mean that they all remain live prescriptions, as it were? Do you understand what I am asking you?
A I understand what you are asking.

D

Q Can you help us?
A Yes. I can see that we did not use the syringe driver on the first page because it was re-written on this page – on page 65.

Q That is what I am trying ---
A Yes, I can see.

E

Q --- to get at.
A I can see what you are talking about.

Q The first prescription ---
A But I cannot explain why it is not crossed through.

Q No, but you can tell us about how things should be done. You have been a nurse for

F

many, many years. If you wanted to stop a prescription, to say, "No, this one is not valid any more," what would the doctor have to do?
A Cross it through.

Q Cross it through? Can you help us? If the prescription on page 63 is still a live one, can you help us as to why it would be necessary to write a further prescription ---
A No.

G

Q Page 65 --- at a higher dose?
A No, I cannot.

Q You cannot. I am not saying you ever ---
A Unless this dose was necessary, was felt necessary.

H

A Q Yes, okay. I am not saying you would ever have done this, but you have live prescriptions here for Oramorph, diamorphine, hyoscine and midazolam, lactulose obviously, haloperidol, two more for Oramorph, diamorphine again and more haloperidol, none of which had been crossed through?
A No. Did it not say in the nursing notes that her drugs were not given after the syringe driver?

B Q I just want to concentrate on these drugs charts for a moment. Would that give a nurse authority to administer any of these drugs?
A It would give them authority, but then none of them would administer those drugs?

Q No, I understand. Okay. In fact there is one we have missed, page 67. This is haloperidol?
A Oh, PRN.

C

Q And what is ---
A And the date on there is the 13th, is it not?

Q Yes.
A Which was when she was first admitted.

D Q Well, the second time.
A The second time was the 17th, was it not, or the 18th?

Q Yes, all right. This is actually, I think, the second time. She is admitted the first time on 11 August. Then she has a problem. But in any event, this is 13 August and this says, "If noisy". How would this be given, this type of prescription?
A It is liquid. It is 2 mg in 1 ml, 0.5.

E

Q So that does not go into a syringe driver?
A Well, she was not on a syringe driver anyway, was she?

Q That prescription would have been oral, would it?
A Yes, it says oral on the prescription.

F Q As a nurse, what would "If noisy" signify to you? Does it mean what it says?
A If the patient was distressed, agitated.

Q And then you can give the haloperidol? Right. One other matter I wanted to ask you about is what I think you refer to in your police interview, is it "subcup" or "subcut" – giving fluids? What is the expression?
A It is giving fluids, not through a vein, but through subcutaneously.

G

Q Right. You have already dealt with this, but I think in your interview you indicated that you thought there was research to prove a patient would probably be more comfortable without subcut. I just wanted to explore with you what you were talking about. The patient ---
A I think there is research to prove that.

H Q To prove what? Just explain to us.

A

A In those days there was. To prove that when the patient was close to death? Is that what you are talking about?

Q Yes.
A Yes. That they are more comfortable without the hydration.

Q So let us just try and explore that a little bit. If you felt a patient was close to death, does that mean you would withdraw hydrating fluids?

B

A I do not know what the form is now.

Q Do not worry about now, but when you were a nurse, if you felt a patient was close to death would you take any action in relation to their hydrating fluids?
A No.

C

Q So who would?
A What do you mean?

Q You have just told us that you thought there was research to show that a patient would be more comfortable. Is that something that was ever done when you were a nurse – withdraw hydrating fluids?
A I remember that research when I was a nurse, yes.

D

Q Is it something when you were a nurse on the Gosport War Memorial Hospital that was ever done or can you not remember?
A I cannot remember.

Q And would you just look through the prescription charts, the drugs charts, that we have just been looking at? Are there any other entries by you that we have missed, as it were? Just on the drugs charts for the moment. Are there any other entries by you?

E

A No, no. We have covered the ones that I ----

Q Right. Finally, on that last topic could you go to page 299, please, at the back of the bundle. Is this a fluid chart from the Haslar?
A This is Haslar, yes.

F

Q And if we go to page 299 we can see what the patient was taking orally on 15 August. She had some squash. Then is it co-codamol?
A Co-codamol, yes.

Q And that is a pain relief?
A Yes.

G

Q We can see what she was having intravenously in the second column?
A Yes.

Q So the first column is her oral liquids that she was able to drink down herself - yes?
A Yes.

H

A

Q Then the second column is her intravenous fluids. Then we can see that at 9 o'clock on 15 August her cannula was removed. That would mean that from then on she was just taking fluids normally?
A Yes.

Q And we can see that she had water and tea and juice and the like. Over the page much the same – that is 16 August, and then the 17 August before she came over to the Gosport War Memorial Hospital - yes?

B

A Yes.

Q Were there any fluid charts in the Gosport War Memorial Hospital? I am sorry if I have missed them. I am not saying there were not.
A I do not recall her drinking like that when she was admitted to us.

C

Q From the time that you were dealing with her, from the 17th?
A She was in such distress, I do not recall. I recall sending her meal back that day to the kitchen to have it minced because she could not eat it.

Q When you say "on that day", do you mean on the 17th, the day of her admission?
A Yes, on the day she was re-admitted.

D

MR KARK: Thank you very much indeed. Would you wait there, please.

Cross-examined by MR LANGDALE

Q I am going to be asking you some questions on behalf of Dr Barton. I am afraid it is more than just one or two, but I will try and keep it as confined as possible to cover the topics that we need to cover. I would just like you to deal with two particular things before I ask you more about background and so on. With regard to intravenous fluids, at the time we are concerned with was there a period of time when the Gosport War Memorial Hospital did not provide fluids intravenously?

E

A Yes.

Q Later on – is this right – intravenous equipment was supplied?
A Yes.

F

Q So they could do just that. During the period of time that we are concerned with with regard to the patient you have been asked about, in fact intravenous fluid was not supplied?
A No.

Q And equipment was not there? Yes?
A Yes.

G

Q And the second particular thing I wanted to ask you about was something you dealt with a few minutes ago, and you were asked about the process of increasing the medication. Obviously we are concerned with controlled drugs here, increasing controlled drugs. I am sorry if this is all a bit basic, but we just need to check it with you. If the doctor, Dr Barton – whoever it was – prescribed a particular dose of a controlled drug you, and all the other nursing staff in your experience, would administer what the doctor had prescribed?

H

A Yes.

A

Q It is just a set dosage.
A Umm.

Q Just taking that simple example, if you, as a member of the nursing staff formed the opinion that that dose was not enough to control the patient's pain, would you take steps to report that to somebody?

B

A Yes.

Q And if you were the person seeing Dr Barton when she was at the hospital, say in the morning, or at any other time, you would report that fact to her?
A Yes.

Q And if you reported the fact to somebody superior to you in the nursing chain, say to

C

Philip Beed, you would expect him to pass that information on to Dr Barton?
A Yes.

Q In the normal course of events?
A Yes.

Q So that the doctor could decide, having heard that the pain was not being controlled,

D

that the dose could be increased?
A (The witness nodded)

Q You have told us already that where the doctor had prescribed a dose with a range to it, whether it is 20 diamorphine to 200, whatever it might be, where there was a dosage prescribed with a range, you and the other staff so far as you are aware would normally start at the lowest dosage in the range?

E

A Yes.

Q I want to ask you this by way of generality. Say you started the patient at 20, if a particular dose – in this case 20 – did not seem to be achieving the object, it was not controlling pain, would you – I appreciate that it is not just you making the decision; it is always you with a senior colleague – endeavour to contact the doctor, Dr Barton?
A Yes.

F

Q Do indicate why it was your view that the dosage should be increased?
A Yes.

Q Normally speaking, that would be the procedure followed?
A Yes.

G

Q Is that right? If, however, when Dr Barton was not available , or you could not contact her, were there occasions when a more senior member of the nursing staff than you would have the power, have the authority, to increase the dose?
A Yes.

Q Within the range prescribed by the doctor?
A Yes.

H

A

Q But is this right as a matter of normal procedure – only in cases where Dr Barton could not be got hold of?
A Yes.

Q And the ultimate decision in terms of the nursing staff for increasing, or whatever it might be, would be a more senior nurse than you?
A At least two.

B

Q I appreciate it is two all the time but you always have to be with somebody more senior?
A Yes.

Q And they ultimately are the ones giving the say-so?
A Yes.

C

Q Obviously you worked together with them for years?
A Of course.

Q And knew them very well. Thank you for dealing with that, just by way of general procedure. We may have to come back to it in relation to other questions that I ask you. In terms of what you have been asked in the past, you were interviewed by the police, I think, back in the year 2000?

D

A Yes.

Q We will all understand if you do not remember dates, and if there is anything particularly important about a particular date I will make it clear. You were interviewed under caution?
A Yes.

E

Q Not a very nice experience, I should not imagine?
A No.

Q But you dealt with the matters you were asked about and it very much, in the interviews in 2000, concentrated on the case of Patient E, Gladys Richards?
A Yes.

F

Q As well as asking you some general matters about procedure at the hospital?
A Yes.

Q Then you made a witness statement. That is a witness statement to the police on 15 December 2004?
A Yes.

G

Q So some four years later, and that very much concerned itself with the patient you have already spoken to us about, Elsie Lavender – Patient B. Then you also made a statement to the GMC producing those earlier statements and records?
A Yes.

H

A

Q May I ask you something generally about Dr Barton. Obviously you have worked with her for a number of years. You have already told us. Did you find her to be a hard-working and responsible doctor, so far as you could judge?
A Extremely.

Q Did you also find her to be somebody who had a complete commitment to the patients' best interests?

B

A Absolutely.

Q And I would just like you to deal with this in case there is some suggestion in the air, and you can speak as one of the nurses who were there for many years, was there ever a case in your experience when you or any other nurse to your knowledge administered analgesics simply to keep the patient quiet?
A Definitely not.

C

Q In case there is any suggestion, to shut them up, because they were giving trouble?
A Definitely not.

Q Did Dr Barton in your view of her, in your experience of her, ever give you the slightest indication that she was prescribing in order to achieve a purpose like that?
A No, she did not.

D

Q In general terms, we all have our little ways and manners, and way of behaving, but in general terms did you find Dr Barton to be somebody who was approachable?
A Extremely approachable.

Q And was she somebody who listened to what the nursing staff had to say or ignored it, or what? How would you describe it?

E

A No, she listened to the nursing staff all the time.

Q Did you find that you, if you wanted to express a view about something, could always approach her?
A Yes, she listened to our views all the time.

Q I would like you to help us, again with a general matter, with regard to the patients

F

who you dealt with over those years. We are concerned, in particular, so far as you are concerned, with the period 1995 to 1998 or thereabouts. We appreciate, obviously, you carried on working there for a number of years. In general terms, did the pressures on your ward, Daedalus, increase in terms of the needs of the patients?
A The pressures increased very much.

Q In general terms, was it the case that you were dealing with, in terms of continuing

G

care, patients who were obviously, in general terms, often elderly and very frail?
A Multiple diagnoses.

Q This is something you explained to the police, multiple medical problems?
A Yes.

Q This is just a general picture?

H

A Yes.

A

Q Problems such as Parkinson's Disease, Alzheimer's, dementia of one sort or another?
A Stroke.

Q Stroke, and in general terms patients who were highly dependent?
A Highly dependent, yes.

B

Q Normally needing two nurses to cope with their ---
A Most often needing two nurses.

Q --- daily needs?
A For daily needs.

C

Q I may have to come back to some generalities, but I want to turn back to the patient you have already been asked some questions about, Elsie Lavender, Patient B. It is back to that patient and then I will come on to the position with regard to Gladys Richards, Patient E, in a moment. I am going to ask if you could have in front of you the file with regard to Elsie Lavender, Patient B. I am going to take you through some of the documents, and maybe there will be one or two extra documents where there is a record of you doing something that you have already been asked about. I am going to try, not only to assist you in answering any questions but also for the assistance of the Panel, to take the entries you made in relation to that patient's records chronologically, just try to take it through in sequence. The earliest one that involves you is, if would you turn towards the end, on page 1018. It has other numbers as well, it says 88 of 103, which I think is something to do with "Pressure Sore Documentation"?

D

A That is right.

E

Q Do you see at the bottom on the left your signature?
A I do.

Q It is dealing with a recording that this patient had a right leg ulcer on admission on 22 February. We can see the date early on. I think that is the earliest record where you have made an entry. I am not asking you about the detail. The consultant is shown as Dr Lord. To follow the history through, would you go back in the bundle this time to page 1005, which I think is one you have already been asked about and I am trying to take this through in sequence. Do you have that?

F

A Yes.

Q That shows incidents with regard to the catheter, is that right?
A Yes.

G

Q Recording that the catheter is draining and so on?
A Yes.

Q We can see your signature and we are familiar with that. Further on to page 1009, can we see your signature again relating to bed baths?
A Yes.

H

Q These are all part and parcel of the normal nursing records that would be kept with regard to patients?

A

A Yes.

Q On please to page 1012 where we can see two entries by you relating to, "Bed rest due to painful joints" and so on, then "Bed rest maintained" giving us an idea of the sort of picture that was painted in terms of these records with regard to patients. This is all 24 February.

B

I would like to move on to a letter date. I think this note refers to something you mentioned in the course of your evidence anyway. Would you move turn to page 1022, the typewritten number 1022. It is a page you have looked at and I am trying to keep the chronology in a sensible order. This is in relation to 29 February. Can we see just over halfway down the page, part of the summary, a date 29/2/96?

A Yes.

C

Q I think that is an entry by you?

A It is.

Q "Blood sugar at midday", and you show the figure of 20. "Dr Barton contacted, ordered", and I think it says, "10 units Actrapid".

A Actrapid, yes.

D

Q Actrapid, whatever it is, and signed by you.

A Yes.

Q Is that the occasion you mentioned in your evidence when you said you phoned Dr Barton because you had a concern?

A Yes.

E

Q That was one occasion you could remember?

A Yes.

Q The action was taken pursuant to her verbal permission, or verbal opinion, as to what should be done?

A Yes.

F

Q That is 29 February. On to 1 March, another entry by you, which is at page 997, the prescription sheet relating to MST. Do you see that? You had better pick out the entry by you, yourself, on the sheet. It is in relation to MST, I think we can see it, perhaps, just over halfway down, "MST 20". Can we pick up your initials on the right?

A Yes.

Q "MC" is you, is it?

G

A Yes.

Q What did you understand MST was given for, in general terms?

A For pain.

Q In what form is it given to the patient?

A Orally.

H

A

Q I think it is just that one entry, is it, by you or your initials appear, perhaps, twice. Does that make sense?
A Yes, 10 o'clock.

Q That is on 1 March. I am not going to ask you to turn up these pages because we have seen them already in relation to the catheter on the catheter sheet on 1 March. There is a record by you that the catheter is draining satisfactorily. There are other nursing records but I am not going to ask you or the Panel to go through them all because we are all familiar with your signature. We have records on 1 March where, "Pressure sore areas were dressed", she was given a blanket bath, "bed rest maintained" and, in a particular case, suppositories being given with no result and an enema being given. We can check all those in the records, we do not need to spend the time to look at each one. Four days later, on 5 March, so far as you are concerned, would you look at page 1003, can we pick up your signature on the right-hand side, about one third of the way down the record. Is that you?
A Yes, that is me.

B

C

Q This is part of the nursing care plan dealing with pressure areas being dressed and so on and, again, without my turning up or asking everybody to turn up all these pages, on 5 March there are other records where we can see you dealing with the draining of the catheter, the dressing remaining in place, that she has been washed and bed rest maintained. They are the same general matters where you were obviously on duty and attending to that patient?
A Yes.

D

Q We need to turn to a page we have already looked at, page 1013. We have seen that on that sheet the 1 March, the complaining of pain in the shoulder is there. That is going back slightly in dates, but it is your entry that we have already covered. We move down to 5 March on that particular page, "Pain uncontrolled, patient distressed, syringe driver commenced 9.30 in the morning. Son informed". In the scale of things, with your experience, when you recorded that "pain uncontrolled", what is that saying – it may be obvious?
A On the medication that she was taking, her pain was not controlled.

E

Q Tell us about the procedure, you say "Son informed"?
A Either myself, or perhaps Philip if he was there, would have rung the son to tell him how poorly his mother was and, with his permission, we were going to start his mother on some morphine on the syringe driver over 24 hours.

F

Q Again, this would be, in your experience, part of a normal procedure?
A This was the normal procedure.

Q If it was the view of the doctor concerned and the medical staff were carrying out the doctor's authorisation as it were and the patient was going to be put on to a syringe driver, normally the relatives – if they were not at the hospital and assuming there was a relative with whom contact could be established – would be informed?
A Would be informed. We would always have their consent before giving a controlled drug.

G

Q Had you, yourself, ever carried out this task?
A Oh yes, frequently.

H

A

Q I appreciate everybody is different and patients are different and you had to deal with different relatives and so on, in general terms what would you be saying to a relative?
A What would I be saying to you, if it was your relative? "Your Dad had a really bad night last night, he is an awful lot of pain. We can no longer give him oral medication because he cannot swallow it any more".

B

Q For whatever the reason might be?
A Yes. "We would like to start him on a syringe driver", and I would explain to you what a syringe driver does and the fact that it delivers a tiny dose of this medication over 24 hours, "Which means your Dad is not going to be comfortable for a little while and then uncomfortable until we can give him another dose of the drug". This drug delivers the same dose over 24 hours.

C

Q You would be explaining the advantage of using the syringe driver?
A Yes.

Q When you carried out this task, did you yourself ever encounter any relative who indicated that they did not want the syringe driver to be commenced?
A No, we had a patient once who was on, I think it was, perhaps, oral morphine and we could not actually give it without ringing their relative to say. She wanted to know every time we gave her relative this particular drug and we did. We complied with her wishes and we did that. But that was only once over the years that I worked there.

D

Q Something you said earlier in the evidence, I want to make sure I understood properly. What if a patient was being put on Oramorph, in other words this was the first time that morphine in any form was being administered to the patient, would you normally try to inform any relative about that?
A Yes. Yes, I did not give the patient we were talking about who came back in from Haslar in great distress, I did not give her any Oramorph without asking her daughters first their permission.

E

Q That was the case of Gladys Richards?
A Yes.

F

Q In general terms it was the normal procedure ---
A We would not give it without informing the relatives.

Q Did you ever, in your experience, encounter a relative, or have contact with a relative, who said in effect, "I do not want you to give my relative..."
A No, only the one occasion I have mentioned. I cannot even remember the lady's name.

G

Q There is another note with regard to the same patient on 5 March. I am not going to ask people to turn it up, but it is two pages on 1015, where we can see your signature saying that, "She continued to leak faeces", just part of the nursing care plan, so that would normally be noted down?
A Yes.

H

A Q Lastly, on this particular date, this particular topic if we can move on again in the bundle to 1022, we can see that the matter which was recorded on the other document we looked at a moment or two ago on 5 March, the entry by you talking about, "Pain uncontrolled, very poor night" and exactly the same information, not expressed in identical form but conveying the same picture, "Son contacted by telephone, situation explained". I think we have covered that.

A Yes.

B

Q Bearing in mind the sort of patients you were caring for at the hospital, when you recorded "very poor night" with an elderly frail lady who was in distress, what picture are we to get from that? Because people can use words in different ways.

A It is the picture of a very restless patient in lots of pain.

Q I appreciate that obviously you are not a doctor, but did you feel that, if you had any

C concern about either the type of medication prescribed or the amount of medication prescribed, you could make a point?

A Yes.

Q Did you ever have occasion in the time you were there, and in the period that we are concerned with up to 1999-2000, to query the medication, either by way of its type or the amount of the dose, with any doctor?

D A I cannot recall querying a dose.

Q I would like to ask you about something you mentioned in your evidence when you were being asked questions by Mr Kark. You spoke about the pharmacist. Do you remember you were being asked questions about ---

A Yes, I remember. The ward round.

E Q --- more than one drug being prescribed at the same time, and so on?

A Yes.

Q What is the picture there? The pharmacist would come in?

A She used to come across from QA every week and then she would go through our stock of drugs, order what was needed, go through everybody's treatment card, check that the drugs given were the correct dosage, the fact that some drugs you cannot give with other

F drugs, et cetera. She would make a note of anything that she wanted Dr Barton to look at, and perhaps change something. And every week she would do this.

Q So that is a regular ---

A It is a regular occurrence.

Q --- visitor and inspection in that sense.

G A Yes.

Q Was the pharmacist somebody called Jean Dalton?

A Yes, she was.

Q So she would obviously be seeing not only the physical stocks of the drugs, but would she be seeing the prescription?

H A She would be seeing everybody's prescription and what they were prescribed.

A

Q So she would be seeing the documents which showed, in some cases, a dose range for diamorphine or midazolam, whatever it was?
A Yes.

Q And would be seeing where drugs were combined in a syringe driver and would be seeing where that occurred.
B
A Yes. If they could not be combined, then she would say so.

Q May I ask you too about another isolated point, but it is one that may come up in other aspects of this case; that is, the Barthel score. Are you familiar with that?
A Yes.

Q What is the significance of the Barthel score, and tell us what would happen if you
C
had to sort it out yourself?
A This lady had a very high Barthel, I recall. We have already looked at it. I think it was 21; therefore she would have been nursed on an air bed, which means ---

Q I am asking you about one thing and I was going to ask you about another. When you say "nursed on an air bed", is that something to do with their skin condition?
A Yes.

D

Q Is that something called Waterlow? Have I got it right?
A Yes, a Waterlow score.

Q What is the difference between the Barthel score and the Waterlow score? What are they dealing with?
A Waterlow is purely pressure care and Barthel is general nursing care.

E

Q Dealing with Waterlow, the higher the rating, or whatever you call it, or the higher the points ---
A Score.

Q --- does that mean more of a problem?
A Yes, it does. This lady, I believe she had bilateral leg ulcers, apart from everything.

F

Q All right. I am leaving that for the moment and just dealing with it generally. Waterlow, the higher you are the worse off you are.
A Yes.

Q Barthel score, the lower you are the worse off you are. Is that right?
A Yes, that is right.

G

Q Did you yourself ever complete a sheet or card relating to a patient's Barthel score?
A Yes, it was something we had to do when the patient was admitted; it was part of the procedure.

Q We have seen examples already, and I am not going to take you through them – whether they can feed themselves and so on.
H
A Yes.

A

Q If somebody rated zero on the Barthel score, in your experience what would that indicate to you?
A Quite self-caring. Self-caring almost.

Q I am sorry – the Barthel score is zero. Is that good in terms of the patient?
A No, it is not good.

B

Q It may be difficult to remember which way round they were.
A It is not something I have done for some years. You will have to excuse me.

Q I think when you were being interviewed by the police, you told them ---
A That was four years ago, the last interview. Well, five years ago, actually.

C

Q Five years ago. I think when you were speaking to them about this, and you were talking about Gladys Richards, you were talking about the Waterlow pressure score prevention – and we have already covered that. In her case, that is Gladys Richards, I think she was 27, which was pretty much on the high side. Then the Barthel score, you were indicating to them – this is page 19 of interview number two – and the patient you were dealing with there, again Gladys Richards, "…because she scores nought, she is totally dependent".

D

A Yes. I believe she was paralysed left and right side.

Q I am pausing for a moment to see whether I need to ask you anything more about the first patient we were dealing with, Elsie Lavender. Again, perhaps a matter of generality but it arises in her case. We have seen the record of the syringe driver being commenced and your note of it. In general terms, assume that Dr Barton had, in anticipation, in advance, prescribed the administration of diamorphine and midazolam – let us just take those two as an example – to be administered subcutaneously. That is what she has done in anticipation.

E

First of all, this. The reason for Dr Barton, or indeed any other doctor who did it in terms of prescribing in anticipation, was to prevent there being a gap between the failure of one form of pain relief and the start of something to deal with pain relief more appropriately.
A Yes.

Q In case the doctor was not immediately to hand.

F

A Yes.

Q No doubt on a number of occasions when there was an anticipatory prescription like that, Dr Barton could be spoken to on a morning round and could give a specific instruction to start.
A Yes.

G

Q Because in order to administer the medication subcutaneously you have to be using a syringe driver, normally a syringe driver would not be started – in other words, the patient would not be put on a syringe driver – unless Dr Barton had specifically authorised it.
A Yes.

H

A

Q Were there ever any occasions which you can recall where a syringe driver was started – subcutaneous analgesia is prescribed – and Dr Barton was not consulted, or her opinion or authorisation sought?
A I cannot remember an occasion.

Q If there was such an occasion, it would be somebody senior to you – if Dr Barton could not be obtained for some reason and the on-call doctor could not be obtained or could not come out – it would be somebody more senior to you who would actually have the final say-so.
A Yes.

B

Q So in the case that we looked at, with regard to Elsie Lavender, you made it clear in your evidence that Dr Barton must have given the authority to start the syringe driver.
A Yes.

C

Q In the cases when that occurred – in the case of Elsie Lavender, you have told us – she would have examined the patient and decided what to do.
A Yes.

Q Was it your experience that in the case of a patient who had, let us say, developed a problem overnight and Dr Barton was informed in the morning of the problem, whatever it might be, she would carry out some examination of the patient – normally?
A Yes.

D

Q Because you have told us that what you would do, or you and the other nursing staff would do, would be to draw her attention in the morning to anybody who had a particular problem that had developed.
A That is right, yes.

E

Q Would that therefore also apply, on any occasion that you can recall, when the report to Dr Barton was that the patient had been suffering overnight and the existing medication did not appear to be controlling the pain, the discomfort, the anxiety?
A Yes.

Q In your experience she would normally carry out an examination?
A Yes.

F

Q As well as discuss the matter with you?
A Yes.

Q I want to ask you one other matter before we turn to the case of Patient E, Gladys Richards. Patients being unrousable – if a patient was unrousable, and assume that this is not a patient who is in terminal decline, normally speaking would the issue be raised as to whether the medication they were on was too strong, too much – in an ordinary circumstance?
A Yes.

G

Q If you found a patient was unrousable, you would obviously want to find out the reason.
A Yes.

H

A

Q On this ward, for all sorts of obvious reasons, patients on occasion died. They were very ill when they came; they were very frail, and they died.
A Yes.

Q Obviously something that you saw more than once. Yes?
A Yes.

B

Q As you became more experienced as a nurse, did you find that you were better able to make a judgment, not as a doctor but as an experienced nurse, as to whether a patient appeared to you to be entering a terminal phase?
A I do not think you can always make that assumption, in my experience. I have called patients' relatives in and, by the time they have come in, the patient was sat up, eating something. It is not an easy thing to do.

C

Q I am not going to disagree with that for a moment. Not an easy thing to do, but did you find your experience and your ability to make a judgment about it improved as time went by?
A Yes.

Q You could get it wrong, of course.

D

A Yes.

Q In the case of a patient who was in the terminal phase of their life, you would find presumably that, when analgesia was administered subcutaneously, diamorphine and midazolam, they would at some stage become unrousable.
A Yes.

E

Q So was your judgment as to the significance of a patient being unrousable dependent on what stage of their care they were at? It may be that I have expressed that badly. Assume an ordinary case where a patient has pain. They are not, in your view, in a terminal phase. They have pain which needs to be controlled and it needs to be controlled by subcutaneous analgesia. That is necessary, but it is not the case that they appear to be in a terminal decline. All right? Imagine that sort of circumstance.
A Yes.

F

Q If such a patient became unrousable, would you want to wonder and investigate why?
A Yes, we would call a doctor.

Q In such circumstances it may well be that it was because the dosage was too high. Yes?
A Yes.

G

Q What I am trying to get at is not that case but a case where the patient is in terminal decline and they are therefore having to be given the diamorphine and the midazolam subcutaneously to deal with the situation, their pain, and so on; but they are, in your view – being blunt about it – dying.
A Yes.

H

Q In such a case, was it your experience that a patient might well be unrousable?

A	A	Yes.

Q	In that last phase, whether it lasted a day or two days or whatever it was. Yes?
A	Yes.

Q	I am going to turn now to what you told us about Gladys Richards.

B	THE CHAIRMAN: Mr Langdale, the witness has now been on the stand since 11:15. I anticipate that this patient will take some time for you to deal with.

MR LANGDALE: It is more than ten minutes.

THE CHAIRMAN: On that basis, we will take a slightly earlier lunch so that you can go into the next phase of your questions. We will return at ten minutes to two. (To the witness) Mrs
C	Couchman, please do not discuss the case with anybody during the lunch adjournment.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. (To the witness) This is just to remind you that you remain on oath. Mr Langdale.

D	MR LANGDALE: I want to turn to ask you some questions about Gladys Richards, as you have already told us. You first encountered her as a patient when you had come back from your holiday or break, or whatever it was.
A	Yes.

Q	And she had been re-admitted to the hospital, having been back to the Haslar in circumstances of which you were made aware. Correct?
E	A	Yes.

Q	Do you have the collection for Patient E, the file? The one I would like you to look at please is the file marked "E" – Patient E. Would you look there, please, at page 34. We can see your name in the bottom left hand section and you are the named nurse?
A	Yes.

F	Q	Would you just indicate what the significance is of you being in this particular case the named nurse. What does that mean?
A	I was supposed to be the main nurse who liaised with the patients and I was the one they could come to if they needed anything.

Q	With the ---?
A	With the patients' relatives.

G

Q	The patients' relatives – yes. So you are their link person, if you like. Yes?
A	I was the go-between.

Q	Any other particular duty that you had?
A	You are the patients' advocate.

H	Q	Yes?

A A You are there to stand up for the patient.

Q You have told us that when she was re-admitted, you could remember this particular incident anyway. You had been on a coffee break of perhaps 20 minutes?
A Yes.

Q And during that time she must have been admitted - yes?
B A Yes.

Q And is it right that the first person to contact you about her or to point out there was a problem was, I think, a care assistant, as you described her?
A Yes.

Q Would that be the same thing as a support worker?
C A Yes, it is a support worker.

Q I think you were able to remember when you spoke to the police about this back in 2000 that the person who came to you to tell you about the problem was somebody called Linda Balduccino?
A Yes.

D Q What was it she was concerned about?
A She came to tell me – I could hear the patient was upset and in great pain – that she was transferred whilst I was at coffee break and that the paramedics transferred her on a sheet instead of the normal canvas, which is obviously much thicker than the sheet.

Q So you were aware that that was ---
A I was aware that there was this problem.

E

Q Caused by ---
A Also she said that she did not think she was lying correctly, and that was probably again adding to her discomfort, but she did not want to move her. She wanted me to do it.

Q I see.
A She was waiting for me.

F

Q Is this the right sequence: after she had spoken to you and told you what the position was ---
A Yes.

Q --- you went to the room where the patient was?
A I went to the room, introduced myself to the sisters.

G

Q So both daughters ---
A Had a look ---

Q Hold on. Sorry.
A Both sisters were there.

H Q The daughters, the two daughters? The sisters?

A A The sisters, her daughters, yes.

Q Right. And was the patient still screaming?
A Yes, she was. So I checked her and found out she was not lying properly. I mentioned it to the sisters, and one of them – one of the daughters, I should say – said, "I will help you. I am an ex-nursing officer."

B Q Thank you. Thank you for that. She helped you?
A She helped me ---

Q You got her into a better position ---
A She helped me position the patient.

Q And did that alleviate the pain and distress?
C A She seemed a little more comfortable.

Q Was she still screaming, or had she stopped?
A Yes, she was still screaming.

Q Still screaming?
A Yes.

D

Q Thank you.
A Which is why we eventually gave her some Oramorph.

Q It was obvious to you from any conversation you had with the sisters, Mrs Richards' daughters, that they were not at all happy about the transfer from the Haslar?
A No, they were not. We also knew – we had had a communication from the rest home
E where she came from to say that there had been whispers of suing the rest home.

Q So you knew when you ---
A We knew there were problems.

Q You knew, without going into unnecessary detail I hope, you realised from what you had been told that the sisters were ready to complain if they felt they had a reason to
F complain?
A Yes, yes.

Q I think also at that stage, or at least in relation to that same day – please tell me if this is wrong – there was a problem with Mrs Richards being able to take the food that somebody was trying to feed her with?
A Yes, yes.

G

Q And then you got somebody to go and mince the food?
A That is right, yes.

Q Back in the kitchen, and have it brought back?
A Yes.

H Q Did that seem to work?

A A No, she did not actually want it.

Q She did not want it?
A She was quite poorly, actually, when she arrived, and looking at the transfer letter, the fact that she could stand and weight-bear... That was quite hard to believe.

Q Did you sometimes find that patients arrived at the Gosport War Memorial Hospital
B with perhaps an impression that their physical state was rather better than it actually was?
A Yes. Yes. We also gathered that they were coming for a rehabilitation. They were told this, when it was obvious to all that perhaps that was not going to happen.

Q Did that sometimes affect, in your view, the view that relatives had as to the prospects for the relative who was a patient in your hospital? Did they sometimes have a rather unrealistic ---
C A I think sometimes they did have unrealistic expectations, and that did not help.

Q In any event, on the day that you saw Mrs Richards in the way you have described, did you later on go into the room again and have a look at her because she was still in pain?
A Yes.

Q Again, I am using what you told the police in the year 2000 for this. Did you indicate
D to one of the daughters – sisters – that you would like to give her mother something to relieve her pain?
A Yes, yes. I asked if I could give their mother a small dose of Oramorph and they agreed.

Q Did you speak to Philip Beed ---
A Yes.
E

Q --- the manager, about it?
A Yes, I did. He agreed with me, and we administered the dose between us.

Q And we can see, as we have already looked at in the file at page 46 – if we can just turn that up again, please. We have the record of really what you have been telling us about just now at the bottom of the page. On the 17th – the day we are talking about – you set out
F the position with regard to, "To remain in straight knee splint," and so on. All the detail is there. Is that your writing over on the left: "No canvas under patient ---"?
A Yes.

Q "Patient transferred on sheet by crew." Then, over the page, still the same day, we can see a further note that you made:

G "In pain and distress – agreed with daughter to give her mother Oramorph 2.5 mg in 5 mls.

Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again."

So that is something one of the sisters was telling you?
H A Yes.

A

Q That she had been told by a surgeon at Haslar?
A That is right.

Q Is that it?

"Dr Barton contacted and has ordered an X-ray."

B

Was that you who would have contacted her?
A Yes.

Q And she had indicated – what – over the telephone?
A Yes.

C

Q "Get an X-ray."
A Yes.

Q That takes care of your notes in relation to that. I would like to ask you a little bid more in terms of Mrs Richards, did you find that she was somebody who, even when she was able to eat, had great difficulty eating?
A Yes, I think she did.

D

Q I think you described it in this way to the police when you were seen by them: "I think even before she had the medicine she was having great difficulty problems [eating]"?
A Yes.

Q "Eat and drink", you said.
A Yes.

E

Q Obviously she was somebody who was in great pain and had multiple problems?
A Yes.

Q When she was put on the syringe driver is it right that there was some discussion between you and Philip Beed? Perhaps I can take it in stages. Did it become clear to you from what Philip Beed said to you that he had already spoken to the relatives about this?

F

A Yes, yes.

Q And the doctor?
A Yes. That would be normal practice.

Q And so it was, as it were, a decision in which the relatives – in this case the sisters – were involved?

G

A Yes.

Q And obviously nobody, in terms of confining it simply to you and to Philip Beed, but nobody wanted to leave any patient in distress and pain?
A No.

Q And I think you also told the police that in your view a couple of days before she died

H

you had got the impression that she was starting to die?

A

A Yes.

Q And described her as being very poorly?
A Yes.

Q Did you get the impression at any time that you had dealings with them when they were at the hospital, that the sisters had any complaints about anything?

B

A At our hospital?

Q Yes.
A Yes. Yes, I did.

Q Would you help us with that?
A One of the support workers became quite friendly with her. She was very much into astrology, this girl. She did the two sisters' charts and they sort of became friendly. We were invited to a spiritualist meeting.

C

Q It is not your fault. I am going to stop you there.
A Yes.

Q Because I think you were going on to say something about a spiritualist meeting which had taken place some time later. Is that right?

D

A No. That was before the mother died.

Q All right. Sorry. Go on. I am confining it to the period when she was still alive.
A Yes, yes. In Chichester. I went myself with Linda Balduccino and another support worker to this meeting.

E

Q Pause there. Was the meeting that you went to after Mrs Richards died?
A No, before she died.

Q Before?
A Before she died.

Q All right.

F

A It was very peculiar because they went round the actual meeting, people saying what they did, this sort of thing, and apart from saying what she did – which was not much, it was not anything at all, I do not think – she said something about what awful treatment her mother had had in the War Memorial. This is in front of the three of us. She obviously got us there to complain about the War Memorial.

Q This is before her mother had died?

G

A Yes, yes. It is actually in the interview. I did tell the police.

Q I appreciate that. I was just trying to make sure that it was a time before the mother had died rather than later.
A We did not actually meet them after she died.

Q So apart from that, when there was this thing being said at the meeting, did either of the sisters ever complain to you directly about the treatment?

H

A A Not directly to me. And in fact after her mother died, she gave about nine presents to the staff, mainly books and things, and then she left. She gave her mother's chair to the ward, which was one of these electric type things, quite expensive chairs. She gave that to the ward. I do not think we had any complain for a few weeks.

Q Sir, may I just indicate this to the Panel. There are some other notes made by this witness in relation to the patient Alice Wilkie. There are not very many of them and they are

B all, if I can use the expression, relating to mundane matters, but since we know what this witness's writing looks like, I do not think it is necessary for me to go to that file and take the Panel through it or, indeed, take the witness through it. My learned friend, Mr Kark, and I can agree it, I am quite sure, if there is any difficulty. I am not going to go into any further records.

(To the witness) May I just ask you please about one other matter. Again, in general terms –

C all right – obviously you have been able to remember certain things with regard to the patient, Gladys Richards ---

A Yes.

Q --- that you told us about. The other patient we talked about, you were not really able to remember ---

A No.

D

Q --- anything of any significance. Would you just give the Panel some idea of the amount of patients who you must have seen at the Gosport War Memorial Hospital?

A I do not have the numbers.

Q What are we talking about? Hundreds or thousands, or what?

A I should imagine it would go to thousands.

E

Q Over the period of time you were there?

A Yes.

Q Finally, would you help us with this. I have asked you some questions about Dr Barton already. It is clear from your evidence that she was somebody who was obviously very busy. Yes?

F A Yes.

Q Was she somebody who took time to speak to relatives? How would you describe her ---

A Yes, she did take time to speak to relatives.

Q Sometimes relatives would be there when she came in the afternoon?

G A Yes.

Q Would relatives ever be there in the morning when she did her morning round?

A No, normally that was perhaps a bit too early.

Q It tended to be later on in the day?

A Yes.

H

A
Q We have heard evidence about her coming back at lunch time or in the afternoon?
A Round day, the day the consultant did her round.

Q Those would be the sort of occasions when relatives might be there and she might be able to speak to them?
A I think they were able to make an appointment as well on round day, when the round had finished, if they needed to come into the office and talk.

B

Q Might there be occasions when she came in on her own deliberately in order to see a relative?
A Yes.

MR LANGDALE: Thank you, that is all I need to ask you.

C

Re-examined by MR KARK

Q Just a few questions from me. In relation to Elsie Lavender, Mr Langdale was asking you about the normal procedure and why a patient would be put on to syringe driver. You have been asked questions in this case – you do not have to look it up – it is file B, page 1013 and you said to him, "We would say that the patient is having uncontrolled pain and cannot swallow any more". Did the two of those have to go together before you would initiate a syringe driver?

D

A If the patient cannot swallow, it has to be administered some other way.

Q I understand that?
A It is either a syringe driver or ---

Q If a patient could swallow, would there be any reason to switch?

E

A No.

Q You told us a bit about the pharmacist and you mentioned somebody, I think, is it Jean Dalton?
A Yes, that is her name.

Q Is it Philip Watling, Mr Watling?

F

A Yes, I think he was over occasionally.

Q The prescription sheets, the sort of documents we have looked at already on which Dr Barton would fill in a prescription and then the nurse administering it would put their initial and the time of the administration, where would those notes be kept?
A At that time, I believe, by the bed.

G

Q What notes would be kept by the bed and which notes would be kept in a cupboard?
A I believe then the treatment card was by the bed and the care plans, the care plans you have been reading from.

Q The drug charts?
A By the bed.

H

A

Q We also know that because controlled drugs were used too, you had to keep a record of the controlled drugs in a Controlled Drugs Record Book. I am holding one up just to show the Panel and we can exhibit these in due course if it is necessary. These books would be kept for each ward?
A They were locked in the cupboard, the controlled drug cupboard.

B

Q They would be a record of every controlled drug that was withdrawn for administration?
A Yes.

Q So, by way of example, this is a book I am looking at for Dryad Ward commenced June 1999 and it has a list of all the controlled drugs in it. When you told the Panel that the pharmacist would come and check the dosage, can you tell us what they would be looking at, which documents the pharmacist would look at?

C

A She would check that book as well when she came over so that the amount of drugs in the controlled drug cupboard had to tally with the book, and then she would check each prescription for each patient.

Q Are you saying that she would go round the ward and look at the prescriptions at the end of each bed?
A Yes.

D

Q What would they be looking for?
A She would be looking for dosage, she would be looking at the drugs that were prescribed for that particular patient, whether they should be given together or, if there were any discrepancies then she would contact Dr Barton.

E

Q Did you ever know her to object to the drugs that were being given?
A I have known her leave a few notes about different things.

Q About what?
A Not about dosages, no, but, perhaps, there are certain drugs which cannot be given together. I cannot give you an example, but I do know.

F

Q Did you ever know her to haul anybody up, Dr Barton or anybody else, to say, "Hang on, you should not be giving that much"?
A She would do.

Q In relation to one of these controlled drugs?
A No, no, I do not think that ever happened anyway.

G

Q You told us also that you, I think, were there when Dr Barton made examinations?
A Yes.

Q When she made an examination, did you see her making a note of the examinations or would somebody else make a note of an examination on her behalf?
A Yes, I would see her making the notes.

H

A

Q You were also asked by Mr Langdale about patients being unrousable, and I think it was being put to you that if a patient was coming towards the end of his or her life, there would come a point when that patient would become unrousable?
A Yes.

Q Is that what you were agreeing with?
A Yes.

B

Q I want to understand what you were saying?
A Yes.

Q If you had any concern about it, you would bring it to the attention of Dr Barton?
A Yes.

C

Q Did you ever say to Dr Barton, "I am very concerned, this patient is unrousable"?
A I cannot recall.

Q Or the medication being reduced as a result?
A No, I cannot recall.

Q Dealing with Gladys Richards, you told us, and it must have been distressing for everybody concerned on 17 August when this patient was screaming and you had to reposition her, do you know who would have put her in the bed, who would have been responsible for this patient?

D

A I would imagine it was the ambulance people that did that actually.

Q Would ---
A Deposited her in the bed.

E

Q I am sorry, can you say that again?
A Put her in the bed.

Q Would anybody have been there from the nursing staff to make sure that things were done properly?
A Yes, the support workers were there, but they knew it was not right.

F

Q They knew it was not right?
A They knew she should have been transferred on a proper canvas which is much thicker than a sheet.

Q When it was brought to your attention that the patient was screaming, the daughters were already there?

G

A Yes.

Q In relation to that patient, you told us that the fact that she could stand and bear weight was hard to believe?
A Yes.

H

A

Q Do you have Patient E's file, I want to know what your evidence is about this. Page 8 is the transfer note from the Royal Hospital Haslar. We can see the note at the bottom, page 8 of Patient E:

"When in bed it is advisable to encourage abduction by using pillows or..."

is it "abduction wedge"?

B

A Yes.

Q

"She can however mobilise fully weight bearing."

"Fully weight bearing", presumably, does not mean that she can dance down the corridor?

A It does not mean to say she can walk, but I did not actually see her mobilised.

C

Q Are you saying you do not believe that note?

A I am saying she was a poorly old lady screaming in pain, but I did not see her mobilised. I did not see her stand.

Q When she was at the Gosport War Memorial Hospital from 17 August when you were dealing with her, did you ever see her out of bed?

D

A No.

Q Would it have been any part of your function to try to mobilise a patient who needed mobilising?

A Yes.

Q Was any effort made to mobilise this patient?

E

A I think she was too poorly.

MR KARK: That is all I ask, thank you.

THE CHAIRMAN: Members of the Panel have indicated to me that they would welcome at this stage some time to discuss amongst themselves the questions that the Panel will be putting to the witness. Therefore, what I propose is that the Panel will remain in the room

F

and I will ask everybody else to withdraw and we will call you back as soon as we are able. Mrs Couchman, you will be taken to somewhere to await and we will try to get you back as soon as possible. We are aware that you have spent a considerable amount of time on the stand and we are grateful for that.

(The Panel adjourned for a short time)

G

(Questioned by THE PANEL)

THE CHAIRMAN: Welcome back. Thank you, Mrs Couchman, for allowing us to hold you back still further. The Panel are now in a position to put their questions to you. We are going to start with questions from Dr Roger Smith who is a medical member of the Panel.

DR SMITH: You will be familiar because you were entered in the notes as a named nurse.

H

A Yes.

A

Q On these wards, where you worked, Daedalus and Dryad, was each patient allocated to a named consultant or did all of the consultants look after the patients?
A Dr Lord looked after the patients on Daedalus Ward.

Q For each of these two patients that we have discussed today, Dr Lord was the consultant in charge of the case?

B

A Yes, I think so.

Q It is just as a matter of enquiry because it caught my eye, who was Dr Matthews – I have lost it?
A I do not know.

Q You do not know who Dr Matthews was?

C

A No.

Q He was on the head of a sheet at Gosport. You said towards the end of your questioning by Mr Kark that, at times, relatives, and indeed the doctors and nurses at the hospital sending you patients, might have had unrealistic expectations of the outcome?
A Yes, we did feel that.

D

Q That when they arrived you thought, "Well that is not going to be possible"?
A Yes.

Q Can it work both ways, that you might have had, at times, unrealistically pessimistic views?
A No, I do not think we did.

E

Q For instance, I think you said that sometimes you could call a relative in because you were very worried that the patient was ill, but when they got in ---
A I did say it was very difficult to actually say if someone was dying or not because, occasionally, we would call relatives in and perhaps they would be sitting up eating when they arrived.

Q You would agree at any particular point in a patient's management, at any particular

F

moment, that may not indicate what is going to happen next?
A Yes.

Q We have dealt with two patients and, although they are quite different patients in what happened to them before they came to Gosport, the same things happened when they got to Gosport. The first was a lady who was a little demented, no she was quite demented, I think, and before transfer she had been mobilised after a fall and she was walking about with a

G

Zimmer and some help, and she was described as being quite well. On the day she went into your ward at Gosport, she received a dose of morphine Oramorph?
A Yes. She had had a transfer from one hospital to our hospital. She had a haematoma on her wound, which I guess was causing her great pain.

Q Your assessment of that patient seems to be different from the assessment of the people who sent her to you in that ---

H

A This is how we found her on our ward.

A

Q You felt that she was in great pain and she received ---
A Not just myself, the staff on my ward.

Q Yes, generally she was found to be in great pain and given a dose of Oramorph and she never regained consciousness?
A Yes, she did. It was a tiny dose when she arrived, 2.5. If you recall from the drug sheet, she had more than one dose that day actually.

B

MR KARK: I am sorry to interrupt. I want to make sure we have not crossed wires. I want to make sure Dr Smith and the witness are talking about the same patient. I think the witness is talking about Patient E, talking about the haematoma. I wondered if that was the patient Dr Smith had in mind.

C

DR SMITH: No, it is Patient B actually.

MR KARK: It is just that the witness may be answering about Patient E.

DR SMITH: Let me generalise it a bit more because I am trying to understand the mechanisms of decision making. The generalisation is that patients – either of these patients could be used as an example – came in and had some Oramorph and certainly one of them never regained consciousness thereafter. The treatment regime continued to eventually become subcutaneous diamorphine.

D

A Not on that day.

Q No, but through the next few days. For instance, the lady who came in in agonising pain who was screaming in pain, we have evidence that she received a dose of morphine and she never spoke again, Oramorph?

E

A I did not think she spoke very much on that admission. I did not actually see her on her first admission, I was actually on leave, but on her second admission when she had to have a dose of Oramorph, I do not think she spoke very much at all.

Q She went on to have more Oramorph and then subcutaneous and so did the other lady we spoke about today. Both of these ladies were unconscious at least at some point, certainly by the time they were on diamorphine subcutaneously. Each day the pump was changed?

F

A After 24 hours it would be empty.

Q On each day the pump, the syringe driver, was continued until they died. Neither of those patients regained consciousness before they died. How do you, a very experienced nurse, you have worked there for 10 years with Dr Barton on the elderly care ward, how do you assess, how do you make up your mind, what an unconscious patient needs in the next syringe driver? First, why do they need it again, can you help us with that. What are the pointers, what are you looking for?

G

A To keep the patient comfortable and pain free.

Q How do you know the patient is comfortable, how do you know whether the patient has pain?
A We can only assume that the patient is comfortable if they cannot tell us.

H

A

Q So why would you continue?
A It is not my decision to continue.

Q It is not?
A No.

Q But you are part of the team and I am trying to understand ---

B

A I am part of the team, yes, but ultimately it is not my decision.

Q Of course it is not, but you are an important person. You, the nurses, are important people in informing the doctor as to how the patient is.
A Yes.

Q If it is the doctor's decision or if it is a joint decision, nevertheless your input is very

C

important. So how would you know whether a patient still needs to continue that pump driver, that dose?
A The only answer I could give is that you do not give it and you just let the patient be in pain.

Q That is right; so how do you know whether, by reducing or stopping the painkiller, the patient will still be in pain or not?

D

A By observation. You would not know any other way.

Q But the pump is not stopped and the dose is not reduced; the patient remains unconscious. So how do you know whether the patient might perhaps not have been in pain any more if the dose was reduced or stopped?
A We do not.

E

Q You do not. So what is the object of continuing this drug regime? Is it that a decision has been made that there is nothing more to be done for this patient; that this patient is now terminally ill? Is that the reason why the syringe driver is changed every day, continuing the same dose or increasing it? (Pause) Is it because somebody has made a decision that there is nothing more to be done for the patient because nothing can be done for the patient? (Pause) I am not asking you if you made that decision.
A I know you are not. I have told you, the decision is not mine.

F

Q Absolutely, but you are part of a team.
A I know.

Q I am trying to understand, and we want to know, if that would have been the case: that you continue these drugs, these pumps, because the team, if you like, or the doctor – whoever – has made a decision, an executive decision, a care plan decision, that "We can't do

G

anything more for this poor patient who has been in terrible pain and we are now into terminal care".
A I cannot answer you.

Q You cannot answer for either of these two patients?
A No.

H

Q Why do you think then that no fluids were exhibited to these patients?

A A No what?

Q No fluids were given.
A I think we have been over that, haven't we?

Q Let me put it a different way. If you thought that a patient had the chance of getting better ---
B A I do not orchestrate a patient's treatment; I carry out orders and do them.

Q I take issue with that slightly. You are a registered nurse.
A Yes.

Q With professional responsibilities, with training, with experience.
A Yes, but I do not prescribe drugs.

C

Q No, but you give drugs. You deliver the drugs; you administer the drugs.
A Mmm.

Q And you are not on trial here.
A I feel as though I am on trial.

D Q I apologise if I make you feel that way.
A I feel as though I am on trial.

Q I am trying to understand whether, in these patients in this ward, decisions were made, rightly or wrongly – and often rightly – that the patient ---
A I think that decisions were made in the patient's best interest.

E Q How was that communicated?
A I do not know what you mean.

Q When that decision has been made, how would everybody understand that it had been made?
A When an order is given and a decision is made, it is made, isn't it? We all know.

F Q But how is it given? Perhaps that is how I should put it. How is it given?
A Everybody knows how poorly the patient is.

Q But what if you are ill the next day and somebody has to come in? How do they know that that decision ---
A Because we all work the same.

G Q So it is word of mouth?
A And written word.

Q Written?
A Mmm.

Q So, in your experience, in that unit it was written down that a patient would be
H designated as – what? For terminal care?

A A No. The patient was on a syringe driver.

Q For pain?
A For pain. Syringe drivers are given in lots of cases, as you know yourself, for lots of drugs, for the ease of giving the drug over a 24-hour period, to have no troughs and peaks.

Q So I come back to what I suppose was my original question. How do you know that
B the patient still needs it for pain if they are unconscious?
A We do not.

Q And so ---
A I do not know how we could know.

Q By reducing the dose and finding out?
C A Possibly, yes, by taking it away and seeing if they are in pain.

Q But that was not done with either of these patients.
A No.

Q Would that be usual in that unit?
A Yes.
D
Q That is all I needed to ask, thank you.

THE CHAIRMAN: The next Panel member is Ms Joy Julien. She is a lay member.

MS JULIEN: My question is about the syringe driver but in general terms, and really about the communication with the patients' relatives. First, I think you started off by saying at
E some point that you informed the relatives about it before.
A Yes, someone would speak to the relatives.

Q One of the things I wanted to clarify was whether you informed them or whether you sought their consent.
A We did both. We sought their consent and informed them.

F Q Before you went ahead?
A Oh, yes.

Q Would that be a one-off or would it happen as things ---
A Certainly on our ward it would happen with each patient.

Q With that patient, you would inform and seek consent initially ---
G A Yes.

Q ...and then that would be it, and then you would carry on making adjustments.
A Yes. We would probably see the relatives again when they came in to see the patient.

Q If there were any changes in the dosage or anything like that, would they be party to---
H A Yes, we would inform the relatives.

A

Q At each stage?
A They would be kept informed all the way along.

Q What form would that take? Would it be face to face or ---
A Face to face or by the telephone if they were not there.

B

Q I think you gave us an example of how you might put it to them. Would you use the same language each time? Do you have a script?
A Hopefully we would use as sensitive language as we could.

Q So you would be adjusting it, depending on the circumstances?
A Yes.

C

Q Would you have anything to assist you, like a checklist, *aide-mémoire* or script, or anything like that?
A No, we are taught how to speak to relatives.

Q Are there key things you need to say to them?
A Pardon?

D

Q Are there key things, key statements that you need to make when you are seeking consent?
A Yes.

Q Could you give me an example of what essential things you would have to say?
A I would say to you, "As you know, your mother has been very poorly for some time and we think she could benefit from a dose of Oramorph. Would you be happy if we gave it to her?" Most people will say, "I would like my mother to be comfortable and pain-free, please".

E

Q Would you explain exactly what it is?
A Yes. If we were using a syringe driver we would explain exactly what it is.

Q In your experience, are most people familiar with a syringe driver? Do they know what it is?
A Occasionally someone is but, no, mostly they would need to hear about it.

F

Q So you would explain it? You would explain what it is?
A Yes, although it is used at home as well, I think, by the district nurses.

Q You mentioned that you would record that you had informed or ---
A Oh, yes, we would always – we should always record that we have informed the relatives.

G

Q So it does not always happen?
A It might escape, if we are called away to another patient. If we are very busy, there are times when perhaps the written work....

H

Q What if you cannot get hold of the relatives?

A We normally manage to get hold of the relatives somehow. Either they come in to see their relative or we can get them on the telephone, or leave a message to ask them to come in.

Q But you do not go ahead until you have actually ---
A Not normally, not till we have spoken to the family.

Q When you say you speak to the family, is it the named next of kin?
A It would be best if the named nurse could do it, but obviously they are not always there or they might be on leave. It could be somebody else who does it.

Q What I actually meant was do you speak to a specific person in terms of relatives?
A We would speak to the next of kin if we could.

Q So it has to be the next of kin?
A Yes.

Q When you are explaining to the next of kin, obviously you talk about the advantages but do you talk about the possible disadvantages or risk associated, or the consequences associated of going on?
A Yes.

Q What would they be?
A I would say the advantages are there are no troughs and peaks, and this drug would be administered over 24 hours whereas, previous to using the syringe driver, we would give the dose four-hourly probably; so the patient will be very comfortable perhaps for two, maybe three, hours and then quite in pain, and have to wait a whole hour before we could give the dose again, till the four hours were up. Therefore to use the syringe driver is much better.

Q In terms of consequences, for instance if the patient would become unconscious and therefore not able to communicate with their relatives, is that explained to the relatives as a possible consequence?
A Yes, we would explain what is happening.

Q I think that is all, thank you.

THE CHAIRMAN: Mr William Payne, who is a lay member of the Panel.

MR PAYNE: Good afternoon, Mrs Couchman. It has been a long day.
A Yes.

Q I have a few questions, I am afraid. I shall keep you as little as I possibly can. Am I right in saying that you worked on the ward for ten years?
A Yes, probably over that.

Q Over ten years?
A Yes, a little over.

A

Q Did you work with Dr Barton throughout those ten years? Was she there for ten years?
A Maybe not at first, because I did work on the children's ward when I joined the hospital; but then the children's ward was taken away.

Q So you had worked with Dr Barton for a number of years anyway?
A Yes, a number of years.

B

Q Did I hear you say that you started there in the Eighties?
A Started where?

Q Did you start at the hospital in the Eighties?
A I think it was 1983.

C

Q My colleagues touched on the syringe driver – and this might sound a basic question to you, but I have no connection with hospitals – but did you get any training in the use of a syringe driver?
A Lots of training, yes. At St Mary's, in QA, War Memorial.

Q Is it a very in-depth training on it, or does somebody show you?
A Well, yes. It is quite a simple instrument actually, like most of them are when you sit down and look at it. And this was 13 years ago, so it had been going some time then.

D

Q So you were well versed in the use of it then?
A Mmm.

Q Did that training incorporate the types of drugs that you would be using?
A Yes. Say we were using Oramorph, morphine --

E

Q And diamorphine?
A Yes. It is a derivative of morphine.

Q And the mixture of different types of drugs?
A Yes.

F

Q You know when you said that you administer drugs and you administer them impairs – there are two of you ---
A The controlled drugs, yes. That is the law.

Q And it is always two?
A Yes, it has to be two.

G

Q There were occasions when you were the senior of those two?
A Yes.

Q And I am right in saying that you said that you would follow the prescriptions and you, in those ten years, never had to increase the amount?
A I cannot recall. Yes, that is what I said.

H

A

Q You would give the minimum?
A Yes.

Q May I ask you to turn to pages 63 and 65? We are on E. Are you with me?
A Yes.

Q Do you recognise the handwriting?
B
A Are you on 63?

Q Page 63 or page 65.
A Yes, I have got both of them here. Yes, I recognise most of that handwriting.

Q That is Dr Barton's handwriting?
A Yes.

C

Q Would you say that this is a normal sheet that is not necessarily just for this patient but this is the type of thing that she would write for every patient?
A Yes.

Q Are these prescriptions – let us say, for instance, page 65 and the diamorphine, 40 to 200. Can you see that?
D
A I have seen it, yes.

Q Would that be normal for her, to write those amounts?
A Yes.

Q For me, that seems to be quite a wide ---
A It is a wide range, yes.

E

Q Forty to 200. You would always start with 40.
A Yes.

Q You said that you had never had to change it ---
A I do not think so.

F
Q But if someone else on, say, the day before had been up from 40 to ---
A I think they would have probably used the same.

Q Yes, but if they had gone up from 40 to, say, 60 and it was your turn the following day to administer the drug, you would have started at the 60, would you?
A If they had, you mean?

G
Q Yes.
A Yes, probably I would have followed on.

Q You have told us that you are trained in this. If you are increasing the dosages, what is a normal increase from, say, 40? What would you normally increase to?
A What would I go up to after 40?

H

A

Q Yes.
A Perhaps it would be 60. From 40 perhaps to 60. But I cannot recall ever going up.

Q But that would be the normal, to go up to about 60?
A Yes.

Q Then you would obviously not increase that for some time at least, because you would see how the pain was monitored.
A Yes.

B

Q I think it was you who told us that Dr Barton would be there at least every morning, at between eight and eight-thirty.
A Yes.

C

Q And sometimes in the afternoons?
A Yes, if we called her in.

Q My question is, if you would only increase it in, say, twenties or maybe forties, and the doctor would be there within 24 hours under normal circumstances, why is there such a range between 40 and 200? I do not understand why that seems appropriate or necessary.
A I see what you are saying.

D

Q But that was how it was done normally?
A Yes, I have seen it before.

Q Were all the nurses happy about this range of prescription?
A I never heard anybody comment on it.

E

Q There had never been any comments ---
A No, I never heard any comment on it.

Q No comments in the past?
A No.

F

Q Nothing complained about years ago?
A No. Because it is there, you do not have to use it, do you?

Q But it is there so you can use it?
A You could, yes.

Q But you had never heard any complaints previously or anything like that?
A No.

G

MR PAYNE: I think those are all the questions I have. Thank you very much.

THE CHAIRMAN: Thank you, Mr Payne. Now it is Mrs Pamela Mansell, who is a lay member of the Panel.

MRS MANSELL: You explained to us that the purpose of the nursing notes, when different nurses come on duty, they pick them up and they can have a look and know how ---

H

A

A This is what is supposed to happen, yes.

Q --- to deal with the patients.
A Yes.

Q I am looking at page 1013 and Patient B. Elsie Lavender.
A I think I have it.

B

Q If we look at the 4th of the 3rd, I get the impression that here is someone with slight pain in the shoulders when moved, so she has the physio exercises, and "Elsie needs reminding," but because there is a slight increase in pain the analgesia is increased. Then the next date, the next day, "Pain uncontrolled. Patient distressed."
A I believe that was overnight, the "pain uncontrolled".

C

Q Yes, yes.
A Because the driver was started at 9.30 in the morning.

Q So you commence. Is that you who commenced that?
A Yes.

Q Is that your name?

D

A Yes, it was me.

Q But this patient could take medication orally. If we turn to 1017. I understood from that, if I look at the 2nd of the 3rd, "Took medication well." I am interested in where the notes are that help me to understand why we have moved from oral medication to syringe driver.
A Yes. That was at night, I believe, that 2nd on the 3rd. So it was three days later that I started the ---

E

Q The syringe driver. But I do not have a note there that indicates to me why the pain in the shoulder is increasing and I find nothing that helps me to understand why we have moved from "Took medication well," to a syringe driver?
A There is not a reason.

Q So that seems quite a step forward.

F

A It was obviously reported to me on the 4th of the 3rd, but not actually written in her care plan.

Q Right. So you can throw no light on that one really?
A Seeing as I started it on the 4th.

Q Because I understood, it is only when patients could not take it orally that you started

G

to use a syringe driver?
A Yes. That was two days later.

Q Yes. It is quite a progression without a note?
A It was quite a long way for a poorly patient, but obviously the night staff actually had not written in since the 3rd.

H

Q Right? So you are talking again about it like being a progressive deterioration?

A

A Yes, yes.

Q Rather than the improvement for the patient?
A Umm.

Q Are you saying it was another patient, where it was seen that the patient was progressing towards death?

B

A No, no. I do not think we thought at that time. We just thought her pain was uncontrolled.

Q The other way. What we do not seem to know is, what has suddenly happened to this shoulder to make it worse, that the pain became uncontrolled?
A Who are we talking about?

C

Q Elsie Lavender.
A Elsie Lavender? She was… Not quite sure… But the diagnosis we had was a brain stem CVA, which was a left and right paralysis.

Q Right?
A Of the body.

D

Q Right?
A So she was actually paralysed.

Q Okay. You probably cannot help me further, then, to understand, to make sense of those notes. Thank you. One other thing, and I think it follows on really from some of the questions that Dr Roger Smith was asking you. You made a statement as you were giving your evidence, and this was relating to Mrs Richards, Gladys Richards, and talking about her

E

progressive deterioration. You said some things about when the patient starts to die. What does that mean – "a patient starting to die"?
A I do not know.

Q "Starting to die."
A I do not know that either. I do not recall saying that now.

F

Q Just that I made quite a note of that.
A No. I cannot tell you when a patient starts to die.

MRS MANSELL: Right, okay. I will leave that one then. Probably I heard something that you did not say. Okay, thank you.

THE CHAIRMAN: You are very nearly there. I am the last member of the Panel and I

G

suppose, by definition, my job is a bit of a sweeper, and I will attempt to sweep up a number of points. First of all, just following on from the evidence that you have just given in respect of Patient B. I think I heard you say that she was paralysed?
A Left and right. Brain stem CVA.

Q From the neck down? I am not a medical member so you will need to help me.
A Her left side. I think I am right in saying that her left side and her right side were

H

paralysed.

A

Q From the neck down, that would be, would it?
A Umm.

Q It is just that on the page that you were referred to, 1013, I note that in the higher part of the page, the second entry, for 28 February – this is 1996, yes.
A Oh yes. I can see she was ---

B

Q "Right arm less painful able to lift it above head height."
A Maybe my diagnosis is not right. I am thinking back.

Q I am not going to hold you to it because ---
A I am not sure whether this was 11 or 13 years, but ---

C

Q It is very confusing when there are so many different records, so many different patients and, as you say, so much time has passed and then you have a variety of people firing questions at you from different corners. I do understand how difficult that can be. Clearly that was not right?
A No.

D

Q Obviously she was able to move. The question that had been asked earlier about the syringe driver – I think you had said that if a patient could swallow, then a syringe driver would not be instituted because there would be no reason. You only use that when the patient is not able to take the ---
A It is used in the medical profession for people. Sometimes people walk around with them in their pocket. It is so they can have whatever drug they are having ---

E

Q I should be more specific.
A --- gradually over the 24 hours, or continually over the 24 hours.

Q But syringe drivers on these wards with these sorts of cocktails that we have been looking at appear again and again.
A Yes.

F

Q In those circumstances you would not put somebody onto a syringe driver if they were able to swallow.
A Yes.

Q Is that the point you were making?
A Yes.

G

Q You also said to us that if you were going to put somebody onto a syringe driver, you would not do it if they were unconscious. That was in response to a question ---
A Yes.

Q --- I think from Mr Langdale. As a non-medic, my rather naïve question is, "Why not"? Is there a reason why you would not?
A Would they need it? I do not know if they are not, and you do not know that they are in pain. Would they be? I do not know.

H

A

Q I am just trying to understand where your answer came from because of course the question would have been again this kind of syringe driver with these kinds of drugs in these circumstances. So I take it from what you say that your point is you would not administer if they were unconscious because if they were unconscious they would not be in pain, so there would be no point. Is that the ---

A Yes.

B

Q That clarifies that one too. Thank you very much. On the matter of consent that I think was particularly dealt with by Ms Julien, you told us at an earlier stage today that we would always get consent before starting them on a controlled drug. If in the normal course of events you were required to start somebody on a controlled drug and you were able to contact the patient's relative, you would give them the information that that was what you wish to do and, as you have said, you would explain why and you would get the consent. Having got the consent to put them on to a morphine or a morphine-type, would you need then to get consent to put them onto a driver or, if you had already got the consent, would it have been necessary?

C

A Yes. It was normal. It was normal to see the relatives before we started the driver, or at least talk to them.

Q Why was that? What is the significance of the driver?

A So that they were kept informed of their relative's condition.

D

Q But if the driver is just containing the same sorts of things – they are opiates designed to keep them pain-free – and you already have permission, is it necessary or is it just a matter of fact?

A It is something. It is a matter of form that we did.

Q Would you say that everybody always did, or that that was your practice?

E

A Yes, yes. On this particular ward, we did.

Q And I think again, picking up from what my colleague had asked, I think you have told us that the words used would depend upon who you were talking to?

A Yes.

Q So, for example, if you were talking to somebody who had only a very basic grasp of medical matters, you might be a lot less specific than if you were talking, for example, to a retired nurse whom you would tell very clearly?

F

A It did not matter who we were talking to. We just tried to make them understand what we were doing, the treatment we were ---

Q Fundamentally what you were doing was giving opiates for the purpose of relieving pain?

G

A Yes, yes.

Q And it was your job to make sure they understood that?

A Yes, yes.

Q You said that you were a named nurse?

A Yes.

H

A

Q One of your duties was rather colourful – that you were a patients' champion?
A Advocate, I said.

Q Advocate.
A Same sort of thing really, just the nurse to look after their interests if they were unable to, and to liaise with their relatives on certain matters – things that they needed, or washing, or whatever.

B

Q So you would be there to fight their corner, as it were?
A Yes, if they needed somebody. Yes.

Q If they were not able to do so. If they were unconscious, for example ---
A Yes, yes.

C

Q --- you would be the one to question if, for example, a driver should continue?
A Well, we would not give the okay for a driver. We would not take the place of the relatives, but...

Q But if you were the champion or the advocate, it would be part of your role to question whether the driver should continue once it had been instituted?
A Yes, yes.

D

Q And did you ever do that, as a matter of interest?
A I never stopped it, no.

Q Did you ever query, as an advocate for a patient, any of the prescriptions that had been given by any doctor?
A No, no.

E

Q Not this one.
A No.

Q Was that because on the whole the doctors that you worked with were always good professionals and there was not a need to do so?
A There was no need to do so, yes.

F

Q You have been very complimentary about Dr Barton. You have told us that from your experience she clearly had the best interests of her patients at heart and you told us that she would always see patients' relatives ---?
A Yes.

G

Q --- when that was needed.
A Yes.

Q How would you describe her?
A I would describe her as looking after each patient's interests.

Q And with the ---
A She had their interests at heart.

H

A

Q And when she was seeing the relatives of patients, how would you describe her bedside manner, for want of a better word?
A It was good. It was good.

Q Would you say that all your colleagues would agree with that particular assessment?
A Yes, yes.

B

Q Mr Payne, I think, asked you earlier about the views of your fellow nurses, about the sort of drug regimes that we have been looking at in these records and asking whether they were normal.
A Do not forget we had a pharmacist look at them every week on the ward.

Q Yes, absolutely, and I understand ---
A So why would we question her?

C

Q Indeed. I understand you to say that there is a pharmacist who would come in once a week and who would conduct an audit and had a whole system of checks and balances, including checking to see the appropriate ---
A Checking the treatment, each treatment card.

Q And no doubt that gave you some comfort?

D

A Of course.

Q Because that is a responsibility that you do not have.
A Yes.

Q But were you aware around 1991, for example, of any difference in opinion amongst some nursing colleagues about, for example, the use of diamorphine?

E

A I was not aware, and I do not think it took place on the ward where I was working.

Q So you were not aware?
A No.

Q But you have subsequently become aware of something?
A I have become aware, but it did not actually take place on Daedalus Ward.

F

Q Right. I am not going to ask you about ---
A I was not actually ---

Q --- what you have become aware of afterwards. It was really what you were aware of at the time that you were working.
A No, I was not really.

G

Q And finally, can I look briefly with you at the matters of admission, and when patients first came in and we had been shown the sorts of referral letters that you were given, and you have explained to us that unfortunately the nursing notes do not come on to you from the releasing hospital, which of course must make life more difficult for you than it would be if you knew precisely what had been happening. Fortunately, though, within the system is an assessment by a doctor, and we have seen in these files and others numerous assessments

H

conducted by Dr Barton. There is a particular phrase that we see that comes up time and

A

time again, that you will no doubt be familiar with. It is: "I am happy for nursing staff to confirm death." Am I right that that is something that you ---

A That was written.

Q Yes. It was a common phrase within the ward, would you say?

A Yes.

B

Q And what did it mean?

A It meant that the nurse in charge could do the confirmation.

Q The confirmation of?

A Or two of you usually would perhaps.

Q The confirmation of?

C

A Of the death.

Q So it is at that stage, assuming that there is going to be a death?

A If it did.

Q I am sorry?

A If. If it occurred.

D

Q Yes. If a death occurred. Was it a signal to the nurses that this was one of those patients they are going to have to take a particular care because death was regarded as being ---?

A No, I do not think so.

Q Would it be a normal thing to have ---?

E

A Yes.

Q In all admissions?

A Umm.

Q Somebody comes in ---

A Yes.

F

Q --- for rehabilitation, recovering from a broken wrist?

A We did not actually have anybody come for rehab with a broken wrist. Not this ward that I was working on. I have had heard a story of a man coming in a broken wrist. It did not come in on this ward.

Q So on your particular wards, then, this was a common occurrence?

G

A On our particular ward we would have patients in with perhaps nine diagnoses. It may be a stroke or what had happened to them last, but they all had a string of diagnoses.

Q And some, or all of them, would have had that note at the beginning?

A Yes.

Q Saying, "Happy to confirm"?

H

A Some or all.

A

Q Did you ever see any patient who had that on their notes at admission, or very soon thereafter, leave the ward recovered, or did they always die?
A I cannot answer that. I do not know.

Q Because you do not remember?
A I do not remember.

B

Q That is absolutely fair. The length of time that has elapsed makes it quite impossible, and perhaps it was an unfair question. Very well. I think that is all I have. Where we go now is that I ask each of the barristers, I am afraid, whether they have any questions arising out of the questions that the Panel have asked. Is that okay? Are you fit to go on with that now, or do you need a break? I know you have been ---
A No, no. We need to get home. We have a long way to go.

C

Q Very well. Then let us go straight across to Mr Langdale and see what questions he may have.

Further cross-examined by MR LANGDALE

MR LANGDALE: Sir, I do have some. I will try and keep them as short as possible as far as you are concerned. Back to Patient B, Elsie Lavender. Do you have that file in front of you?
A Yes.

D

Q You will remember that a member of the Panel was suggesting to you that the case of Elsie Lavender, Patient B, and the case of Gladys Richards, although they had different backgrounds, that there were similarities in relation to what had happened to them at Gosport. It was suggested that they had been rendered unconscious as a result of morphine very soon after their arrival. Do you remember the suggestion being put to you?
A I remember the suggestion, yes.

E

Q I would like to use you to take a look at the history to see what similarities there are. Looking at Patient B, Elsie Lavender, if you look at the very beginning of the file, there is a helpful chronology. It saves you looking through masses of pages. This is the history. Do you see that it shows how she went into Haslar following a collapse?
A Yes.

F

Q I am taking it shortly. That was in March 1995 and the year we are concerned with, February 1996, she goes into Haslar following a fall. On 6 February, this is still in the Haslar, she is commenced on Amoxicillin and she is prescribed coproxamol and dihydrocodeine, which is administered – in other words she gets it – until she is transferred to Gosport. That is on 6 February. Over the page, still at Haslar, the 8th, "Seen by a physiotherapist"; 13th she is seen by a consultant geriatrician; the 16th, Dr Tandy, "Transfer recommended"; 20 February, "Reviewed by physiotherapist", still at Haslar; over the page, there she is on Daedalus on 22 February.
A Yes.

G

Q On that date, assuming that is right, she is prescribed the same drug that she was already on at Haslar.
A Yes.

H

A

Q There is no change when she arrives at the Gosport War Memorial Hospital. Dr Barton is the person who deals with that. Following on, let us look at the history, 23 February she is not unconscious; 24 February she is not unconscious; over the page you can see that Dr Barton has changed the prescribed drug to MST, which is morphine sulphate tablets. Is that right?
A Yes.

B

Q Still not unconscious. 25 February it is administered, still not unconscious; 26 February, the same drug is administered and on that date, as you can see at the top of the following page, some four days after she has been admitted to Daedalus, Dr Barton does what we have been calling an anticipatory prescription because she prescribes diamorphine?
A Yes.

C

Q If the staff had thought it appropriate to administer the diamorphine, if they had, they could have contacted the doctor?
A Yes.

Q And said, "We think it is time to start". That does not happen, you can see, because on 27 February, the next day, the morphine, the MST continues, and on 4 March, that is almost a week later, four, five, six days later, she is still on morphine sulphate, still conscious. "Reviewed by Dr Barton" on 5 March and then on that date the diamorphine is administered subcutaneously. Do you see that?

D

A Yes.

Q Can we take it that she was not unconscious throughout that period of time?
A Yes.

E

Q Can we tie that point up and turn to a page you have looked at before, page 1013. You can see that she is obviously conscious on the dates covered by that page until we get to the bottom.
A Yes.

Q You will have noticed that the analgesias administered are "fairly effective". She is less painful on 28 February, there is some movement in the right arm. On 1 March she is obviously conscious because she is complaining of pain and slight pain on the 2nd. On 4, March can you see that ---

F

A What number are you on?

Q Sorry, 1013 at the bottom.
A I cannot find 1013.

G

Q Page 1013?
A It is not the printed 1013?

Q It is a typed or printed ---
A You were talking about 28 March, were you? This one only goes up to 06/03.

Q That is the page I am asking you about. I ran through the top dates showing that she is obviously not unconscious, she is conscious. On 4 March she is seen by the physio. Let us

H

A look at the exercises when you were asked about your recollection of whether she was immobile in terms of her arms. On 4 March the physio appears to be recommending turns of the head to the right, that is three turns?
A Every two hours.

Q And five neck retractions every two hours, obviously not involving the use of the arms, at least if I am reading it right it does not, but "Elsie needs reminding", so she does
B that. "Analgesics increased", "Pain uncontrolled, patient distressed". Does that mean, again, that she was not unconscious, she just had a pretty bad night?
A Yes.

Q The syringe driver was commenced at 9.30 and you followed up your normal procedure of explaining matters to the son and informing him?
A Yes.

C

Q Pain was controlled by the syringe driver on the record on 6 March. I think we can see that that appears to be a rather different history to the history of Gladys Richards who is the lady who came in on readmission to Gosport?
A Yes.

Q Can we turn to her so we can see whether there is any similarity. Would you turn to
D the file for Patient E, Gladys Richards. Looking at the very beginning of the file again, do you see there is the chronology, do you have that?
A Yes.

Q We can see it goes back quite a way in the early part of 1998. Can we move on to 11 August, which is the third page in on the chronology. She has been operated on at the Haslar, she comes into Daedalus on 11 August, is reviewed by Dr Barton as we can see on
E the 11th. Dr Barton prescribes Oramorph and also does an anticipatory prescription for diamorphine and the other drugs, midazolam and so on, and that is on the 11th. She is reviewed by the nursing team on the 12th. Oramorph is administered but none of the diamorphine anticipatorily prescribed to be administered subcutaneously is administered. She stays on Oramorph on the 13th. She does not stay in the Gosport War Memorial because she has a fall and is readmitted to Haslar on the 14th.

F She comes back, having been administered in the Haslar – it may be wrong – Oramorph. Back to Daedalus on the 17 August which is when you first saw her. You described what happened when she was in a great deal of pain from the unfortunate transfer, it would seem?
A Yes.

Q The Oramorph is administered, as it had been before she left. She is reviewed again on the 18th and that is the first day when the diamorphine is administered. That goes on in
G the way we can see on the chart with regard to that lady.
A Yes.

MR LANGDALE: That is all I wanted to deal with you so far as any questions from me are concerned.

THE CHAIRMAN: Mr Kark?

H

A

Further re-examined by MR KARK

MR KARK: Not very many questions. Dealing with that last patient, just for the Panel, the drug chart at the Haslar is at page 286 onwards. I think midazolam was prescribed in that period and Oramorph was prescribed, but not administered. I want to return to Patient B again, page 1013, which we have already spent quite a lot of time on. Mr Langdale just took you through it and I will not go through all of it, but it appears that right up until 4 March she was able to speak. Are you with me?

B

A Yes, I am with you.

Q She is seen by the physio, he recommends some exercises for her and he says, "Elsie needs reminding. Analgesia increased". Can we take it from that that the patient at that stage still must have been talking?

C

A Yes.

Q On 5 March you told us that that note that you made, "Pain uncontrolled, patient distressed" came from the night nurses?

A It must have done, must it not, because it was first thing in the morning?

Q That is what I want to ask you about. How do we know that it did not come from the patient herself?

D

A I can only assume because it is not actually written down and it should have been written on her night chart that she had a really poor night.

Q I understand that, but this is your note?

A If she had said to us in the morning, "I have a very painful shoulder", she had said that before, we would not have administered a syringe driver for that.

E

Q When you decided to administer this, would she have been talking to you or would she have been already ---

A I cannot say, can I?

Q That is why I ask you?

A It is 11 years ago.

F

Q That is why I asked you earlier, would you have given a syringe driver to somebody who was unconscious?

A No, no I would not. I assume she was given it because she had had a very painful night.

Q The only note you have comes from the nursing staff.

G

A From me.

Q If the patient is awake and talking to you, we have heard a lot about relatives' consent, what about the patient giving consent. Would you have asked the patient for consent...

A Yes.

Q ... to start a syringe driver?

H

A Yes.

A

Q You would?
A I could have asked the patient if she would like some morphine for her pain.

Q That is different in a sense. Would you have said specifically to a patient, "We would like to start you on a syringe driver, is that all right?"
A I could have done.

B

Q Would you have made a note of that,"Patient consents to syringe driver"?
A Like I say, she had been complaining of pains in her shoulders right from the first.

Q She has pain from her shoulders all the way along and I wonder what triggers---
A Even the 28th. I said she was distressed, so I assumed she had a really distressing, painful night.

C

Q It follows on from a day when she had some physiotherapy?
A Which may have caused pain, of course.

Q Would you have thought a syringe driver was the appropriate answer to that?
A It depends how much pain she was in, does it not? I obviously thought she was in a lot of pain. Previous to that, even on the 27th, she was complaining of a painful shoulder and we did not put her on a syringe driver then.

D

Q You told us earlier, and I am afraid I had not picked up on this but it came from questions that I think Mr Langdale asked you, that you did not have kits for intravenous fluid. Is that right?
A No, I do not think we did then.

E

Q If the effect of a syringe driver is that the patient becomes unconscious, the effect of that equally is that they cannot take fluid any more. Is that right?
A Yes.

Q If they cannot take fluid any more and you do not have any intravenous kits, what is going to happen to the patient? What effect is that going to have on their body?
A (Pausing to review documents) I am just looking for a fluid chart and I cannot find that.

F

Q If the patient becomes unconscious because a syringe driver has started, is there an effect not only from the opiates but also from the fact that the patient is not getting any fluid?
A We always gave the patient mouth care and moistened their mouth.

Q Yes, I understand that. It is to make the patient more comfortable. But is that going to rehydrate the patient?
A No, it is not enough.

G

Q Was there any system for rehydrating a patient once the syringe driver had started?
A Yes, we used to give the patient a sub-cut, but I cannot remember if we gave it when Elsie Lavender was on the ward.

H

Q I am sorry, just explain that, could you? A "sub-cut"?

A A We place a little needle under the skin, in the subcutaneous part of the skin. The actual needle has a tube on it, which is connected to an IV bag; so we could actually give the patient fluids.

Q I am not a medical person, so I might have misunderstood. When you said you did not have any intravenous kits, I assumed that was what you were talking about.
A That is IV, into the vein. I cannot remember if we had the sub-cut on the ward at this
B time when Elsie Lavender was there.

Q If you did not, would there be any other way of getting hydration into the patient?
A No.

Q If you did have a sub-cut, intravenous kit, would that be noted on the record somewhere?
C A It should be, yes. There should be a chart for it.

Q When you get consent, as you spoke about to a number of Panel members, from one of the patient relatives – and that is to the start of a syringe driver – would you explain to the relative, "But we don't have any system for rehydrating your mother/your father"?
A We would explain if they asked us, yes.

D Q I am sorry? You would explain if they asked you?
A We would have explained if they had actually asked, yes.

Q If they did not ask…?
A Yes, we would explain.

Q You would explain?
E A Mmm.

Q The effect of that would be what on the patient?
A I mentioned before that there was research at one point to show that that was more harmful for the patient.

Q Is that when the patient is in the last stages of life?
F A In the last stages, yes.

Q It is when the patient is dying. You do not want to rehydrate them.
A Yes, but I should imagine that is why the sub-cut was brought in: for wards that could not use the IV.

Q One last topic, and it is very short I promise you. This is in relation to Patient E and
G her hip. Do you remember when she came back she had a haematoma?
A Yes.

Q The doctor was asking you about how you make a decision about the level of pain relief that that patient would need, if you would ever wake them up again. Do you remember that discussion you had with him? If the patient is unconscious, how do you tell that they still need pain relief?
H A I said I cannot understand how anyone can ascertain that.

A

Q No, we understand that. Is there any active measure that can be taken to relieve a haematoma?
A I am not sure. Not being a surgeon, I cannot really answer you.

Q Do haematomas sometimes resolve spontaneously?
A Yes.

B

Q Would you have any way of knowing whether that haematoma resolved after the X-ray or not?
A Unless we gave another X-ray, I do not know.

Q Or woke the patient up and asked if it still hurt?
A But we did give her 2.5 mg of Oramorph at the time. It was only a small dose, for her pain.

C

Q Not from the 18th onwards.
A When she came; when she actually was admitted on the ward, that is what I gave her.

THE CHAIRMAN: Mrs Couchman, that really is the end. Thank you very much indeed for coming to assist us today. I know it is very hard, particularly when you have to take so many questions from so many different people over such a sustained period, and we are extremely grateful to you for maintaining your patience and good humour. You are free to go.

D

(The witness withdrew)

THE CHAIRMAN: Do we have any news of Dr Peters?

E

MR KARK: We do. We have finally made contact with her. We gather that she did not realise that she was meant to come today. I have to say that my instructing solicitors had made quite strenuous efforts to ensure that she did know, and it is a surprise and unfortunate that she did not.

We have rescheduled her at the moment, after much discussion, for 30 June, which is something of a sort of clear-up day before we start on the expert, and we have made it very clear how important it is that she does attend on that day. In a sense, it is actually a good thing she did not come today, because we would have run out of time to hear her. As a result of that, we are essentially still on track; but, as one can see from this last witness, we do think that things are going to go rather slower with the nurses, who we are beginning to get to.

F

The next event, as it were, is the reading of Mr Jewel's statement; but you, I expect, will want a bit of time to change gear and have a look at Patient I, Enid Spurgin's opening and note. Then tomorrow, other than that reading, we have three relatively short witnesses for you. They are all coming to talk about Mr Geoffrey Packman, and no doubt you will want time to read that as well. We are therefore in your hands as to how you want to play this.

G

THE CHAIRMAN: I am not going to ask the Panel to embark on any more reading today. It has been a long, difficult day, I think, for all of us, but a useful day none the less.

H

A What I propose is that the Panel will start here at 9.30 tomorrow as normal and will use the first 30 minutes to reacquaint themselves with Patient I; then we can hear the statement read. Then I guess that it will be another period of study before we get on to the witnesses.

MR KARK: Sir, I do not think that you have Patient I's medical records yet.

THE CHAIRMAN: No, we do not.

B

MR KARK: I do not know if that is included in the 30 minutes that you are giving yourselves.

THE CHAIRMAN: No, probably not. I think that would be over-ambitious.

MR KARK: Can I say that Patient I's notes are about the thinnest so far, if that is any

C encouragement to you; nevertheless, they will take a bit of time. I would have thought that you might want to set aside an hour.

THE CHAIRMAN: Shall we say not before 10.30, unless you are otherwise requested to attend?

MR KARK: Yes, certainly.

D

MR JENKINS: Sir, can I deal with one matter arising from the transcript of yesterday? I do not know if you have it in front of you.

THE CHAIRMAN: We can swiftly do that.

MR JENKINS: I just have one, what I hope is a typographical error, because it was me

E speaking at the time. It is Day 6, page 41E. The question I think I asked was, "But was she", meaning Dr Barton, "telling you that your *husband's* condition, sadly, was rather poor?" The word has come out as "benzodiazepine's".

THE CHAIRMAN: Yes, they are not phonetically similar but I think that you are probably right.

F MR JENKINS: I am grateful. I think the answer that the relative gave, Mrs Kibley, was "I cannot think of the *word* at the moment", not "ward".

THE CHAIRMAN: Again, I think that is likely.

MR JENKINS: I raise it while it may still be fresh in the memory. I will not trouble you again if there is an error as small as the second one, but the first was rather a departure from

G what I think I said.

THE CHAIRMAN: Any careful scrutiny of minutes will always reveal a few like that, but that is clearly quite an important one; so thank you for that.

MR LANGDALE: Perhaps we can ask Mr Jenkins to check all the transcripts!

H

A

THE CHAIRMAN: What an excellent idea! As he has been so under-employed so far, it seems only fair that he carries his share!

The Panel adjourned until 9.30 a.m. on Wednesday 17 June 2009
and the parties were released until 10 a.m.

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3

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 19 June 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY NINE)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

INDEX

Page No.

Statement of Ernest John Stevens, read

Statement of June Mary Bailey, read

PHILIP JAMES BEED, Sworn

Examined by MR KARK	6
Cross-examined by MR LANGDALE	47
Re-examined by MR KARK	73

A

THE CHAIRMAN: Good morning, everybody. Mr Kark, the Panel have taken the opportunity to read through Patient L's bundle and also to reacquaint ourselves with your opening in respect of Patient L.

MR KARK: Sir, I am very grateful. The statements that are going to be read in relation to Patient L: there are two statements, one from the husband of Jean Stevens and one from her daughter. The reason that they are not able to give evidence is that both are ill, and both have provided doctors' letters. I have had a discussion with my learned friends about the reading of their statements. These statements are read not by agreement, as it were, in other words they are not agreed evidence, but it is not challenged that they can be read under the Criminal Justice Act because they are unwell. So it is not agreed evidence but it is accepted that it can be read.

B

C

You have the power, of course, to receive evidence of this nature. Section 114 of the Criminal Justice Act 2003 provides that you can receive this evidence if you are satisfied that it is in the interests of justice for it to be admissible, or one of the other categories is under section 116, that the relevant person is unfit to be a witness because of his bodily or mental condition.

D

You have of course in any event power under Rule 50 to allow evidence, provided you are satisfied that no injustice would be caused and that your duty of making due inquiry into the case makes its reception desirable.

MR LANGDALE: Sir, may I just confirm what Mr Kark has said.

E

THE CHAIRMAN: Thank you, Mr Langdale. Given the clear importance of these two witnesses' evidence and given the fact that we understand that neither are well enough to attend and given that Mr Langdale very kindly accepts that they may be read, on the understanding that they are admissible only in so far as they are those patients' evidence and that it is not agreed evidence, we are happy for you to continue.

MR KARK: Thank you. The first statement is that of Ernest Stevens. He says:

F

"I am the husband of Jean Irene Stevens". That is our Patient L. He exhibits a copy of her witness statement that he made for the police. He says, and this is the GMC statement so that was made relatively recently on 5 April 2008:

> "My wife did not see Dr Barton, or any other doctor, from the time that she was admitted to the hospital until the time that she died. I can be sure of this as I was by her bedside the entire duration of her stay in the hospital.
>
> I do not believe that my wife was in any sort of pain, and therefore did not require a double dose of diamorphine, as she was not indicating any signs of pain or distress, something which I would be able to identify as an ex-ambulance man.
>
> My wife has not administered any fluids whatsoever from the time that she died."

G

H

That was her GMC statement. He give a rather fuller account in a statement that he made to the police dated 8 September 2005 and he said this:

A

"I live at the address known to the Police. I am the widower of Jean Irene Stevens, who died on 22nd May 1999.... at the Gosport War Memorial Hospital, Bury Road, Gosport. I have been asked to provide some background information about my wife.

My wife was born on Code A .... in Gosport, Hampshire. Her parents were Harry and Eleanor Victoria Collings. She was one of five children, all girls. Two of her sisters died in their teens due to someting like diphtheria or TB and her other sisters, Lillian and Iris, died around the age of 70 year and 80 years.

B

Harry Collins died around the age of 79 .... and Eleanor died around the age of 69....

My wife worked throughout her life as a shop assistant or canteen assistant.

C

We had two children, Carol in 1946 and June in 1949. Both pregnancies were straightforward with no complications.

My wife was relatively healthy but in 1994" – he says – "she began to experience stomach trouble....."

D

He made a statement in due course correcting the 1994 date to the 1970s. He says:

"She was experiencing a lot of pain and discomfort.

She was admitted to Haslar Hospital in Gosport for an exploratory operation, during which they removed her appendix. The problem persisted and in 1996 she was again admitted to Haslar where she was diagnosed as suffering from diverticulitis. She underwent surgery and had a small part of her bowel removed.

E

She went on to have two further operations on her bowel. Apparently she had lesions in her bowel due to the operations and it was this that was causing her pain.

As a result of this my wife was in constant pain and was prescribed pain killers.

F

She also suffered from slight arthritis in her back, but despite this she was fully mobile and able to get about without assistance.

On Sunday 25th April 1999.... we spent the day at home. Jean had cooked a roast dinner and tidied everything away as usual. We had our usual night cap before Jean went to get ready for bed.

G

I heard a thud and went to see what had happened. I found Jean lying semi-conscious in the bathroom. I called an ambulance and Jean was taken to Haslar Hospital in the early hours of Monday 26th April.

By visiting hours that evening Jean was propped up in bed fully conscious. She had lost the use of her left arm and leg but was fully alert and able to speak.

H

She had lost the ability to swallow and was being fed through a tube. She had to learn

A to swallow again in order to be moved to a rehabilitation ward before she could come home.

At one point it was thought that Jean had suffered a small heart attack and she was admitted into the CCU (coronary care unit) at Haslar overnight as a precaution. There were no other attacks and Jean only spent one night in the unit.

B I spent every day with Jean and I could see her getting better. The stroke had only affected her left side.

Jean made very good progress and was reviewed by a Dr Lord, from the Gosport War Memorial Hospital. Dr Lord said that Jean had a sufficient enough swallow for her to accept her on to the rehabilitation ward at the Gosport War Memorial Hospital. It was arranged that Jean would be transferred to the Gosport War Memorial Hospital on

C Thursday 20th May 1999....

During the evening of Wednesday 19th May 1999.... Jean was visited by June and her husband Ted. I had spent the day with Jean as usual and June had come in after she had finished work.

We were all in good spirits as Jean was moving towards coming home. We were

D planning a big family party for when she came out of the War Memorial Hospital.

I left Jean happy and in good spirits. I was told that Jean would be transferred to Daedalus ward around lunch time the following day and that I should visit her at the Gosport War Memorial Hospital after 1 p.m...."

We know from our chronology and our notes that she was indeed transferred to Daedalus on

E 20 May.

"At 1.30 p.m.... on Thursday 20th May 1999.... I arrived at the ward and had to wait to see Jean as the nurse said that they were settling her in.

I was shown into a cubicle opposite the nurses' desk, saw that Jean was lying in bed with her eyes closed I would describe her as being in a coma. She did not move, she

F did not speak, she did not respond in any way to my being there. I was stunned by her condition.

I stayed with Jean all night. I sat next to her bed and held her hand.

I did not know what was going on or why Jean had deteriorated so quickly. No one came and told me what was happening. I was totally shocked and distraught.

G

I could hear the noise of a machine coming from Jean's bed and I could smell a sickly smell. I used to work as an ambulance man and I recognised the smell as being morphine.

On Friday 21st May 1999,....at some point during the afternoon, I was approached by a man called Phillip. He was a charge nurse or 'sister' on the ward. He said to me

H something along the lines of 'your wife is in a lot of pain, can we have your

A permission to double her morphine?'

I felt very confused and upset. I did not understand what was happening but I was very concerned for my wife's well being. I thought that if the staff thought that my wife was in pain then they knew best. I have my 'permission' to Philip for my wife's morphine to be increased.

B He told me that he would phone Dr Barton for her permission to increase the dose.

Around 8.30 p.m.... on Saturday 22nd May 1999....Jean died.

From the time I saw her at the Gosport War Memorial Hospital, I only saw her open her eyes once.

C I never head her make any sound at all, nor did I see her give any physical indication that she was in pain or discomfort.

I know that my wife had a syringe driver. I saw the tube going into her stomach and I could hear the sound of its motor.

D After Jean died the driver was still going and I asked the staff to switch it off after about half an hour as I could not stand the sound of it.

Jean's death certificate gives her cause of death as cerebrovascular accident, which I understand to be a stroke.

Her death certificate was signed by Dr Barton."

E As you know, I am afraid we do not have that death certificate at the moment. We are still trying to get it

"My wife is buried at Ann Hill Cemetery, Gosport.

F Whilst Jean was at the Gosport War Memorial Hospital, I never saw or spoke to any doctors and the only person who spoke to me about my wife's condition was the male nurse Phillip on that one occasion."

That deals with his evidence and there follows a statement from June Mary Bailey. She has made a statement for the GMC proceedings, dated 7 June 2008, in which she says:

"I am the daughter of Jean Stevens."

G She effectively produces her police statement, which was dated 16 April 2004.

In fact, I am sorry; I think I gave the wrong date on Mr Ernest Stevens' statement. I gave you the date it was printed but the date he made it was the same date as we have seen, as before, so apologies.

June Mary Bailey says:

H

A

"I live at the address know to the Police. I have been married to Edward Bailey for the past 37 years.

I am the daughter of Ernest and Jean Stevens. My Dad is till alive and my Mum died at the
Gosport War Memorial Hospital on Saturday 22nd May 1999....

B

I have been asked if I can remember the events leading up to my Mum's death.

On Sunday 25th April 1999.... my mum had a stroke, she was taken to Haslar Hospital in Gosport. By the following evening she was propped up in bed and chatting away happily. She had lost the use of her left arm and leg but she was able to talk as before and she still had all her faculties.

C

My Mum continued to get better and arrangements were made for Mum to be transferred to the Gosport War Memorial Hospital to the stroke ward.

She was due to be moved on Thursday 20th May 1999.... and I visited her on the Wednesday evening. Dad and Ted were there and Mum was in good spirits. We were all laughing and joking and planning a big family party for when Mum came home. Mum and I were talking about perming her hair and she was talking to Ted about her garden. You would never have known that Mum had suffered a stroke to look at her, she looked so well. Her skin had a lovely colour and she was so happy and cheerful.

D

I left her around 9.30 p.m.... and my last words to her were 'the next time I see you it will be at the War Memorial'.

E

Around 6 p.m.... on Thursday 20th May 1999.... I went to Daedalus ward at the Gosport War Memorial Hospital. I walked along the corridor with my Dad and walked past a single room where an elderly lady was sleeping. I carried on walking but my Dad called me back. He took me into the room where the old lady as asleep. I was totally stunned, this woman was my Mum. She was totally unrecognisable as the woman I had said goodbye to the night before.

F

Her eyes were closed and she appeared to be in a coma. I took hold of her hand but she didn't react. I could hear the sound of a machine working. It sounded so loud as the room was very quiet. I looked underneath my Mum's bedclothes and I saw a machine lying on her stomach. Throughout my visit I didn't hear or see anything which would indicate that my Mum was in any pain. She never made a sound or movement at all.

G

Around 6 p.m.... on Friday 21st May 1999... I visited my Mum with Ted. My Dad was there as always.

I talked to my Mum and held her hand. She didn't' respond in any way. We left around 10 p.m....

H

During the morning of Saturday 22nd May 1999.... I received a telephone call [from] a man who identified himself to me as 'Phillip from the War Memorial'. He asked

A me if I could come over straight away as my Mum was deteriorating.

Between 1 – 1.30 p.m...... I arrived at the hospital with my son Steven. The male nurse Phillip took us in to a room. He told us that my Mum was deteriorating. Steven asked him if the move from Haslar Hospital had put Mum into a coma and Phillip replied that it didn't help her.

B I was very upset and crying. I went in to see my Mum. Dad was sat holding her hand. I stayed with my Mum until about 10 p.m.... During the entire visit she never moved or displayed any emotion.

I was taken home by my daughter Susan, and had only been indoors for a few minutes when the hospital ran to say that my Mum had died.

C I went straight back to the hospital and saw my Mum. I remember that I could still hear the sound of the motor of the pump.

I have been asked if I was spoken to by any member of the hospital staff in relation to the treatment of my Mum. I was never informed of anything apart from when Philip spoke to me on the telephone and later in his office about my Mum getting worse."

D That deals with her statement and I do not propose to read the statement of Edward Bailey unless I am invited to do so. He is the husband of June.

Just to remind the Panel, and they have checked their chronology I know, this patient was transferred to Daedalus ward on 20 May and reviewed by Dr Barton.

THE CHAIRMAN: Mr Kark, may I ask if the Phillip referred to in both of the statements
E just read is the Phillip that we are to see?

MR KARK: We cannot say but it is very likely to be. We are about to hear from Mr Beed, who is our next witness, and I think we will see that he did make various notations on the drug chart for this patient.

THE CHAIRMAN: Thank you.

F

MR KARK: So far as this patient is concerned, in fact the syringe driver seems to have been started on 21 May at 7.20 in the evening.

May I now call, please, Philip Beed?

G

PHILIP JAMES BEED, Sworn
Examined by MR KARK

(Following introductions by the Chairman)

Q Is it Mr Philip James Beed?
A Yes.

H Q Can you tell us your qualifications, please?

A Registered general nurse.

Q When did you qualify?
A 1984.

Q You qualified I think when you were in the Navy. Is that right?
A I did, yes.

Q You left the Navy in 1989, you worked for BUPA for five years, then you worked at the Oxford Brookes University and then finally in 1998, did you take up the post at the Gosport War Memorial Hospital?
A What year did you say?

Q 1998.
A That is correct, yes.

Q Tell us, please, what your role was there?
A I took up the post of clinical manager on Daedalus Ward.

Q What does that really mean, clinical manager?
A I am the senior nurse in charge of the ward, with 24-hour accountability for nursing care of the patients on the ward, managing the nursing staff and the nursing assistants.

Q Prior to coming to this role, what experience had you had of elderly care?
A I had worked in a variety of posts, both surgical and medical, dealing with patients across a whole age range, but you appreciate that predominantly in medical care, most patients are elderly, so by virtue of working as a nurse I was working with elderly patients as well as patients of other ages.

Q Had you had any particular training, or was it simply something that you picked up, as it were, as you worked? Had you had any particular training in geriatric care?
A Yes. Geriatric care was a component of my general training when I was a student nurse and there were aspects of nursing the patients I was looking after which was pertinent to the fact that they were elderly and there were other aspects of moving to an elderly care ward which I picked up through induction and orientation to the ward when I joined the hospital.

Q Prior to coming to the Gosport War Memorial Hospital, had you yourself used syringe drivers?
A I had not, no.

Q So who inducted you, as it were, into the use of syringe drivers?
A I had an induction period. Part of that included time spent on one of the wards over at Queen Alexandra Hospital, which specifically provided palliative care, and I also had support from other senior nurses and managers in the hospital to make sure that I was familiar with all the practices involved in the hospital and the care of the patients and that would have included how to make a decision when to – how to look at patients' pain control and, if a syringe driver was required, how to set it up, how to monitor it and how to look after it and how to look after the patient.

A

Q The training that you had had at the Queen Alexandra you told us was on a palliative care ward.
A Yes.

Q So end of life?
A Yes.

B

Q Who held the similar or same role as yours on the other ward, on Dryad Ward, that we have been hearing about?
A That was, at the time I took up post, a nurse called Jill Hamblin.

Q So it is Ms Hamblin on Dryad Ward and you are on Daedalus Ward?
A Yes.

C

Q I want to ask you, please, a little bit about Daedalus Ward and also about the hospital generally. Obviously please confine your answers to the period when you were there. You started in 1998. When did you leave?
A I was there for I think about six or seven years, so that would have taken me to 2005 I think.

Q During that time, I just want to ask you about the facilities at the Gosport War

D

Memorial Hospital. Did it have an Accident & Emergency Department throughout that time?
A It had an Accident Treatment Centre, although I do not think it had exactly that title, but in 1998 when I started, it had a Minor Injuries Treatment Unit.

Q We have heard about various other wards. We have heard about Sultan Ward. Sultan Ward looked after what sort of patient? Can you help us?
A Sultan Ward was a GP ward. So patients were admitted under the care of their

E

general practitioners.

Q We have also heard about Mulberry Ward. Can you fill us in?
A Mulberry Ward was an elderly mental health ward.

Q So far as Daedalus Ward is concerned, was that all on the ground floor of the hospital?

F

A Yes, it was.

Q As was Dryad Ward?
A Yes, it was.

Q Were they connected in any way?
A No.

G

Q How far apart are they spaced?
A They were in separate wings.

Q Was there any interaction between Dryad Ward and Daedalus Ward? Would Ms Hamblin come over and discuss things with you or would you go over there and discuss things with her?

H

A We would meet at meetings, but we would not normally, unless there was something that very particularly appertained to that we needed to communicate with one another, as colleagues sometimes do.

Q How many beds did you have on Daedalus Ward?
A 24, I believe.

Q The beds were there to house what sort of patient?
A We had eight slow stream stroke rehabilitation beds and in 1998, when I was first appointed, the others were continuing care beds.

Q When patients came to you, first of all, did they come to you at any stage for palliative care?
A There were some patients who were admitted to us for palliative care, yes.

Q But in general, what were they coming to you for?
A Always different things. We had eight rehabilitation beds for stroke patients and that left 16 continuing care patient beds. So either stroke rehabilitation or continuing care.

Q Can I ask you about staffing? You have told us about your role. Let us go upwards from you first of all. We know of course there was a clinical assistant, in other words, Dr Jane Barton.
A Yes.

Q Was she the first port of call, the doctor above you in terms of the care and responsibility for these patients on your ward?
A Yes.

Q Who was above her?
A There was a consultant who had responsibility for the ward called Dr Lord.

Q Let us deal with Dr Lord first of all. How often would she attend the ward?
A We had initially weekly ward rounds, but then they became twice-weekly. I would not be able to tell you off the top of my head when they became twice-weekly.

Q When they were weekly, can you remember which day of the week Dr Lord attended?
A No, I cannot remember.

Q Was it a morning or an afternoon visit?
A It was an afternoon. It was from lunchtime usually through till well after five o'clock.

Q When she did her ward round, would Dr Barton be with her, or not or sometimes?
A Dr Barton would always be with her, unless of course she was on annual leave or absent from work for some reason. But otherwise, yes, she would always be there.

Q Did you yourself liaise either regularly or irregularly with Dr Lord?
A I liaised regularly with Dr Lord.

Q So far as Dr Barton is concerned, how often would she come to the ward?
A She came to the ward daily.

A

Q At a fixed time?
A First thing in the morning, prior to starting her GP practice clinic.

Q First thing in the morning meaning what?
A I believe it was some time between 8 and 8.30.

B

Q How often would you be there when she attended?
A I worked shifts, as did all the staff, so it would be when I was on early shift. I worked probably three early shifts a week, but some of those might have been weekends.

Q So would it be a fairly regular occurrence that you were with her?
A I would usually expect to meet with Dr Barton once or twice a week.

C

Q Dr Barton, we know, had a regular GP practice, indeed still does. Do you know how far away her GP practice was from the hospital?
A At that time, probably about five to ten minutes' drive.

Q So far as you are concerned, was she available to you when she was not at the hospital? Were you able to contact her?
A Yes, I was.

D

Q Did she have a bleep or a mobile?
A We could contact her via the surgery and usually get her fairly quickly.

Q If Dr Barton was not available, were there other doctors at the surgery with whom you had an arrangement?
A Yes. If Dr Barton was not available, whichever of the other doctors was duty would actually cover the ward.

E

Q Did other doctors from that surgery on occasion attend your ward?
A Yes, they did.

Q We know that Dr Barton worked Monday through Friday. What happened at weekends and at nights?
A At weekends and at nights, we were covered by whoever was duty for the practice. So there was a doctor covering from that practice.

F

Q Does that mean effectively there was, to use what some think is an awful expression, 24/7 cover, full-time cover by a doctor at all times?
A Yes.

G

Q Apart from her regular morning visit, did Dr Barton regularly attend at any other time of the day?
A Whenever we had admissions, we would advise her and she would come and clerk the patient in on the ward.

Q What does that really mean? The patient comes in. So what do you do?
A What do I do or what did Dr Barton do?

H

A

Q What is done?
A From the nursing point of view, the patient has to be assessed and documentation written up. From Dr Barton's point of view, it is again assessing, making sure we had all the right medications written up and any other medical interventions that were required were correctly prescribed.

Q Who would carry out the assessment?

B

A Which assessment are we talking about?

Q If Dr Barton was there, who would carry out an assessment?
A Dr Barton would assess the patient medically, but the patient would also have a quite extensive nursing assessment on arrival at the ward.

Q Were you there on occasion when Dr Barton performed an assessment?

C

A Yes.

Q Did you ever see her making notes of her assessments?
A Yes.

Q You have dealt with this in your police interview. I wonder if you are able to give us any sort of idea about how busy Daedalus Ward was? You had 24 beds. How often were

D

those absolutely full, as it were, or did you normally run at something lower than 24 patients?
A During my time on the ward, the ward was nearly always full or nearly full and very busy.

Q When you say "full or nearly full", what are you talking about?
A It would be unusual to have more than two or three empty beds.

E

Q In terms of staffing below you, tell us about the nurses, first of all; how many did you have who were on duty at any particular time of the day?
A My aim would always be to have at least two qualified nurses on duty during the day shifts. There were quite regular occasions when there was one qualified nurse on duty for a shift.

Q What about support staff?

F

A Then to have a total of six staff on an early shift and a total of four staff on a late shift; if we had more than that that was a bonus and enabled us to increase the quality of care that we could provide.

Q Were you able to use bank staff if necessary?
A We did use bank and agency staff if it was necessary.

G

Q Whose decision was it that the ward had become so busy that you needed extra help?
A That would be my decision as clinical manager or if I was absent the senior member of staff on duty.

Q Did you use bank yourself? Did you actually actively use them?
A Yes, we did.

H

A

Q I want to deal with the issue of pain control and your training or your knowledge of pain control and analgesia. First of all, tell us, please, about the prescribing practice on Daedalus Ward; who is entitled to prescribe?
A Prescriptions need to be written by a qualified medical doctor.

Q And during the time that you were there who would that normally have meant was writing out the prescriptions?

B

A It would have been Dr Barton, Dr Lord or one of the other partners in Dr Barton's practice.

Q We have seen – and we have become very used to looking at – variable does; so various doses of opiates and you know that those were prescribed, presumably?
A Yes, I do.

C

Q Just tell us, please, about how those would come to be administered and whose decision it would be to begin a syringe driver?
A Part of the assessing and caring for patients would involve monitoring whether they are in any pain and if they were in pain whether they required analgesia to manage that pain; and if they were in pain analgesia could be given in accordance with the current written prescription for the patient.

D

Q Who would make the decision to start a patient on a syringe driver if Dr Barton was not there?
A That is a decision that could be made by nursing staff and would be based on the patient's overall condition, if they are in pain and what is the appropriate course of treatment for them.

Q You said if a patient was in pain.

E

A Yes.

Q Just concentrate on opiate medication first of all; was opiate medication used for patients who were not in pain, to deal with other issues as it were?
A No, I have never experienced a patient being given opiates for any other reason than pain control.

F

Q What about agitation?
A No, I have never experienced patients being given opiates for agitation.

Q And you would not do that?
A No.

Q So were there occasions when a prescription having been written up by

G

Dr Barton you, for instance, would make a decision that the time had come for a syringe driver to be initiated?
A That might occur, yes.

Q How would you set the dose?
A I would usually start at the lowest prescribed dose and monitor the patient and see whether that controlled their pain.

H

A

Q Would you always start at the lowest dose or were there occasions when you went above the lowest dose?
A I cannot think of an occasion when we did not start at the lowest dose.

Q If you are present and there is another nurse with you – because we gather there would have to be two nurses to make the decision to administer opiates – would you normally be the senior nurse?

B

A As the clinical manager I would have been the senior nurse on the ward, yes.

Q What would you know about the drugs that the patient had previously been on prior to you initiating the use of a syringe driver?
A We would have the patient's drugs chart so we would have a record of medication that had previously been given.

C

Q At another hospital?
A Yes; the patients who came to us would always come with their notes and their previous drug charts.

Q Were some of the patients that came to you opiate naïve: in other words, they had not had opiates in the run-up to their arrival at your hospital?
A Yes.

D

Q How, if at all, would that effect your decision on the application of a syringe driver?
A Analgesia that the patient was given would be in relation to their overall condition and their level of pain; so the assessment and decision-making would be based on how the patient presents on assessment.

Q If the time came when in your view a patient required a syringe driver to be initiated,

E

provided that there is a variable dose prescription would you need to go back to Dr Barton, or would you be able to do it on your own initiative?
A It would not automatically be necessary if Dr Barton was available on duty and there was a change in the patient's condition then we would go back to her, but there would be times when those decisions needed to be made out of hours.

Q If that decision has to be made out of hours would you contact one of the other GPs

F

available to you, or would you make the decision on your own?
A Not necessarily; a decision could be made at ward level.

Q What about the increase of the administration of opiates? Who would make that decision?
A Patients who were receiving opiates would be continually monitored to see whether their pain is adequately controlled and if over a period of time it was not adequately

G

controlled then the decision could be made to increase the level of analgesia that they were receiving.

Q Did you do that on occasion?
A There were occasions when we did that because patients were very obviously in pain.

Q Would you necessarily have to go back to Dr Barton before you did that?

H

A I would not automatically have to do that, no.

A

Q What was your practice? Would you normally go back to Dr Barton; would you not bother unless you felt you needed to? How did it work?
A We would contact Dr Barton if we felt we needed to.

Q Are you able to give us an idea of what proportion of occasions you felt you needed to go back to Dr Barton and what proportion of occasions you felt, "I can do this; it is obvious I should use an increased dose"?

B

A I really could not without looking at the patients' notes from those periods, I am afraid.

Q If you yourself were making a decision to increase the dose how would you decide by how much to increase it?
A We would usually go up by the next numerical value; so you would go up in smallish increments.

C

Q So say you started somebody on 20 mgs of diamorphine over 24 hours what would you go up to if you felt that was necessary to increase?
A 25 or 30.

Q Why would you go up in those sorts of incremental rates?

D

A You would want to assess whether the patient's pain was then controlled at that level and if it was not you could consider a further increase, but usually the next incremental step would be adequate to provide adequate pain control for the patient.

Q Going back a little bit, were there occasions when a patient of yours had been on oral morphine – Oramorph?
A Yes.

E

Q Were there occasions when a decision was made to switch from Oramorph to a syringe driver?
A Yes, that happened on occasions.

Q What would be the catalyst for such a decision?
A The patient's pain not being adequately controlled by oral morphine or the patient not being able to take oral morphine.

F

Q What sort of conversion would you apply when you switched from Oramorph to a subcutaneous dose?
A We had a conversion table which was in a handbook provided by a local hospice, so it was probably documented and assessed which allowed us to convert oral morphine to diamorphine via a syringe driver.

G

Q Is that something called the *Wessex Protocol*? Do you want to have a look at it?
A Yes.

Q If you look to your left you will find a file simply called Panel Bundle Documents I and if you turn up tab 4 of that.
A Yes, that would have been it.

H

A

Q Does that ring a bell?
A It does, yes.

Q Can you remember when you first read this document or a version of it?
A I would have seen that as part of my induction programme when I joined the ward.

Q If you turn to the printed number page 5 – page 6 of the internal numbering – do you see that there is something there which is called the WHO – World Health Organisation – Analgesic Ladder?
A Yes.

B

Q Is that a concept with which you were familiar?
A Yes.

C

Q If you go over to page 6 you will find a heading – page 8 of the internal numbering – "Use of morphine".
A Yes.

Q Again, would you have read this during the course of your induction?
A Yes.

D

Q If we go down to paragraph 3 we can see these words:

> "Start with a low dose and increase by 30-50% increments each day until pain controlled or side effects prevent further increase. Doses can be rounded up or down according to the individual need. A common dose sequence is 5-10 – 15-20 – 20-30 – 30-40 – 40-60 – 60-90 – 90-120 ..."

E

And upwards. Would you have been aware of that guidance?
A Yes.

Q May I ask you this: do you know the difference between a guidance and a protocol? I do not mean that as an exam test, as it were, but do you know that there is a difference between a guidance and a protocol?
A I would recognise it as a difference; I do not think I could actually quote it.

F

Q Did you regard this as a protocol that you had to follow or a guidance that perhaps you would be best advised to follow?
A I would regard this as a guidance.

Q If we go down to paragraph 5:

G

> "Use continuing pain as an indication to increase the dose and persisting side-effects, e.g. drowsiness, vomiting, confusion, particularly in association with constricted pupils, as an indication to reduce the dose. If both pain and side-effects are present, consider other approaches.
>
> Once pain is controlled consider converting to 12 or 24 hourly sustained release preparation for convenience using the same total of daily dose."

H

A

So the concept is to get up to the point where pain is controlled and then keep it at that level if possible; is that about right?
A Yes.

Q "Always make available immediate release morphine for breakthrough pain."

Tell us what that means? What is breakthrough pain? It may be obvious, but tell us.

B

A If the pain is controlled most of the time but then there are episodes when the patient is experiencing pain despite it appearing to be controlled.

Q Would that be an indication in your view to increase the dose generally or simply to use a one-off injection? How would you deal with breakthrough pain?
A In 1998 we were not using one-off injections to control breakthrough pain, so depending on the level we might leave the level as it is or might increase the level of the syringe driver.

C

Q Look at 7, please:

"When oral administration is not possible because of dysphagia ..."

Is that nausea?

D

A No, dysphagia is an inability to swallow.

Q I am sorry:

"... vomiting or weakness, consider changing to diamorphine by subcutaneous infusion using a syringe driver."

E

So let us look at that. It is the inability to swallow; it is vomiting, in other words not being able to keep down the Oramorph; or weakness. How would you translate that?
A If a patient cannot be given analgesia by the oral route then subcutaneous would be an appropriate route to use – might be an appropriate route to use.

Q "The conversion from oral morphine to subcutaneous diamorphine (total daily dose) varies between ⅓ – ½ allowing some flexibility depending on the requirement for increased or decreased opioid effect."

F

Did you understand that concept that when diamorphine is given subcutaneously the effect of the drug is greater than if given orally?
A Yes.

Q Would you say that you applied this guidance to reduce the dose down to ⅓ or ½?

G

A Yes.

Q What about your nursing staff; would you expect them to be similarly knowledgeable or not?
A Yes, I would expect them to have the same level of knowledge.

H

A Q We have heard of the concept during the course of the case of named nurses and we had a description of what that really means from a nurse called Ms Couchman – you will probably remember, I expect.
A Yes.

Q Just tell us, please, what your understanding of named nurse means?
A It is when every patient is allocated to a qualified nurse who takes specific
B responsibility for that patient's care plans and their programme of care, and that allows a greater degree of continuity of care for the patients but it also allows the patients and their relatives to have a particular nurse that they can relate to should they have specific issues or problems or want to discuss things.

Q To what extent would the named nurse have any particular responsibility in relation to the administration of drugs, or would they not have any particular responsibility?
C A Administration of drugs – it would have been the responsibility of the nurse on duty at any particular given time and where patients had a named nurse those nurses were working shifts covering seven days a week and two shifts, so in any given 14 shifts in a week there would be significant periods when a named nurse was not on duty; so not every aspect of the patient's care could be left down to the named nurse.

Q We have heard that there was this concept that the named nurse was meant to be the
D patient's – somebody called it "champion" and another person called it "advocate", but let us stick to advocate. Would the named nurse necessarily be consulted prior to the syringe driver being started or not?
A If the patient's named nurse was on duty, then certainly they would take the lead in that patient's care, but that would not necessarily be the case. You could be at a point when the named nurse was on days off for two, maybe three, days, and then that would not be practical. That would leave the patient in pain until that decision had been made.
E

Q Let me come back again then, please, to syringe drivers and the purpose of initiating subcutaneous doses of diamorphine together with what other drugs are put into the syringe driver. How do you tell when the patient's pain is controlled? That may be an obvious question but how do you know?
A Well, because of the symptoms of pain, which might include a whole range of things, but the patient telling you they are in pain, visual expression, reaction. Those symptoms
F would be reduced or alleviated.

Q So far as you were concerned, was the purpose of using diamorphine to control pain by reducing a patient to a state of unconsciousness?
A No.

Q Would you, so far as you are concerned, say that you looked out for that? So would
G you be looking out for the point at which a patient became unconscious?
A Yes, you would but you would expect a patient on analgesia --- It would not be unusual for a patient on opiate analgesia to become unconscious, particularly if they were receiving palliative care.

Q Sorry, can you just repeat that? It would be unusual ---
A It would not be unusual for a patient receiving palliative care to become unconscious
H as a side-effect of the pain control they are receiving.

A

Q You also used the expression "palliative care". Palliative care means care given to a patient at the end of their life?
A Yes, that is correct.

Q So when do you take a decision that a patient is for palliative care?
A It is based on their overall condition and their medical problems and their likely

B prognosis.

Q When you initiated a patient on a syringe driver, in your mind was that the initiation of palliative care?
A It would not necessarily be but in a lot of cases it was.

Q You have told us already you would be entitled to make the decision about the

C deployment of the syringe driver?
A Yes.

Q Does it follow, and I simply want to understand this, that you would be effectively on occasion making the decision that the patient was for palliative care?
A Because patients were reviewed regularly, it would have been already identified that the patient's condition was deteriorating and their prognosis was poor, so I do not think we

D would have been making that decision at that point in time.

Q Who would?
A The nursing staff would not have been making that decision; it would have been implicit within the overall care that the patient was receiving.

Q But that would be a function that the nursing staff could deal with?

E A Sorry?

Q That would be something that the nursing staff could decide – that the patient was now due for palliative care, a palliative care regime?
A We could decide to initiate a syringe driver but I do not think that is necessarily the same as the deciding the patient for palliation.

F Q I am asking specifically about the palliative care regime. Would you be able, as a nurse with your other nursing staff, to take the decision that a particular patient was for a palliative care regime?
A I do not think so, no.

Q You do not think so?
A No.

G

Q Who would make that decision?
A It would usually be a medical decision.

Q So on your ward that would be?
A Dr Barton or a consultant or one of the duty doctors.

H

A

Q I want to ask you a bit about the hydration. At the time that we are discussing, and you started in 1998?
A That is correct.

Q And we are really interested, as you know, in this case, as far as you are concerned, in 1998/99. In 1998 and 1999 did you have facilities on Daedalus ward, once a patient was unconscious, to rehydrate them; in other words, to use what I would call intravenous methods, but you will probably correct me?

B

A We could not rehydrate patients with intravenous methods but we could use subcutaneous fluids to maintain hydration.

Q How would that work? Explain that to us?
A Intravenous fluids but infused in the subcutaneous layer of the skin, usually in the abdomen. It is a slower method but it is one that can be used in a community setting.

C

Q So you did have the facility to rehydrate patients?
A Yes.

Q If you were using a syringe driver, how would you make the decision as to whether to rehydrate a patient or not?
A In '98 when I was working in hospital, the usual practice for patients who were receiving palliative care was not to hydrate them during that period. There was evidence that that was actually making things more uncomfortable for the patients and we not actually of any benefit to them.

D

Q What I actually asked you was when you would make a decision using a syringe driver, not necessarily palliative care, and you told us there was a difference? So when you are just using a syringe driver, when you would make a decision not to rehydrate a patient or once you are using a syringe driver, do you just stop hydrating?

E

A Usually we would hydrate patients on medical advice.

Q So it would be again down to the doctor to decide whether to hydrate a patient?
A Yes.

F

Q And if you do not hydrate and keep a patient well hydrated after the use of diamorphine, what is the effect of that upon the patients?
A The patient would become dehydrated.

Q Yes. That means there is nothing presumably going through the bladder, the kidneys, et cetera?
A Yes.

G

Q Help us: does that lead to a deterioration of the patient?
A It could do if it was a patient who you wanted to make a recovery, yes.

Q If it was a patient that you wanted to make a recovery, would you not want to keep them hydrated?
A Yes.

H

A Q But if you did not want them to make a recovery, you would not rehydrate them? Is that how it works?

A When I was working on the ward in 1998, the evidence that I had seen and looked up and was advised was that for patients who were receiving palliative care, that rehydration could make them uncomfortable and was not necessarily beneficial. So in those cases, patients were not hydrated at that time.

B Q If we see in any of these cases, and you can only talk about the practice I suppose on Daedalus ward, that a syringe driver has been initiated and there is no hydration in place, are we to take it that that patient has been destined, as it were, for palliative care?

A Yes.

Q May I just ask you a bit about midazolam, and again this is not meant to be an exam. You can only tell us what you know about the effects of various drugs. What do you know about midazolam?

C

A It relaxes patients,. It is an anti-hypnotic.

Q When you say it relaxes patients; in what circumstances would it be used?

A If the pain is causing the patient agitation, then it would actually help to calm some agitation.

D Q You told us earlier you would not use diamorphine for agitation but midazolam might be useful?

A If the pain was accompanied by agitation, yes.

Q Were there occasions when diamorphine and midazolam were used together?

A Yes, here were.

E Q Does midazolam, so far as your understanding of it, also have a sedating effect?

A Yes, it does.

Q Does it depress the respiratory function?

A Yes, it does.

Q So using diamorphine and midazolam together, both would depress the respiratory function?

F

A Yes.

Q Before we move on to deal with the case of Gladys Richards, I just want to ask you a bit about the records. You were interviewed by the police in this case, were you not?

A I was, yes.

G Q That was back in July of 2000 over I think really a pretty full day for you; is that right?

A Yes.

Q And you either reviewed then or had reviewed a number of the records?

A Yes, I had.

H

A

Q Let us deal with the nursing records, first of all, and we will look at some obviously. Do you say anything generally about the quality of the nursing records?
A We worked very hard to keep the nursing records as up to date as possible. Sometimes that was rather difficult. We had to juggle the nursing needs of patients and the needs of relatives and keeping documentation. I do recognise subsequently that our nursing records probably could have been better.

B

Q I am not going to ask you to comment upon Dr Barton's records because I do not think that would be fair, but when Dr Barton was doing her morning rounds, would she ever have somebody with her, normally have somebody with her?
A Yes, one of the nurses on duty would be with Dr Barton.

Q The notes for each patient would be kept where?
A The medical notes were kept in the ward office.

C

Q Drug records, prescription charts and the like?
A In 1998 I think we kept those in one large folder.

Q In the office?
A In the office.

D

Q Where was the office in relation to the ward?
A The office was in the centre of the ward.

Q When Dr Barton was doing her rounds, would she have the notes available to her?
A She would, yes.

E

Q What about the notes from the previous hospital? Normally I think all of the patients that we are dealing with in this case, and I suspect most of your patients generally, came from either the Haslar or the Queen Alexandra, is that right?
A They did, yes.

Q When normally would you get the notes from those hospitals?
A The notes were supposed to accompany the patients on transfer. Sometimes they did not and sometimes they followed 24 hours later.

F

Q Are you able to say how often they were delayed? Was that regular or irregular?
A It was a fairly regular practice. The Queen Alexandra is a very busy hospital. I suspect they came late in 1 in 10 or 1 in 20 cases.

Q So the majority came with the patient?
A Yes.

G

MR KARK: Sir, I am about to move on to Gladys Richards and that is going to take a little while to deal with. The witness has been here for an hour. I do not know if you want me to start.

THE CHAIRMAN: We will take a break now. We are going to take a break now for 15 minutes, so that you will have a chance to rest and hopefully get a cup of tea or coffee.

H

A Please remember that whilst you are giving evidence you must not talk to anybody other than the staff who will take you to and from. Thank you very much indeed.
A Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Kark?

B

MR KARK: Mr Beed, we were about to turn to the case of Gladys Richards, who is our Patient E. Could I ask you to take up, please, the bundle to your left, which is marked bundle E? you will find at the beginning a chronology and just to remind us all of what happened to this unfortunate lady, she was admitted to Accident & Emergency on 29 July 1998 at the Royal Haslar Hospital after falling in her nursing home and fracturing the right neck of her femur. The Royal Haslar Hospital seems to have had a connection with the Gosport War

C Memorial Hospital. I think it is just up the road, is it?
A It is very local, yes.

Q How far away is it?
A Three or four miles.

Q So was there a fairly regular transfer of patients between your hospital and the Royal

D Haslar?
A Yes, there was.

Q We see that she was operated upon on the following day, 30 July. I am going to ask you first of all to have a look at the drug charts to see what sort of drugs she received prior to arriving at your hospital. If we start at page 238 of this bundle, this is a record of once only and premedication drugs. I am not going to spend much time on that. Over the page, page

E 239, we can see that haloperidol was prescribed and it looks as though that was administered fairly regularly. Is that right?
A Yes.

Q Haloperidol would be used for what?
A It is for calming patients with psychosis or similar types of problems.

F Q Is it sometimes used where a patient has dementia?
A Yes. For use in dementia management.

Q Could I ask you to go on, please, to page 243? We can see that morphine was used on the day of the operation.
A Yes.

G Q You are probably very used to reading these records and we are slowly getting used to understanding them. We can see that the dosage was 2.5 mg by an intravenous route. Would that mean in this case by syringe?
A It would have been a syringe rather than a syringe driver, yes.

Q That was given on 30 July. Then on 31 July, she was given a total of 5 mg in the very early hours of the morning and then at 7.05. Then on 1 August she was given 2.5 mg and on

H 2 August she was given 2.5 mg. She was prescribed co-proxamol. Is that an analgesic?

A

A That is an oral analgesic, yes.

Q The co-proxamol does not seem to have been in fact administered. Is that right?
A That is correct, yes.

Q She was prescribed haloperidol, which, as you have told us, may have been to deal with agitation, and that seems to have continued I think in fact throughout her time there.

B

Then we can also see that she was prescribed co-codamol. I think that is codeine phosphate and paracetamol mixed together.
A It is, yes.

Q Is that an analgesic?
A That is an oral analgesic.

C

Q Below morphine on the analgesic ladder?
A Yes.

Q We can see that she was given that fairly regularly up until about 7 August. Is that right?
A Yes.

D

Q Then we can see on 9 August, if we look at the far right-hand side of the page, co-codamol. There is an entry for 9 August and then it seems to have been crossed through. Can you help us as to what that would signify?
A The most likely scenario would be that the medication had been got out for the patient, but actually there was some reason why it was not given or was not taken by the patient, so the entry was deleted to indicate that it had not been given.

E

Q I may be missing it, but it looks as if the last time this patient had morphine was 2 August.
A That would be what the prescription here indicates, yes.

Q If we go to page 246, we can see – I am afraid it is terribly mixed up – there is a fluid balance chart, the earliest of which I think is actually on page 255. I am sorry for the order of these, but a policy decision, as it were, was taken not to re-order everything again. As you

F

probably appreciate, these have been re-ordered so many times and it may have been the right, it may have been the wrong decision, but I am afraid that is why they are in the state that they are and that is why we are going to be relying on Mr Fitzgerald's chronology. But page 255, I think you will find, is a daily fluid balance chart. Would that be the fluids that were being at that stage administered to her intravenously?
A No. Those indicate oral fluids being given to the patient and urine output.

G

Q Page 255 I think is intravenous.
A Yes.

Q Because that is the day of her operation, so you would expect those fluids to be intravenous.
A Yes.

H

A

Q We can see, as we move through the records, if we go to page 253, which is the following day, 1 August, it seems that she was able to sit up and have some tea and squash, quite a lot of it.
A Yes.

Q Then just moving to 2 August, page 251, we can see from there on she seems to be regularly taking tea, juice and water.

B

A Yes.

Q Do you have a recollection of this patient, who was transferred to your ward we know on 11 August?
A I have some recollection.

Q Can I take you, please, to page 22 of the records? This was written the day before she

C

comes to you and it sets out Mrs Richards' history:

> "Gladys sustained a right fractured neck of femur on 30th July … she had a right cemented hemi-arthroplasty and she is now fully weight bearing,, walking with the aid of two nurses and a zimmer frame."

Then it gives her past medical history, it reveals that she had had a six-month history of falls

D

and Alzheimer's, it shows that the drug she was on was haloperidol, which we have discussed, and co-codamol and "2 prn". Does that mean twice daily as required?
A No. It would mean two co-codamol tablets. There should be a frequency with that as well. I would expect that to be four-hourly.

Q So that the pain-killing element of any drugs that she was on, that would be the co-codamol, would it?

E

A Yes.

Q It reveals:

> "Gladys needs total care with washing and dressing, eating and drinking, although her daughters are extremely devoted and like to come and feed her at mealtimes (although I feel they could do with a rest). Gladys has a soft diet and enjoys a cup of tea.

F

> Gladys is continent, when she becomes fidgety and agitated it means that she wants the toilet. Occasionally incontinent at night, but usually wakes."

And it reveals that her bowels were opened on 9 August.

> "Occasionally says recognisable words, but not very often.

G

> Wound: Healed, clean and dry.
>
> Pressure areas: All intact, bottom slightly red, but not broken."

Meaning the skin is not broken.
A Yes.

H

A Q Then:

"Thank you for taking Gladys and I hope that she settles well."

Is that a classical sort of note that you would have received?
A Yes.

B Q Can you help us as to whether you would have received this with the patient?
A As far as I am aware, that came with the patient.

Q Then we go to page 30. This is Dr Barton's note.
A Yes.

Q Can you just help us? Before we read through Dr Barton's note, you got a note from C the Royal Haslar which says that she is fully weight-bearing, walking with the aid of two nurses and a zimmer. I will not repeat everything in the referral letter. What did you think your role at the Gosport War Memorial Hospital was in relation to this particular patient?
A This patient was transferred to us to recovery from the hip surgery and for rehabilitation.

Q So she would need help getting out of bed, presumably?
D A Yes.

Q And getting her walking?
A Yes.

Q I do not know how much you know about post-operative care. I expect at your level, a reasonable amount.
E A Yes.

Q Would it be important with an elderly patient such as this to get them walking fairly quickly?
A You would have to balance that with safety for the patient and the staff and my expectation of a patient with dementia is that it would probably take some time to get them mobile.

F

Q But that would be the purpose, the aim?
A Yes.

Q Let us have a look at Dr Barton's note:

"Transferred to Daedalus Ward ..."

G

You can probably read her writing rather better than we can. Can you help us?
A

"Transferred to Daedalus Ward continuing care. Fractured right neck of femur on 30 July.

H Past medical history – hysterectomy @ 55

A

External operations
Deaf
Alzheimer's

On examination — Impression frail demented lady
Not obviously in pain
Please make comfortable"

B

Q I think I will help you. "Transfer with hoist", is it?
A Yes.

Q "Usually continent"?
A Yes.

C

Q "Needs help with ADL"?
A Yes. That is activities of daily living.

Q Then we have a Barthel score I think of 2 and, "I am happy for nursing staff to confirm death".
A Yes.

D

Q I just want to ask you about these notes. Would you read Dr Barton's notes to see what was needed for the patient?
A Yes, I would.

Q How would you read the words, "Please make comfortable?" Are they to be read in an ordinary English way, or do they have a particular significance?
A No. I would just regard that as meaning making sure that the patient is comfortable, not in any pain at all.

E

Q There is a note from Dr Barton that she is not obviously in pain.
A Yes.

Q Then we see the words after that, "I am happy for nursing staff to confirm death." How often did you see those words written in Dr Barton's writing?

F

A This is something that would be written in patients' notes and this pertained to the fact that we were a community hospital without medical staff on duty around the clock, so it meant that if a patient's condition deteriorated and there was an expected death, we did not necessarily have to call in a doctor.

Q Can you help us as to why it might be written into the notes for this particular patient? Was this patient expected to die?

G

A The patient was not, but I think it had become custom and practice within a community hospital for that to be part of the instructions, so that it was there should it become necessary.

Q So it was to your understanding custom and practice?
A Yes.

H

A Q With every patient who came into the Daedalus Ward, the doctor would write that she was happy for nursing staff to confirm death?
A It would not necessarily have been every patient, but it would have been some of the patients that came into us, yes.

Q So it would be written for some patients, but not all?
A Yes. I think that would be correct.

B

Q Do you know which patients?
A I think that would depend on Dr Barton's medical assessment of the patient.

Q That would mean what? What was she assessing when she wrote those words to your understanding?
A She would be looking at the patient's overall presentation and possible prognosis.

C

Q Can we have a look at the drug chart, because we can see what Dr Barton prescribed for this patient on admission and how it was administered. If we go to page 63, we can see that she wrote up Oramorph.
A Yes.

Q Is that 10 mg in 5 ml?
D A Yes.

Q We can see that that was administered twice on the day of her admission.
A Yes.

Q The first entry. Is that yours?
A That is correct, yes.

E

Q That time has confused us slightly. We can see a time after that of 11.45. Do you see the first entry?
A Yes.

Q Can you help us with that?
A I would say that would be 1415.

F

Q Can that be right?
A I would need to correlate that to the controlled drug record to establish that.

Q We are going to try and get the original document for you. The note that follows is 11 August, 11.45. Would you, as a nurse, be taught to use the 24-hour clock?
A We would normally, yes.

G

Q So we ought to read that 11.45 as being 11.45 a.m.
A That could not be correct though, could it, because that is not in sequence.

Q That is what I am asking you.
A So I would think it more likely that that should read 23.45.

H Q Right. So either the first entry is wrong or the second entry is wrong.

A Yes.

Q But they do not seem to be consistent with each other, do they?
A Which is why controlled medications have to be recorded in a controlled drug register which would actually help verify the two nurses that came.

Q We have the controlled drug register behind us so we will look through those, I hope in a break, and see if we can find the right one for you. In any event it looks very much as if you have issued Oramorph at 14.15; yes?
A Yes.

Q And that is a dose of 10 mgs?
A Yes.

Q Would you have been aware that this patient had not had any sort of morphine since she was last given it at the Haslar?
A I would have seen the previous drug record, yes.

Q You would have seen it?
A Yes.

Q So would you treat this patient or regard this patient at this stage as being effectively opiate naïve?
A Yes.

Q Can you help us why you decided to initiate a dose of 10 mgs?
A It would have been to do with the level of pain the patient was observed to be experiencing.

Q Would you make a note of that?
A Yes.

Q We have a number of nursing notes to which I will direct you as best I can. If we go to page 38 – I want you to identify this document for us if you would.
A That is part of the patient's nursing assessment.
Q When would this be completed?
A This would have been done as soon as practicable or after the patient is admitted to the ward.

Q Who would fill this in?
A One of the nurses that was on duty.

Q Not you?
A It might be me or it might have been one of my colleagues.

Q I am sorry, what I meant was looking at this document, this writing.
A That has not been completed by me, I do not believe.

Q Can we then go please to page 50; is this a nursing care plan?
A Yes, it is.

A

Q When is this filled in?
A Nursing care plans would be initiated on admitting the patients to the ward but if there were any other problems they could be initiated at any time while the patient is in our care.

Q This seems to have been started on 12 August, is that right?
A Yes.

B

Q "Requires assistance to settle and sleep at night. Desired outcome to promote a satisfactory night's rest.

Nursing action: ensure comfortable and warm in bed. Night sedation if required. Observe for pain."
A Yes.

C

Q "Remove dentures. Call bell at hand."

Then we can see on 12 August that haloperidol was given because she was agitated and crying at night.

"Did not seem to be in pain."

D

A Yes.

Q Where would you have made a note of the patient being in pain on 11 August?
A It would usually do that in the running commentary on the patient's care somewhere within the notes.

Q Would you always, do you say, make a note if a patient was in pain or is that something that might get missed?

E

A It is something that should always be done, yes.

Q Going back to the prescription for a moment, can I pass you the originals of these. (Same handed) Looking at that can you help us as with that date of the Oramorph and the time – is that 14.15?
A It is, yes.

F

Q It follows from that – going back to page 63 – that the time following must be 11.45 p.m., if they are in the right order.
A If they are in the right order it would be, yes.

Q With this patient we have a summary that we looked at, at page 36 and perhaps we should go to that. Is this where we would find the chronological nursing note?

G

A That would be part of it, yes.

Q This is 11 August, so this is the day of admission. Who would make this note?
A One of the qualified nursing staff would write this up either during the shift or at the end of the shift.

Q Again, it is not your note? Does that look like your writing?

H

A It does not look like my handwriting, no.

A

Q We are going to try and find the original of this for you because we have the best copy, as it were, that we will copy but it may be that the original will be clearer. It is dated 11 August 1998 and I am going to make an attempt at interpreting it, so please follow and if you think I have it wrong would you shout?

"Admitted from E6 Ward Royal Hospital, Haslar."

B

A Yes.

Q "Into a continuing care bed. Gladys has sustained a right fractured head of femur on 30 July 1998 ..."

A Neck of femur.

Q I beg your pardon:

C

"... neck of femur on 30 July 1998 in Glen Heathers Nursing Home. She has had a right cemented hemi-arthroplasty and she is now fully weight bearing and walking with the aid of two nurses and a Zimmer frame."

A Yes.

Q "Daughter visits regularly and feeds mother. She wishes to be informed day or night of any deterioration in mother's condition."

D

A Yes.

Q "Swabs taken for MRSA screening. Daughter does not want mother to return to Glen Heathers."

A Yes.

E

MR KARK: After that there is something of a blank.

MR LANGDALE: It is completely blank.

MR KARK: It is completely blank. Certainly the back page is completely blank. We are very happy to pass you the originals of the nursing notes if you think that that would help you. Perhaps I will do that. (Same handed to the witness) I just want to see if you can help us,

F

Mr Beed, if you can indicate where it is indicated on 11 August that this patient was in pain and why that might require the dose that you administered.

A No, I cannot see a record of that in the notes that you have shown me.

Q What we will do, over the short adjournment – which is what we call lunch – we will provide you with a room and the notes and somebody to sit with you. I do not want you to feel under pressure, as it were, and therefore you cannot find something that is actually there.

G

But I do not think we have been able to find anything either. Can you help us, please, why you might not have made a note to justify the administration of morphine on the patient's admission?

A The only reason I can think of would be if the ward was extremely busy and there were multiple demands on my time and it was something that I overlooked doing.

Q But in normal circumstances ought there to have been a note?

H

A I would expect there to be a note recording why that analgesia was given, yes.

A

MR KARK: Back to the drugs chart, please, page 63.

MR LANGDALE: Could I look at the original document?

MR KARK: Could Mr Langdale be given the original document? (Same handed)

B

(To the witness): Mr Beed, you administered a dose at 14.15 and then we can see that after that more doses were administered, one apparently at 11.45 in the evening and then the following day, 12 August, and also on 13 August, and also on 14 August.
A Yes.

Q And 10 mgs being administered on each occasion.
A Yes.

C

Q And you say that that would be administered for pain?
A Yes.

Q I will ask you again, do you think that it might be given for agitation?
A No, it would be for pain, although agitation may be a symptom of pain.

D

Q But would you have taken account of the notes that you would have read, as you told us, that if this patient seemed to be agitated it might well be because she wanted the loo?
A Yes, we would have taken account of that.

Q So you would not automatically think, "The patient is agitated, she must be in pain"?
A No, that would be one of a number of symptoms which might indicate pain.

E

Q Can you identify your entries here – it may be fairly obvious – you have a sort of "B" and a bit of a squiggle ---
A With the Oramorph prescription, do you mean?

Q Yes.
A The first one you identified.

F

Q The 14 August.
A The 14 August, 17 August, three entries and again 17 August in the third column.

Q Below that we can see a prescription for diamorphine, for a variable dose between 20 and 200 mg of diamorphine; yes?
A Yes.

G

Q And that is to be administered, if you chose to do it, by syringe driver?
A Yes, if a patient's condition changed and that was indicated.

Q So does that mean that if you, for instance, as the senior manager on that ward took a view that it was necessary you could initiate a syringe driver anywhere between those two variable doses?
A Yes.

H

A Q We can see that diamorphine was not actually administered; yes?
A Yes.

Q We see that hyoscine was, but not until 17 august, so I am going to ignore that for the moment; and if we look below do we see midazolam?
A Yes.

B Q That also I think was not administered until 18 August?
A Yes.

Q Could we go over to page 65? We can see that Lactulose was prescribed; what would that be for?
A That is a laxative.

C Q We can see your initials, I think.
A Yes.

Q Haloperidol.
A Yes.

Q On 11 August at 18.00 hours do we see your initial?
D A Yes.

Q Does that mean that you would have administered that dose because this is a regular prescription, so it means that that is to be given to the patient at specific times?
A Yes.

Q And on 11 August she would not have been with you of course at 8 o'clock in the
E morning.
A No.

Q So the first time you could give that would be at 6 o'clock at night.
A Yes.

Q And that is what you have done. And that would be for agitation, would it?
F A Yes.

MR KARK: Then below that we can see another entry for Oramorph, but this is now under the regular prescription column and Dr Barton has set out the times when that should be administered.

MR LANGDALE: PRN.

G

MR KARK: Yes. Let me just deal with the time first. 6 o'clock, 10 o'clock, 14.00 hours and 18.00 hours and how would you regard that to be administered? We see on the left, as Mr Langdale has pointed out, in a big box PRN.
A Yes.

Q Which I think means *pro re nata* which means as the occasion arises.
H A As and when required, yes.

A

Q How does that lie with the prescription on page 63 dated 11 August, also for Oramorph, also for 10 mgs in 5 mls? I want to know how this witness would read these prescriptions as to what he should do with them. Do you know why there are two prescriptions?
A I am not sure but my nursing action would be to ignore one of them because it would appear that they are a duplicate.

B

Q Then underneath the first Oramorph on page 65 we also have PRN – is that Oramorph again?
A Yes.

Q Is it a higher dose? In the first box under "dose" you have 2.5; is that milligrams?
A Yes – 2.5 mls.

C

Q 2.5 mls, I am sorry. Then in the second box we have 5 mls.
A Yes.

Q So that would be the equivalent of 10 grams.
A It would be 10 milligrams.

D

Q Thank you; 10 milligrams. Again, how would you as the nurse read these records as to how you were meant to deal with them?
A The first one allows for a regular dose if required with a slightly higher dose at night if required.

MR LANGDALE: I am sorry to interrupt again. Since the comparison is being made between those PRN Oramorph on page 65 and the Oramorph on page 63, perhaps the witness' attention should be drawn to he dates if it is being suggested there is a duplicate.

E

MR KARK: The first one is dated I think 11 August on page 63. Is that right?
A Yes and this one is dated 12th.

Q And the second one is dated 12th.
A Yes.

F

Q But the one dated 11 August you have actually acted upon throughout the patient's time there?
A Yes.

Q Could you have acted on either of them?
A You would not react on both because it is obviously a duplicate. Usually when a drug is re-written, it would be normal to score through the drug which it is replacing.

G

Q Again, just as part of nursing practice, I want to understand this. On page 65 somebody has marked a number of Xs in the boxes. The purpose of that would be what?
A To indicate that the dose was not given at that time.

Q And the reason for that lies presumably on page 63. That prescription was being acted upon?

H

A	A	Yes.

Q	Then, over to page 67, we can see another prescription I think for haloperidol dated 13 August.
A	Yes.

Q	Let us try and come back now, please, to this patient. She was admitted to your ward
B	on 11 August and she was started on Oramorph on the basis of the prescriptions that the doctor had written?
A	Yes.

Q	Were you I think aware that on 13th the patient had an accident?
A	Yes.

C	Q	If we go to pages 46 and 51 of our notes, at page 46 we will see at the top "13 August 1998". Whose note is this? Is it yours?
A	It is not mine and I cannot ascertain the signature there.

Q	I am glad you have the same problem we have had but let us not worry about that for the moment.

D	"Found on floor at 13.30 hrs. checked for injury, none apparent at time hoisted into safer chair."

Then is it 19.30?
A	Yes.

Q	"Pain right hip internally rotated. D r Brigg contacted. Advised X-ray."

E

Now, Dr Brigg was who?
A	One of the partners at the practice.

Q	We have heard from him. Would he be contacted because Dr Barton at this stage would not be on duty?
A	Yes, because this was out of hours.

F

Q	Dr Brigg would be able, if necessary, to prescribe analgesia, would he?
A	Yes.

Q	We have looked at this before. We can see that the note is timed at 1300 hours but seems to relate to an event that happened half an hour later. So can we take it that the timing must be wrong?
G	A	Yes, one of those two times must be wrong.

Q	We know that she was kept at your hospital on the night of 13 August. She was given Oramorph, as we have seen, and the following day is you aware that her hip was X-rayed?
A	Yes.

Q	Where would the X-ray have taken place?
H	A	The X-ray took place at Gosport War Memorial Hospital.

A

Q And I think it was found that a dislocation had taken place?
A Yes.

Q And, as a result, was the patient to be transferred back to the Haslar?
A Yes.

B

Q For reduction of the dislocation?
A That is correct.

Q Is that what happened on 14th, she was taken back to the Haslar and operated upon?
A Yes.

Q Can you remember members of the family being around and about with this patient?

C

A Yes, I can.

Q We have seen notes about the two daughters. Do you have a recollection of the two daughters?
A I have some recollection.

Q Were they, either one of them, unhappy abut what had happened with their mother?

D

A Yes, they were.

Q In terms of her falling out of a chair and what had happened?
A Yes, what I would expect.

Q If we now go to page 23, please, is this a note that you made on 14 August, the day that she went off to the Haslar?

E

A Yes.

Q Can you just read it for us?
A "Haslar A&E

Patient to A&E for reduction of dislocated right hip. No change in treatment since transfer to us 11 August '98, except addition of Oramorph PRN. 10 mg Oramorph given at 11.50. We will be happy to take her back following reduction of the dislocation."

F

Q We know that the patient then remained at the Haslar until 17th?
A Yes.

Q Then she transferred back to your ward?

G

A Yes.

Q 17 August I think was a Monday. If you go to page 46, so back to the nursing note, would you just shout out, please, if any of these notes are yours, but do we see against the date 17 August,

"Returned from Haslar. Patient very distressed, appears to be in pain".

H

A

Then there is a note:

> "No canvas under patient. Patient transferred on sheet by crew."

What is the relevance of that entry, please?
A We would normally expect to transfer a patient with a stretcher canvas under them, which would enable stretcher poles to be inserted, but would enable the patient to be safely transferred from an ambulance trolley to a bed or vice versa, and this patient did not have a canvas under them.

B

Q Sorry?
A This patient did not have a canvas underneath them.

Q And the effect of that would be what?
A It meant that the ambulance crew transferred the patient using the sheet they were on and stretcher poles rather than the proper equipment.

C

Q And the effect upon the patient would be?
A That could cause them to be in pain; it could cause further injury.

Q When she came back to you, as she did on 17 August, had this incident with the sheet not happened, again, what would have been your normal understanding of why she was coming back to your hospital?
A For us to continue rehabilitation.

D

Q We know that the patient appears to be in considerable pain on 17 August as a result of this transfer?
A Yes.

E

Q There is a note that she is very distressed and we know, if we go to page 47, this is a note by Nurse Couchman.

> "13.05 In pain and distress ......Daughter reports surgeon to say her mother must not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an X-ray."

F

Then we see that an X-ray was performed in the afternoon:

> "Films seen by Dr Peters and radiologist. No dislocation seen. For pain control over night and review by Dr Barton in the morning" – mane.

A Yes.

G

Q Can we go to page 31, please? We can see in the middle of page 31 that there is an entry for 17 August '98.
A Yes.

Q This appears to have been made after readmission.
A Yes.

H

A

Q So after the transfer on a sheet?
A Yes.

Q And again your understanding, please: when she was transferred, would she have been placed directly on to her bed?
A Yes.

B

Q If she is coming back from an operation at the Royal Haslar, she is not going to be sat on a chair, or is she?
A No, we would transfer her initially from trolley to a bed.

Q Dr Barton's note, and it is not timed obviously although it is dated, is –

"Readmission to Daedalus from RHH. Closed reduction under intravenous sedation. Remained unresponsive for some hours. Now appears peaceful.

C

Plan: continue haloperidol."

A Yes.

Q Then, is it "Only…"
A Yes. "Only give Oramorph if in severe pain".

D

Q Then "See daughter again"?
A Yes.

Q The next day we have this note from Dr Barton, 18 August: "Still in great pain." Is it "Nursing a problem"?
A Yes.

E

Q Do not agree with me because I may well be wrong.
A That looks like "Nursing a problem".

Q And then I am not sure what the next is.
A "I suggest subcutaneous diamorphine/haloperidol/midazolam. I will see daughters today."

F

Q I think it is, "Please make comfortable".
A Yes.

Q So that is 17 August. If we go back to the drug chart at page 63 first of all, do we see that she was administered Oramorph on 17 August by you?
A Yes.

G

Q On four occasions?
A Yes.

Q And on 18 August? If we look below we can see that midazolam was started on the 19th, I think it is. Is that right?
A Yes.

H

A Q If we go over to page 65 --- I am sorry, I think that date actually is 18th. If we go to page 65 we can see the diamorphine by syringe driver was started. Can you help us with this, because I think this is your entry? Towards the bottom of the page, "Diamorphine 40-200 mg"?
A Yes.

Q Just help us please: what did you administer, when and why?
B A On 18th at 11.45, 40 mg of diamorphine via a syringe driver and 5 mg of haloperidol by syringe driver.

Q If we keep a finger in page 65 and go back to page 63, we can look at the Oramorph that this patient had been receiving. I will come back to the midazolam. Can we have a look and see the Oramorph the patient had been receiving. On 18 August somebody has given her 5 mls at is it 12.30?
C A I need to cross-reference on the controlled drug record because I cannot make that time out.

Q It may not matter the exact timing but she has plainly been given I think it is at 0.1230, so in other words in the early hours of the morning is the idea, and then also at 4.30 in the morning she is being provided with two doses of 5 ml each. Yes?
A Yes.

D

Q And that would be the equivalent of what 20 mg?
A Yes.

Q Because the dose written up by Dr Barton is 10 mg and 5 mls?
A Yes.

E Q I think even my maths allows for that to be 20 mg on 18th.
A Yes.

Q The intravenous or the subcutaneous diamorphine that she is provided with, 40 mg, would you yourself have queried that at all?
A I would have wanted to check that dose before giving it.

F Q Why?
A To make sure that it was the right amount for the patient.

Q Because what you told us earlier was that you were aware of the conversion rate?
A Yes.

Q And the normal conversion rate to keep a patient on the same level of pain relief,
G I appreciate there might have been an intention to increase it, the same rate of pain relief for this patient would be no more than 10 milligrams, would it?
A Correct, yes.

Q In fact it has gone up to 40 mg of diamorphine. If we now go back to page 63, we can see right at the bottom that the prescription for midazolam which Dr Barton wrote on 11 August now gets initiated on 18th?
H A Yes.

A

Q And it is initiated by you?
A Yes.

Q And that would add, would it, as you have told us I think, to the sedating effect?
A Yes.

B

Q Whose decision would it be to add midazolam as it were to the cocktail?
A That was in the medical instructions from the patient being reviewed by Dr Barton.

Q So when you filled up the syringe driver, on what basis were you doing it? Why were you filling it with those drugs?
A Because the patient was in a great deal of pain and wanted to relieve that pain.

C

Q And the calculation about how much pain relief they should receive would be whose?
A The prescription was written by Dr Barton but we were able to assess and see that the patient was in a great deal of pain.

Q May I just ask you this: did you think at this stage you were applying the Wessex Protocol?
A Those were guidelines, so obviously the patient was in a great deal of pain, so we were actually increasing the analgesia beyond what we might normally do.

D

Q Now we know that that level I think of analgesia continued through 20 August, the same rate I think of midazolam, is that right, and 21 August. Just have a look, please, yourself.
A Yes, that is right; it continued the same.

E

Q Prior to initiating that syringe driver, would you, do you think, have tried to obtain anybody's consent?
A Yes, we would have spoken to the family about the patient management of Mrs Richards' pain.

Q "We" would be who?
A I know Dr Barton saw the relatives and I also spoke to the family myself.

F

Q Who do you say you spoke to?
A I spoke to one of the daughters, Mrs Lack.

Q Just remind the Panel, that was Mrs O'Brien, who we heard from. Was this patient at the time that you initiated the syringe driver provided with any hydration?
A No.

G

Q What did you think – you, as a nurse – was causing this patient's pain?
A The doctor who reviewed the patient felt that the patient was most likely to have a significant haematoma at the operation site.

Q At the time that you initiated the syringe driver, did you appreciate what the likely consequence was going to be of that?

H

A We did feel that the patient's condition seemed to be deteriorating at that time.

A

Q At the time that you initiate the syringe driver, if the patient is not kept hydrated, the patient is going to deteriorate. Is that right?
A Yes.

Q I am only repeating what you told us earlier.
A At that point in time, the patient was being offered oral fluids if she would take them.

B

Q Just keeping a finger where you are, can you turn to page 300? This is dealing with 16 and 17 August, when the patient was still at the Haslar. We can see that the patient was in fact drinking a fair amount.
A Yes.

Q Quite a lot.
C A Yes.

Q I do not think we have any fluid charts for your hospital. Can you recall that this patient was not in fact hydrated?
A The patient would have been offered oral fluids whilst awake, but I do not believe we have a fluid chart.

D Q Can you remember how long the patient remained awake once the syringe driver had started?
A That is not something I can remember, I am afraid.

Q Once the patient loses consciousness, would you ever try to reduce the dose so that the patient could become conscious again to speak to her?
A It would not normally happen if a patient was receiving palliative care and in
E Mrs Richard's case her care had been decided as palliative by that time.

Q So somebody had made a decision, had they, that this patient should receive palliative care?
A Yes.

Q Who?
F A Dr Barton.

Q It may be you cannot remember, but can you remember if there was any discussion about any active methods to reduce the haematoma?
A I cannot remember in the case.

Q When you talk about palliative care – I just want to make sure we all understand – we
G are talking about the stage where it has been decided no longer to attempt to cure the patient.
A Yes.

Q We know that this patient died on 21 August in the evening. I am going to move on, please, to Patient D, Alice Wilkie. Could you put away that file and take up file D, please? I want you to help us, please, rather more briefly with two other patients. We have some updated pages for file D, so I wonder if those could be handed out now? They are better
H copies of what we have. (Same distributed) Can I just make a suggestion? If we leave them

A as they are for the moment, carry on with the evidence and if we get to a stage where we need the better copies, hopefully it will be in the clip you have been provided with. Alice Wilkie had been admitted, just to remind ourselves, to the Queen Alexandra Hospital on 31 July for an unresolved urinary tract infection. She had been given some haloperidol there, she was reviewed by Dr Lord and then transferred to Daedalus ward. This was the patient in respect of whom we were examining the note made "Do not resuscitate". So far as this patient is concerned, Mr Beed, could you turn to page 145 of the notes? Do you have any recollection

B of this patient at all?

A I cannot remember this patient, no.

Q I am not going to ask you to comment on her generally, but I would just ask for your assistance, please. If we go to page 145, do we see a drug chart for this patient?

A Yes.

C

Q We can see I think your initials.

A Yes.

Q Can you just read this through for us? This is 20 August. We know that a prescription had been written out by Dr Barton I think on 17 August, although in fact it is undated. It must have been prior to 20 August. We know that.

A Yes.

D

Q We can see the prescription on page 145. It says "Diamorphine". Is it 80-200?

A 20-200.

Q Have you administered some drugs to this patient via syringe driver?

A Yes. At 1315, I cannot read what the dose is of diamorphine, and also 20 mg of midazolam.

E

Q How would you have fixed on the dose of 30 mg?

A 30 mg would have been based on the level of pain the patient was perceived to be in.

Q Can I ask you this? If we were to go through these records and find you administered diamorphine and I ask you why you administered it, although you cannot remember the patient, can we take it you are always – and I do not mean this rudely – going to say, "It was

F because of the pain the patient was in"?

A Yes. There would be no other reason for giving diamorphine.

Q Underneath that, we can see midazolam was also initiated at the same time.

A Yes.

Q Should we take it with this patient that she, at this time of the initiation of the syringe

G driver, was designated, as it were, for palliative care, or not?

A I would not be able to remember that.

Q If we find, again generally, that patients are started on a syringe driver and then they are not given any fluids, or there is no note of them being given any fluids, is that an indicator of palliative care?

A Again, that is indicative of palliative care, yes.

H

A

Q Could you have a look at page 194, please? Is this a note made normally on her admission?
A Yes. This is general information as part of the nursing assessment.

Q Your name appears simply as manager.
A Yes.

B

Q If we look at the bottom left box, the very last box that is filled in, would you have filled this document in?
A No. This would have been filled in by one of the other nursing staff.

Q If I ask you questions about this patient's care, you are not going to be able to assist us, because you cannot remember the patient.
A I would have to refer to the notes to jog my memory.

C

Q I think your notes are limited in this case simply to the drugs that you administered. Can we turn, please, to the last patient, Patient L? Just to remind ourselves, you were the manager of Daedalus Ward and you did not get there until 1998.
A That is correct, yes.

Q It follows that you would not have had anything to do with the care of any patient on Dryad Ward.

D

A No.

MR KARK: Sir, I have prepared an expanded version of our patient identification schedule, which includes what ward the patient went on to, when they went on to it and when they died. I have certainly personally found that helpful, because it is sometimes difficult to remember which patient went on to which ward.

E

THE CHAIRMAN: I am grateful.

MR KARK: I will show it to Mr Langdale first. (Same distributed) May I suggest we put at the beginning of C1 and treat it as part of the working document? We can see that in fact Mr Beed would have been in place, as it were, on Daedalus Ward for Patients D and E and then only for Patient L, because although Patient B was admitted to Daedalus Ward, it was before Mr Beed started work there. (To the witness) Just turning to Patient L – and again, I am not going to spend very long on this patient – she is the lady called Jean Stevens. Again, do you have any recollection specifically of this patient?

F

A No, I do not.

Q We have been dealing with her this morning, so I expect the Panel remembers that she had been admitted to the Royal Haslar Hospital in April, having collapsed at home, and then she was looked after at the Haslar for about a month before she was transferred to Daedalus ward. If you could take up bundle L, the first page is 1299. This is a nursing note. Again, I do not think your writing actually appears here, does it?

G

A No, that is not my writing.

Q But we can see it is a transfer from the Haslar following a right CVA. We can see from the bottom:

H

A

"Her speech is slurred ... but [she] appears to be quite alert and aware of her surroundings."

In fact, the next note we have is two days later, when the unfortunate patient died. Can we go to page 1309, please? Again, can you just glance through those notes and see if your writing appears?

A Yes. There is an entry by me on 21 May 1999 at 1800 and a second entry at 1945.

B

Q Could you just take us through those?

A Yes.

"Uncomfortable throughout afternoon, despite 4 hourly Oramorph.
Husband seen and care discussed, very upset. Agreed to commence syringe driver for pain relief, at equivalent dose to oral morphine with midazolam. Aware of poor outlook but anxious that medication given should not shorten her life. Father David (Roman Catholic priest) asked to come and see Mr Stevens.
Daughter, Jane Bailey, called in and informed of situation.
Message left for 2nd daughter, Carol Whilliam, at Rockley Park Holiday Camp to contact us.

C

Then at 1945:

D

"Commence syringe driver
20 mg diamorphine, 20 mg midazolam in 24 hours"

Q Could you just go to page 1342? That is the drug chart for this patient.

A Yes.

E

Q We can see that on the day of her admission, 20 May, she was administered three doses of Oramorph.

A Yes.

Q Is that right?

A Yes, that is correct.

F

Q Again, I may well need help with my maths, I am afraid, but the dosage prescribed by Dr Barton is 10 mg in 5 mls.

A Yes.

Q So at 1430 she is given 5 mls, is that, or is that mg?

A That is mg.

G

Q Because it seems to switch between milligrams and millilitres. This is 5 mg, is it?

A Yes. It is an oral suspension, so 10 mg in 5 mls. Normal practice would be to put both the volume and the amount, but of course it is not a very large box to do that in.

Q I am not going to criticise that, but I just want to work out what she was getting. The first administration of Oramorph that she gets is actually 5 mg.

A Yes.

H

A

Q That is not your initial, I do not think.
A No.

Q The next dose she gets on the same day and that looks like 2.5; is that millilitres?
A That would look to me like 2.5 mls and 5 mgs – so 5 mgs and 2.5 mls.

Q So the total being 5 mgs?

B

A Yes.

Q Then the next one, is that also effectively 5 mgs?
A 5 mgs and 2.5 mls, yes.

Q So on 20th, the day of her admission, she has received a total of 15 mgs.
A Yes.

C

Q Then the next day, sticking with Oramorph for the moment, does she get another 5 mgs at 07.35?
A Yes, 2.5 mls which would be 5 mgs.

Q So the day before the syringe driver starts she is on 15 mgs total of morphine?
A Yes.

D

Q Then the next day you have administered to her via a syringe driver 20 mgs; is that right?
A Yes.

Q And 20 mgs of midazolam?
A Yes.

E

Q I think we have looked at that. On 21st in the morning at 07.35 you administered 5 mgs. Is there more after that? Sorry, would you just give me a moment? (Mr Kark and Mr Fitzgerald conferred) Mr Fitzgerald has pointed out something under his chronology and I am trying to find it in the notes. I think there are further prescriptions for Oramorph on page 1344 but it does not look as though any of it was given. I will come back to that. Please just confirm this: if we look at 1344 and 1346 there are prescriptions for Oramorph but do

F

they have a cross against them? Sorry, 1346 – Mr Fitzgerald, I suspect, is right: is this you administering?
A That is not me administering but there has been a dose given at 10 o'clock and again at 14.00.

Q Of Oramorph?
A Of Oramorph, and that would have been the 5 mls four-hourly, so 10 mgs at 10

G

o'clock and 10 mgs at 14.00.

Q So that is 20 mgs on that day, 21st?
A And 5 mgs at 07.33

Q 25 mgs.
A Yes. 7.33 there was a dose of 5 mgs; a further dose of 10 mgs at 10 o'clock and a

H

further dose of 10 mgs at 14.00. So, yes, 25 mgs.

A

Q Going back to page 1342, can you help us – and it may be obvious from the prescription from which you were working – why you started at 20 mgs subcutaneously?
A If I look back to the nursing note it was indicating that despite those four-hourly doses of Oramorph the patient was still in pain and that was not controlling the pain; and that would have been increased from the dose that was being given. On 20th we had increased the dose from 5 mgs up to 10 mgs and we were giving that regularly and the patient was still in pain.

B

Q Can we take it from the start of the syringe driver on 21 May: would the patient lose consciousness on those doses?
A Not necessarily so; 20 mgs is quite a low dose.

Q Going back to the note at 1309, that you made:

C

> "Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with midazolam."

Would you have explained what the effect of the midazolam would be?
A Yes, I would have done.

Q "Aware of poor outlook but anxious that medication given should not shorten her life."

D

How would you account for that when you decide how much drugs to administer?
A The drugs would be given purely for pain relief and to keep the patient comfortable.

Q Then we can see your note says that at 7.45 p.m. – or 19.45 hours – commence syringe driver. And the note underneath that:

E

> "Condition has deteriorated. Very bubbly."

That is not your note, I think?
A No.

Q But is that something that you found once you had instituted a syringe driver – that if the patient is lying in bed that they would quite often get a bubbly chest?

F

A They could do yes; that is something that did happen.

Q Was that something that you came across?
A Yes.

Q Is that why hyoscine was prescribed?

G

A Yes.

Q I have been leading; I did not think there would be any objection to that piece of leading. We see hyoscine through the notes; what would it be given for?
A It helps to dry up the secretions if the patient has a very bubbly chest that is making the breathing difficult and making them uncomfortable.

H

Q Would there be any other reason for giving it?

A	A	No.

MR KARK: Sir, that, I think, is all that I want to ask – and conveniently it is now one o'clock – but I would quite like to reserve my position so that I can check my notes.

THE CHAIRMAN: By all means. We will rise now and return at two o'clock.

B	Mr Beed, I remind you that you remain on oath and you must not speak to anybody about the case. I think you are going to be taken to a room that has been arranged for you in accordance with what Mr Kark was saying earlier. Thank you very much everybody, two o'clock please.

MR KARK: Sir, we are happy to provide the original notes. Somebody will have to remain with Mr Beed whilst that is done.

C

THE CHAIRMAN: Yes, we understood that.

MR KARK: If the Panel is content for us to do that we will speak to him purely administratively for that to happen.

THE CHAIRMAN: Yes, we are perfectly content with that.

D

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Mr Beed, I hope you managed to get some lunch whilst doing your homework?
A	Yes.

E	THE CHAIRMAN: Excellent. I will pass you back to Mr Kark and remind you that you remain on oath.

MR KARK: Mr Beed, I have very little more to ask you. First of all, on the homework front did you find any notes revealing the pain that you were talking about?
A	No, I could not find anything in those notes.

F	Q	Did you find any fluid charts for the GWMH?
A	No, I could not.

Q	You told us a little earlier about how busy the wards were. You were interviewed, as we know, back in July 2000; we are now pretty much nine years on from that and can we take it that your recollection back when you were interviewed by the police was significantly better then than it would be now?
G	A	It would be, yes.

Q	I am going to remind you, if I may, of what you said to the police about how busy the wards were. For my learned friends it is the first interview, page 8 of 37, at the bottom. I can show it to you if you want to have a look at it but perhaps I can just read it to you:

H

A

"We have 24 beds on the ward. We have only actually been full on about three or four occasions in three years that I have worked at the War Memorial, but usually we run about 17/18 patients."

Does that trigger a memory? Would that be about right?
A If that is what I said on that occasion that would be correct.

B

Q Then you say:

"For 18 patients the ward gets very busy so you have to prioritise your work. If we went above 18 we need to bring in bank staff."

A Yes, that was correct.

Q You said also:

C

"We should never cross that line because I can bring in bank staff."

Meaning that you would bring in bank staff if you felt you needed to?
A Yes.

Q One other matter about which I wanted to ask you and that is in relation to

D

Mrs Richards. Again, I can remind you, if necessary, of what you told the police but can you remember whether Dr Lord ever reviewed Mrs Richards?
A I cannot remember, no.

Q I think certainly at the time when you were interviewed you did not think she had seen her on admission on that first occasion.
A If that is what I said on interview then that would be a correct recollection, it being

E

nearer to the time.

MR KARK: Thank you very much indeed; would you wait there.

Cross-examined by MR LANGDALE

MR LANGDALE: Mr Beed, I am going to ask you some questions on behalf of

F

Dr Barton. I would like to take up, while we have it in our minds, the point which you were just asked about in terms of numbers of patients and so on – back to that first interview at page 8. Leave aside the precise numbers because one appreciates that it is very difficult to remember exactly and things no doubt changed over a period of time, but in general terms in terms of the patients who you were receiving on Daedalus, you have described the general position, but did you find that sometimes – not just on a few occasions – patients just were not well enough for rehabilitation?

G

A Yes, that was very often the case.

Q We have heard something about this from other witnesses. Did you find, in your view, that there was perhaps a tendency of the hospitals where these patients had been treated to pass them on to you, to Gosport War Memorial Hospital, perhaps a little bit before they were ready on occasion?
A It certainly felt that way, that the patients really were not in a position where they

H

were ready for rehabilitation when they arrived with us.

A

Q We had the example with regard to Mrs Richards – weight bearing, so the transfer letters say, but when she gets to you, was there ever a situation where in fact she was able to walk about with the aid of a Zimmer frame or anything else?
A When she was transferred to us we were having to use a hoist to transfer her.

Q And I think something that Dr Barton recorded on her clinical notes on admission. When we see that expression does that signify really that the patient does not appear to be able to mobilise herself or himself?
A That would indicate that, yes.

B

Q Did you find too on occasion – this is not a criticism of them – relatives had a rather higher expectation of what was going to happen to their relative who was a patient than was really practical or realistic?
A Yes, that was sometimes the case.

C

Q A feeling – perhaps understandable – that the relative concerned who was a patient at the Gosport War Memorial Hospital would be back home before too long, whereas in fact that was rather unlikely?
A Yes. Patients often needed quite slow, gentle rehabilitation with us and then were with us for some time.

D

Q In any event, whatever the transfer letters said about the patients you obviously needed, in terms of your resources, your staff and your experience, in a lot of cases to take the time to assess the needs of the patient.
A Yes.

Q It was not always possible to immediately decide precisely what was feasible and what was not?
A No.

E

Q I think you can also speak just by way of a general situation – this is with regard to patients' transfer to Gosport War Memorial. I appreciate with Gladys Richards that it was a pretty bad transfer from her point of view for the reasons you have indicated when she was readmitted on 17th, but in general terms did you often find with elderly and frail patients that the transfer itself had rather taken it out of them?
A Yes. I think the move from one hospital to another and the journey often seemed to take them a step back further in their rehabilitation, if you like.

F

Q Did you also find, perhaps particularly with patients who were suffering from some form of dementia – whatever it technically was, Alzheimer's or something else – that the transfer itself would be thoroughly disorienting for them.
A Yes, it often could be.

G

Q And had a tendency to increase their confusion.
A Yes.

Q And might that also of itself create a situation where deterioration took place rather than improvement?
A Yes, it could.

H

A

Q Because it was a very broad-brush approach.
A Yes, it could.

Q In terms of patients deteriorating, again dealing with frail, elderly patients who received some form of surgical treatment or whatever it might be, did you find that deterioration in some cases – not in every case – could be quite rapid?

B

A Yes, in some cases it could.

Q In terms of the pressures on you and the staff under you, you spoke about that and you have been reminded of certain passages with regard to it, and it meant – as you expressed it to the police – that you always had to be wary of whether you got to a point where you simply could not cope.
A Yes.

C

Q But in general terms you managed to keep the right side of that line, even if it was very much under pressure.
A Nurses are very much used to working under pressure, so having a busy ward was not something that was unusual to us and it was how do we make sure that it remains safe for patients and safe for staff, and sometimes that was easy and sometimes that was quite a challenging thing to do; but it was something as manager to try to ensure at all times.

D

Q You could bring in bank staff, but only occasionally; is that right?
A I had the authority to bring in bank staff – that was dependent on bank staff being available – and of course bringing in bank staff or having extra bank staff is not always as beneficial as having your own staff who know the ward and who know the patients.

Q And of course you had patients who were suffering in some instances from a number of medical conditions or medical problems.

E

A Yes, lots of patients have multiple pathologies.

Q And at times on the ward you might find several patients being poorly at the same time or needing attention for one reason or another?
A Yes, that would be a regular occurrence.

F

Q You could have patients who might fall out of bed, that sort of things?
A Yes.

Q And indeed you needed, apart from performing your nursing duties or general care duties, to try to get to speak to relatives and find the time to explain things to them?
A Yes.

G

Q No doubt relatives of different patients would vary as to quite how many demands they made on your time in some instances?
A Yes.

Q May I just ask you this generally in terms of your feeling at this time? We are focusing, in terms of 1998 and 1999, in terms of your role in this case. What was the general attitude of the nursing staff towards relatives? Did people tend to think they were just a bit of

H

A a nuisance or did people try and do their best to explain things to them when they were asked and to pay attention to them?

A We very much felt it was important to keep them informed and involved and listen to them and talk to them and try and find the time to do that.

Q If a relative was particularly demanding and was wanting to know on a number of occasions what was going on, did you try to make sure that you, as it were, bent over

B backwards to make sure their concerns were properly dealt with?

A Yes.

Q I am going to come on to the case of Mrs Richards in a moment. I am just dealing with in general terms as you saw it and what you tried to do?

A Yes, I can think of lots of occasions when we spent a lot of time with relatives to try and help them at what was a difficult time for them.

C

Q In particular, with regard to the fact that their relative, the patient, was receiving controlled drugs, and obviously we are focusing in this case on Oramorph and then the step back to diamorphine and midazolam, what was the general practice there when the time had come for those drugs to be administered in terms of contacting relatives, assuming there were relatives there at the hospital? What in general did you try to do?

A Our aim usually would be to talk to relatives and involve them in that decision so they

D knew what was happening and try and make that discussion prior to changing the patient's drug regime.

Q You also spoke or mentioned as well slightly earlier on in your evidence when Mr Kark was asking you some questions a moment or two ago that with all the pressures that were on you, not impossible pressures but pressures and a busy ward, you needed to prioritise. Can you help us a bit with what that actually means in practice?

E A Trying to determine when there are multiple demands on our time which patients' needs were the greatest or what other activities were the most important to do first, and then work through those in that order, so that everything that needed to be was done. I think on some occasions there were things that we just physically could not do, making sure that what we deemed were the most important things were the things that actually got done.

Q I think you were indicating that if one found an example where something which

F should have been recorded was not recorded, the most likely explanation was really the pressures on staff at the time?

A When I think back to 1998, I know that one of the reasons our documentation was poor was because we spent time and prioritised care of the patients and talking to relatives and documentation and therefore did not get the time that it required to be done at the level that we would have wished it to be.

G Q Again in general terms, everybody is different and obviously the nursing staff all had their individual personalities, but in general terms, did you find that the staff, that is those of whom you were in charge, were experienced and competent?

A Yes, I had every confidence in the staff that worked with me.

Q Did you ever feel there was any real risk of anybody on the staff choosing to up a dose for no reason at all with regard to a patient?

H A No, I had no reason to think that could occur.

A

Q I am going to put this to you as well as a general proposition. Was there ever any question, so far as you were concerned, of patients who maybe were difficult to manage, difficult to nurse, being given controlled drugs in order to keep them quiet because they were causing a bit of a problem – anything of that kind?
A No, I never knew that to happen or had the expectation that that would occur.

B

Q If you had thought that it was happening, what would you have done about it?
A I would have dealt with it accordingly with the patient and the person concerned.

Q With the staff, there are obviously periods in the day, late in the day, early in the morning and so on when there was a hand-over between for example day staff and night staff, that sort of thing.
A Yes.

C

Q People coming on to a shift, people going off a shift. Did you feel in general terms that the nursing staff were unaware of what the general picture was with regard to patients in the sense they were not able to get information, or did you feel that nursing staff were keeping track of patients' progress or lack of it?
A Nursing staff were keeping track and there were good hand-overs between the shifts.

D

Q We have heard evidence already of how a pharmacist used to visit obviously more than Daedalus but we are focusing on Daedalus as one particular ward. Is that right?
A That is correct.

Q Was that pharmacist, maybe not on every single occasion, called Jean Dalton? Does that ring a bell?
A Yes.

E

Q Would you help us, please, with what the pharmacist would do in terms of her visits?
A She would check all the patients' drug charts, check our controlled drug record and check our stock levels, and if any of those have any cause for concern or there is anything needed discussing or checking, she would bring those to the attention of the nurse in charge to deal with or bring it to the attention of the medical staff if that was necessary.

F

Q So the pharmacist would be able to see what the patients were being prescribed?
A Yes.

Q What was being administered and would obviously be able to see dose ranges and dose combinations?
A Yes.

G

Q Did the pharmacist ever express to you any concern about the dose ranges with regard to controlled drugs?
A Not that I can recollect.

Q What sort of things were pointed out? Can you remember?
A The ones that I can remember were when drug doses appeared incorrect on drugs other than uncontrolled drugs or when patients were on medications that could interact with each other.

H

A

Q And the pharmacist would visit I think weekly, is that right?
A That is correct.

Q Was she somebody, so far as you could tell, who was pretty thorough in carrying out her job?
A Yes, I felt she was.

B

Q What would be available to the nursing staff if they needed to check or wanted to check on a particular dosage or any conversation or anything like that, any conversion between one type of drug and a variation of the same drug? What would they have available to them, apart from talking to people?
A They had the Wessex Palliative Care Guidelines but also in the BNF of which we had least one copy in the ward; there was information about drug doses and ranges. There is a conversation table in the BNF as well.

C

Q I would like us to take a moment, with your assistance, to look again at volume 1. You were looking at this earlier today so it is going back to the same document. I just want to draw everybody's attention, through you, to certain things at tab 4 in that file. The document itself makes it clear that these are guidelines to assist relevant staff in relation to clinical management. I think, following common sense but we are able just to get it confirmed by you, from time to time a guideline might not be followed because there was a reason?
A Yes, that would be correct.

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Q Looking at the page numbering which is peculiar to the file itself, in other words, page 3 of tab 4, the bottom right hand corner as one looks at the file, it shows in the introduction what palliative care is in terms of the description given by the guidelines. Do you see that on the right at the top?
A Yes.

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Q "...active total care of patients and their families, usually when their disease is no longer responsive to potentially curative treatment, although it may be applicable earlier in the illness"

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That just is a very rough description. Is that something you would agree with in general terms?
A Yes, I would.

Q May I just ask you this in the context of palliative care? There would presumably quite often come a time with the patients on Daedalus where it was appreciated that palliative care was all that anybody could do?
A Yes, that would be correct sometimes.

G

Q That it was not going to be feasible or sensible to seek any further surgical or other intervention?
A Yes.

Q Maybe because of the state of the patient, their frailty, their deterioration, things of that kind?

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A Yes.

Q And a decision would have to be made, I appreciate you would not be the arbiter of it but it would be something you would be concerned to have an eye to, as to whether in the best interests of the patient dealing by way of palliative care with the symptoms was in fact preferable in their interests to seeking to have them undergo something which might cause or was likely to cause further pain and discomfort without any successful result?
A Yes.

Q When it was clear that palliative care was what as to be provided to a patient, did that mean that you just gave up hope or did it mean that you still tried to see what could best be done? Describe it in your own words?
A If it was decided a patient was going to receive palliative care, then the principal aim was to make sure the patient is comfortable and well looked after. Obviously you still continued to assess and observe and monitor the patient. So if a patient's condition changed in either direction, that would guide the care that was being provided for that patient.

Q And it may be that these terms are used in a rather loose way but would you see palliative care or a patient who was in need of palliative care being in a situation different to being terminally ill or were both things pretty much the same?
A Terminally ill is usually a term that someone who has got a specific illness which is reaching its end stage, whereas I think the patients that we were dealing with often had multiple pathologies and complex problems as opposed to a specific terminal illness.

Q In terms of entering the terminal phase of their lives, for whatever reason, is that something different to a patient being in need of palliative care? Presumably it is because you might come out of palliative care if things moved in your favour?
A Yes. I guess that could happen.

Q I appreciate these are not, as it were, scientific terms. Just looking back to the page we were looking at in the palliative care handbook, towards the bottom of that section:

> "Cautionary note: some of the drug usage recommended is outside product licence, either by way of indication, dose or route of administration,. However, the approaches described are recognised as reasonable practice within palliative medicine in the UK."

A Yes.

Q Would you move on to the next page, page 4 in the handbook, on the left hand side, to that section is headed "General Principles of Symptom Management" and indicating for example at the third bullet point down:

> "When symptoms are difficult to control there may be more than one cause, or there may be hidden emotional, psychological, social and spiritual factors."

Yes?
A Yes.

Q And the next bullet point down but one:

A

"Be careful that drug side effects do not become worse than the original problem".

Was that something that you were aware of?
A Yes.

Q Is that something you have an eye to in your treatment?
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A Yes.

Q Then over on the right, a section headed "Pain". The first paragraph is really relating to cancer patients and I am not going to trouble you with that. It goes on in the next paragraph:

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"Most pains arise by stimulation of nociceptive nerve endings; the characteristics may depend on the organ involved. The analgesic ladder approach (see over) is the basis for prescribing but careful choice of appropriate adjuvant drugs such as anticholinergics for colic, NSAIDs for bone pain and benzodiazepines for muscle spasm, will greatly increase the chance of effective palliation."

Again, you are aware of that?
A Yes.

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Q Moving a little further down:

"Diagnoses

There is no easy way of measuring pain in a clinical situation; as such, it is generally held that pain is what the patient says it is."

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Let us jus think about that. Did you find with a number of patients who came on to Daedalus that they were not able to communicate very well?
A That would have been the case with some patients, yes.

Q And obviously in cases of patients who were suffering from some form of dementia that could be a real problem?
F
A Yes.

Q And indeed I think in the case of Gladys Richards she was really saying very few words before she ever came on to Daedalus which anybody could comprehend. It may be that her relatives could understand a bit more, but very often you could not ask a patient for a proper history?
A That is correct.

G

Q Did you therefore, in trying to assess the pain and the degree of pain that a patient was in, have to use your experience and observation of what others might be able to tell you?
A Yes, using things like non-verbal clues to what is happening.

Q You told us, and I am not challenging you on this for a moment, that you would not specifically use diamorphine to treat agitation but agitation in patients of this kind might
H
often indicate that they were in pain?

A

A Yes, it could.

Q Because you have got to look to that sort of thing, what is causing the agitation, sometimes your considered judgment was that it was obviously pain that was causing it?
A Yes.

Q Similarly distress generally with a patient is another sign of them being in pain?

B

A Yes.

Q Obviously if you take an example like screaming, a patient might be screaming because they were in pain; a patient might be screaming if they had dementia or some similar problem, because of the disturbed state they were in generally.
A Yes.

C

Q So sometimes it was quite difficult to make a judgment.
A Yes. It would be difficult in some cases.

Q Can I just ask you this? Whatever the difficulties may be, you would only administer controlled drugs if there was a prescription, but when you did and you were seeking to administer a drug to deal with pain, did you always satisfy yourself that as best you could judge it, it was pain that they were suffering from?

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A Yes. Before giving he controlled drug for pain relief, I would need to do that, unless you were as certain as you could be that the patient was in pain and that was the necessary treatment for that patient.

Q In general terms, would you say that was the attitude of your nursing staff, those under you?
A Yes, I would.

E

Q Then in the same handbook causes and risk factors are dealt with. There are physical causes, and it sets out those sort of matters. Then non-physical, in terms of causes of pain and risk factors:

> "Anger, anxieties, fears, sadness, helplessness, spiritual, social and family distress."

F

True to your experience, those factors need to be considered.
A Yes.

Q It goes on:

> "If pain is difficult to control, remember:
>
> All pains have a significant psychological component and fear, anxiety and depression will all lower the pain threshold. Remember also the likely effects of life changes associated ...."

G

It then goes on. I am not going to trouble you with the rest of it. Again, looking at that first sentence, do you agree with that as affecting the pain threshold?
A Yes, I would agree.

H

A

Q Did you find in a number of patients that anxiety and fear were something that weighed pretty heavily in their minds and in their attitudes?

A Yes. That was certainly the case with a lot of patients that we looked after.

Q I am not going to trouble you with the next page, page 5. We may have to look at that again in the course of the hearing. Can you move on to page 6, where the handbook is dealing with the use of morphine and talking about initially instructions to the patient. In

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some instances, was that something which was really a non-starter, with the state of some of the patients?

A It would be if the patient was not able to understand verbal information, yes.

Q But you would, in such cases, endeavour to inform the relatives as best you could, assuming there were relatives there.

A Yes. We always felt it was very important to keep relatives informed and to

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communicate well with them.

Q It sets out matters to do with what happens if oral administration is not possible and so on. I am not going to go over that with you. Over on the right-hand side of that page, under the subheading "Opioid equivalents", did it register with you that although that was a useful, if you like, table to give you an idea of the equivalents, it was only an approximate guide?

A Yes. I would regard that as a guideline.

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Q Similarly, in general terms, as a general underlying guideline, if somebody is on Oramorph and you had to switch them to diamorphine, for whatever reason, a rule of thumb is that you reduce it by half or maybe a bit more.

A Yes.

Q That sometimes would be appropriate.

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A That would sometimes be appropriate, yes.

Q But on other occasions it plainly was not.

A If the patient was in a great deal of pain, then that might ---

Q Did you also have to bear in mind that if Oramorph was not controlling the pain and the doctor had made the decision that it was appropriate, having prescribed of course, for

F

analgesia to be given subcutaneously – and here, diamorphine – if that had been decided to be the case, you would need to up the dose to cope with the fact that the Oramorph had not been controlling the pain.

A Yes.

Q In other words, it is not a straight conversion, but it is a conversion with a raise to take care of the fact that the patient needed further pain control.

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A Yes.

Q We are going to come on to a case, because it is referred to in the notes, where in fact you endeavoured to do a straight conversion from one to the other – we can look at that in a moment – but in general terms did you find that that quite commonly was the case: that once the stage had been reached where the switch had to be made to subcutaneous analgesia, diamorphine, there would be an increase, not just a straight conversion?

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A Certainly that occurred on occasions. How often that was the case, I could not say.

A

Q I am sure you could not possibly, but in general terms that could happen. Again, it was all determined by what was regarded as the right dose to make the patient as comfortable and as pain-free as possible.
A Yes.

Q That is all I am going to ask you about that Palliative Care Handbook. You have given evidence already, and I am not going to ask you to repeat it, about the use of syringe drivers. I think we have probably all now heard enough about what the advantage of using a syringe driver is, so I need not take you through that in any further detail at this stage. In general terms, did you feel confident that your staff, the staff under you, knew how to first of all properly operate syringe drivers?
A Yes. I was confident of their ability to do that.

Q And that they had maybe not gone on specific courses, but certainly at the very least received on the job training so as to make them proficient in their use.
A Yes. They had all received the necessary on the job training.

Q In terms of patients who were at the stage of palliative care, you were seeking to administer – subject to what the doctor had prescribed, we must not forget – but in general terms, particularly if you had a dose range, you were seeking to achieve a level of sedation, or whatever word one uses, which kept them pain-free.
A Yes.

Q Did you sometimes find that patients who were having diamorphine and midazolam administered would become more and more drowsy?
A Yes, that was sometimes the case.

Q And at times unrousable?
A Yes, at times.

Q In such instances, did you find patients who might be drifting in and out of consciousness?
A Yes. Some patients, their level of consciousness varied.

Q So a patient might appear to be unconscious at some stage in the afternoon, but in fact when being moved at night or something of that kind, would make it clear they plainly were conscious.
A Yes.

Q Obviously you would not be seeking to render a patient unconscious.
A No. We would want to try and keep them relatively pain-free for the majority of the time.

Q But obviously there might come a time when they were virtually unconscious.
A Yes.

Q Help us with that, as to what the approach was.
A If the patient became ---

A

Q If the patient is becoming more and more drowsy, less and less rousable, maybe unconscious at times, maybe coming into consciousness at others. How did that affect your monitoring of the pain control that they were receiving and the midazolam's sedative effect?
A The overall condition of the patient in terms of their pain relief, their level of consciousness would be constantly monitored, but especially so at times when the patients were being attended to, which would perhaps be – patients were observed constantly, but patients would need typically to receive intensive care with help in washing and dressing and keeping clean every three hours or so and that would involve moving them to stop them getting pressure sores. That sort of time is when you would really observe whether the patient was comfortable. Patients often would become uncomfortable on being moved, but it was judging whether that level of pain and discomfort was tolerable for them or intolerable for them. Then future drug doses and future treatment could be based on how the patient was reported at those times.

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Q Bearing in mind obviously the perfectly proper in every sense of the word desire to keep a patient pain-free, what do you say to the suggestion that a patient should be taken off subcutaneous analgesia to enable them to suddenly be able to speak? Do you see that as sensible or what?
A If patients were clearly receiving palliative care and they were getting some break-through pain when they were being provided with nursing care, then it would have been my view that removing or reducing the syringe driver would be likely to increase their pain levels and make them uncomfortable again.

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Q We are talking about pain in general terms in these sorts of situations. We are talking about real pain; we are not just talking about a bit of discomfort.
A No. We are talking about patients being significantly in pain and often generalised pain, so in no particular area.

E

Q Patients with sacral sores, pressure sores. What about that in terms of causing people pain in your experience"
A That would be uncomfortable and we would have to nurse the patient to try and prevent that sore worsening. Of course, the sore itself would probably be uncomfortable for the patient.

F

Q So just to give us the picture, you would be used to patients being in pain so that they were sometimes crying out.
A Yes.

Q Maybe screaming in pain.
A Yes.

G

Q And maybe exhibiting real signs of pain, even if briefly, when moved at night.
A Yes.

Q When a nurse recorded something like "Pain on moving" at night or a patient had a distressing, uncomfortable night, we are talking about real pain, rather than a moan or a groan?
A Yes.

H

A

Q Before you ever get to the Gosport War Memorial Hospital and were in charge of Daedalus Ward in 1998, you had had some experience of dealing with patients who needed palliative care, had you?
A I had some experience, yes.

Q Did you find the experience that you had acquired helpful in terms of assisting you to make a proper judgment about what was required in terms of a patient's needs so far as pain control was concerned?
A My experience prior to Daedalus, yes, it was helpful.

B

Q And no doubt on Daedalus your experience was ---
A It increased my experience significantly moving to Daedalus ward, yes.

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Q Was it the case that the nursing staff, not only you, but also the staff so far as you were aware, were good at communicating with the doctor, in this case, Dr Barton, the clinical assistant, or other doctors who appeared or indeed consultants, good at communicating what they had observed with regard to a patient's condition?
A Yes. We had a multi-disciplinary approach on Daedalus ward and I think communication between doctors and nurses and the therapists was very ...

D

Q Was that something you tried to foster yourself?
A Yes. We developed and built on that, but it was already there when I arrived and we worked to develop it further.

Q It is certainly not your fault, but the attendance of doctors was in a sense far from 24-hour attendance. Shall we put it in that way?
A Yes. It was a community hospital.

E

Q Dr Barton would be there in the morning doing her morning round, as it were, or morning check, with particular patients being drawn to her attention if there was a particular problem.
A Yes.

F

Q She would be there for 8 to 8.30, that sort of time. She would come back on a lot of days about lunchtime or something like that and would deal with clerking in new admissions. Yes?
A Yes.

Q And might indeed have to come back on other occasions during the day.
A Yes.

G

Q And come back on occasion to see relatives.
A Yes.

Q Then you would have the consultants, Dr Lord or whoever it might be, coming round and doing their rounds in the sort of timescale that we have heard about. But for very large parts of the day and night – indeed, all night – it would be the nursing staff who were dealing with the problems that there were.
A That is correct, yes.

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A

Q May I ask you about Dr Barton, please? Did you find her somebody with whom you could readily communicate?
A Yes. Dr Barton was very easy to talk to and I felt we had a good professional relationship.

Q So far as you could judge it – you are not a doctor obviously – did she seem to be making sensible, professional judgments about the patients she was dealing with?

B

A Yes. In my experience, she was.

Q Did she also seem to you to be somebody who was very hard-working?
A Yes, she did.

Q And very committed to the best interests of the patients under her care?
A Yes. I always thought she had the patients' best interests at heart.

C

Q In general terms, what did you observe of her manner with and her general approach to relatives who might want to find something out or needed to ask something? How did you see it?
A Dr Barton was always willing to talk to relatives if that was required and would find the time to do so. I think, like all of us on the ward, time was a difficult factor for us, but I think she always found the necessary time and answered their questions and gave them relevant information.

D

Q We have heard about note keeping maybe not being as good as it should have been and things of that kind. Did you have any difficulty, whatever the brevity or otherwise of Dr Barton's notes, in knowing what her medical judgment and opinion was about patients?
A I always felt I could understand what had been said or written and, if I was not sure, I always knew that I could ask for clarification.

E

Q When she was called out or indeed when she was at the hospital in any event dealing with the admission of a new patient, did you, from what you could see and what you could judge, think that she took care over her clinical assessments of patients?
A Yes, I did.

Q I am going to turn now, if I may, to three particular patients you were asked about this morning. First of all, we can deal with the patient Gladys Richards and perhaps you could take file E. On the day that she was first admitted – and we have looked at Dr Barton's clinical notes at page 30, if we can just take a minute to remind ourselves of them.

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On page 30 we can see the notes made on 11th and I am not going to read through all of those again. But as you indicated to us "Please make comfortable", did in effect mean make sure that she is not in pain.
A Yes.

G

Q We have to bear in mind that this lady, who I think was in her early 90s, if I remember correctly?
A Yes, that is correct.

Q Had had this operation – a far from uncommon kind of problem with people who fell. You were quite used, no doubt, to patients in that sort of state.

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A Yes.

A

Q And somebody who, so far as your experience was concerned, might very well be in some pain soon after admission.
A Yes, that would be quite typical.

Q Even if not obviously in pain on admission.
A Yes.

B

Q We have been through all the records to see what record there was of your actually administering Oramorph and you say that you definitely did but there just does not happen to be a record of it; obviously that is because Dr Barton had prescribed it – you could not have done it otherwise – and we have seen the prescription.
A Yes.

C

Q Can I ask you this, Mr Beed: what sort of degree of pain would cause you to administer Oramorph, which has been prescribed by the doctor; can you give us an idea?
A The patient was very obviously in significant pain and showing signs – crying out, very agitated and pain was made worse on movement.

Q So we can take it that there was something that you had observed or other nursing staff had observed which caused you to think it was right to give her Oramorph.

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A Yes.

Q In your experience, with patients of this sort of age and a lady in her circumstances – a frail, demented lady – what was the prognosis like in general terms in such cases?
A Elderly demented patients who suffered a fracture in their femurs, the outlook is not always terribly good.
Q That was not something that meant you simply did not bother but you would have in

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your own mind the fact that there was a possibility this patient might go downhill.
A Yes, that was something that you regard as a possibility.

Q In general terms – and we will take this lady's case as an example – Dr Barton on occasion might prescribe in an anticipatory fashion a dose of diamorphine often coupled with midazolam.
A Yes.

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Q The purpose of that – and we have heard from other witnesses – was to enable the staff to be able, if it was necessary, to administer subcutaneous analgesia if for some reason the doctor was not available or could not be obtained.
A Yes.

Q Can I ask you this: in such a case where you have a prescription that is there – it is not

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saying it is to be administered straight away or anything like it, but it is there available for use – and there is a dose range, and let us say it is 20 to 200 just to take a figure – if a patient was already on Oramorph or any other opiate, MST, whatever it might be – normally the staff, whether it was you or anybody else, would endeavour to check with the doctor before starting subcutaneous analgesia.
A We would usually endeavour to do that, yes.

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A Q Obviously if Dr Barton comes in in the morning and the Oramorph is no longer controlling a patient's pain the staff can tell her that and she can say, on the information given, "I think it right that it is started" – or examining the patient or whatever it might be.
A Yes.

Q But on occasions, if no doctor was available and no doctor could give the okay to it, if I can use that expression, you as the senior person on the ward or any other senior member of
B the nursing staff could institute it, could start it.
A Yes.

Q In general terms, you have told us, it was clear that you would start at the minimum dose prescribed.
A Yes.

C Q In general terms, if you or any other member of your staff considered that the patient's pain was not being controlled at whatever the lowest dose was and that the dosage ought to be increased, normally you would endeavour to speak to the doctor about it.
A Yes, we would.

Q Is this right: it was only in cases where the doctor was not available and there was no other on-call doctor available that the staff – and senior staff again, it is not just an ordinary
D nurse doing it as she feels like it – we have heard about two nurses being told every time controlled drugs are administered, and so on – have the authority to increase the dose if they felt it was justified.
A Yes, that is correct.
Q And any increase in dose coming about in those circumstances would be picked up by the doctor the next day.
A Yes.

E

Q Assuming it was a weekday and if it was a weekend it might take longer.
A Until the next working day.

Q But if there was a problem you could always contact the on-call doctor over the weekend.
A Yes.

F

Q Assuming that you could get hold of them and they were not already engaged on other matters.
A I would say that contacting doctors out of hours was sometimes easier than at other times.

Q I would like to deal with the question of hydration, about which you were asked a
G number of questions, although it did not arise at this stage so far as Mrs Richards was concerned. It may well be that things changed but in 1998 and 1999 in general terms there were not the facilities to provide intravenous fluids, is that right?
A That is right, yes.

Q We have heard from another witness – and I will not trouble you – that change came and later on it was possible to do that.
H A Yes.

A

Q In terms of the equipment being available.
A Yes, it was possible later on.

Q And if you are providing intravenous fluids to a patient to keep them hydrated and so on, what is the importance of there being a medical presence or availability in the sense of a doctor?

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A It would have needed a doctor to insert a venflon and if at any time that venflon was not patent and became blocked then you would need a doctor to re-site the venflon.

Q So did it come about that there was this change when more doctor assistance was provided at the hospital?
A Yes. We started giving intravenous fluids to patients when we had a full time associate specialist working on the ward.

C

Q We will be hearing about Dr Barton resigning and therefore ceasing to be in post. After that was more medical assistance or cover provided in terms of doctors being available?
A Yes. After that we had a doctor who was available during working hours from Monday through to Friday.

Q So in general terms there every day of the week, as it were, or available every day of

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the week, and is that the time when the supply of intravenous fluids was something that was carried out and the equipment was there to do it?
A Yes, that was introduced at that time.

Q I am not going to go over it again with you but you pointed out that the view in any event in 1998 was that in terms of palliative care patients to seek to re-hydrate them would cause more problems than it solved.

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A Yes, that was the view and there was evidence in the literature which would back that view.

Q Would you help us with how you saw it – what was the problem if you tried to re-hydrate somebody who was in that sort of condition?
A The giving of fluids subcutaneously, which was the route that was available to us, could only be done for a limited amount of time and was felt to cause the patient discomfort

F

at the site of infusion. So the benefits of hydrating were outweighed by the disadvantages for the patient.

Q We have seen the picture with regard to Mrs Richards in general terms but initially things moved along fairly satisfactorily.
A Yes.

G

Q Her pain was being controlled.
A Yes.

Q And then came the occasion when there was the fall and, as you say, you were not surprised that the relatives were rather unhappy about the fact that she had had this fall on 13 August, as it was. You told us about Dr Briggs being consulted and advising an X-ray but it should be done the following morning; and Dr Briggs saying that she should have analgesia

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during the night.

A

A Yes.

Q On the 14th – if we can look again at page 30, that same page in the file, the clinical notes made by Dr Barton and the bottom of that page, 14th August:

> "Sedation/pain relief has been a problem. Screening not controlled by haloperidol but very sensitive to Oramorph."

B

Do you see that?
A Yes.

Q What does that signify? Maybe you will not be able to specifically remember the detail but if you can, do say so. What does that signify to you – "very sensitive to Oramorph"?

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A That the Oramorph at that time was helping to control the pain.

Q It says: Screening not controlled by haloperidol …"

And there is something after that, but I do not know what it is:

> "…but very sensitive to Oramorph."

D

A Yes.

Q "Fell off chair last night. Right hip shortened and internally rotated. Daughter aware and not happy."

That covers what you have already told us about.
A Yes.

E

Q "Plan X-ray."

Then Dr Barton raising the query:

> "Is this lady well enough for another surgical procedure?"

F

Just a query she was raising. Could you have been aware of that query she had?
A Yes. I think that would have been a relevant thing to ask of anyone who is elderly and frail and had only just had a surgical procedure, as to whether they were fit for a second procedure if it was necessary.

Q Because that was a problem which had to be seriously considered.
A Yes.

G

Q Are you in fact going to be causing more misery to the patient or are you going to be doing something which helps them.
A Yes.

Q Over the page, page 31, still the same day, Dr Barton's note, as it were, to Commander Spalding, saying:

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A "Further to our telephone conversation ..."

Obviously she has been on the phone to him:

> "Thank you for seeing this unfortunate lady who slipped from her chair and appears to have dislocated her right hip. An hemi-arthroplasty was done on 30th. I am sending X-rays across. She has had 7.5 mls of 10 mgs in 5 mls Oramorph at midday. Many thanks."

B

So obviously she had concluded that it was right for her to go back and see what could be done by way of any surgical procedure.

A Yes.

Q And we know of course that she was there for two to three days and returned to Daedalus on 17th.

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A Yes.

Q In terms of that return to Daedalus, this was the occasion when she had been brought back or placed in bed, whatever the mode of transfer was, in a way which had obviously caused her significant pain.

A Yes.

D

Q And obviously attempts were made to try to deal with that and this, we have heard, was a lady who was screaming when she was there at the hospital; do you remember that?

A Yes.

Q There is just a particular matter about which I need to ask you in connection with that, if I may. You had by this time been having a conversation with the daughters about the situation – one or other of them or both of them – is that right?

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A That is correct, yes.

Q They could see that she was in discomfort themselves, obviously, because they were there and it was apparent to anybody. You indicated that you had given pain relief – this is when you were speaking to the police about it – at one o'clock. Are you able to help us on the drug chart – it may be the best place to look – at page 63 – and I want to pick it up on the 17th – Oramorph at the top, do you see in the middle section of the columns?

F

A Yes, at 13.00.

Q So that is you, giving it and recording it in the usual way.

A Yes.

Q It has been suggested that you gave two injections directly into Mrs Richard's thigh in addition to doses of Oramorph; is that right or is that wrong? There is no record of it.

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A No, I did not do that; that is wrong.

Q Can you be confident that if you had given two injections directly into her thigh – those were the words that were used – that you most certainly would have recorded that?

A I could not have done that without a prescription to do that and there is no prescription for that.

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A

Q Thank you. That brings me on to something about which I wanted to ask you. At every turn, where we are talking about administering Oramorph or any morphine equivalent or indeed anything else like diamorphine – but let us stay with Oramorph and other forms of morphine – were there ever circumstances when you could administer such a drug without there being a prescription?

A No. A nurse cannot prescribe a controlled drug without a written prescription and that is not anything that I have ever done.

B

Q So we can effectively rule that out as something that occurred?

A Yes.

Q Thank you. I do not want to go into what may have been somewhat troubled past history, but can I ask you this: did you find with regard to Mrs Richards that she was a lady who obviously was very confused and could not communicate with the nursing staff at all?

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A Yes, that was my experience.

Q Her daughters indicated that they could understand or they knew what she was saying. Did you yourself ever witness or hear any communication when you were in the room with Mrs Richards and daughters – one or other or both of them? Did you ever hear her communicate with them?

A No, I did not; I did not personally experience that.

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Q Did you on occasion notice that there appeared to be a disparity between what the daughters were saying about Mrs Richards and what the other nursing staff had observed?

A Yes, sometimes that was the case.

Q I think you indicated in your statement made to the GMC that Mrs Richards was agitated and that in your professional view that was because she was in pain?

A Yes.

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Q Again, I am not concerned with the detail at all but did there at times seem to be something of a contradiction between what the daughters were saying about Mrs Richards – one daughter saying one thing and another daughter saying another?

A Yes, that was the case.

Q We can take it I think from what you have been telling us that you were doing your best to listen to their concerns and to deal with them?

F

A I spent a lot of time with both of Mrs Richards' daughters individually and together trying to communicate with them and help them and reassure them and answer their questions, as best I could.

Q In terms of the setting up and use of the syringe driver and the administration of the subcutaneous analgesia, is it the case that the daughters were aware of what treatment was being provided, the medication?

G

A Yes. One of Mrs Richards' daughters was a retired nurse, which obviously helped her understanding, but, yes, I felt they both understood explanations that were given to them by myself and colleagues, both nursing and medical colleagues.

Q Apart from the fact that they were understandably pretty unhappy about their mother's fall on 13th at Gosport War Memorial Hospital, did they ever complain to you about anything

H

A that was being done by way of the treatment that was being given to their mother, the medication?

A No, they did not.

Q If we can take up again Dr Barton's clinical notes, and we were at page 31, do you see that on 17th where she is dealing with the readmission – the date is a bit confused but we have been through that – she says towards the last line but one of that entry, "Only give Oramorph

B if in severe pain".

A Yes.

Q Did you follow that in terms of your dealing with this patient?

A Yes, we did.

Q "See daughter again", and the following day, 18th, the patient is still in great pain.

C Correct, so far as you are concerned?

A Yes.

Q "Nursing a problem. I suggest diamorphine, haloperidol, midazolam. I will see the daughters today. Please make comfortable."

Again, in accordance with what you can recollect of the history of this case?

D A Yes, that is correct.

Q It may not be that the daughters were both present at every moment but one or other daughter or both of them were made aware of what was going on?

A Yes.

Q The type of drug that was being administered?

E A Yes.

Q The reason?

A Yes.

Q And the possible course of events that might take place?

A Yes.

F

Q Did either of them ever say to you, or to any other member of staff in your presence, that they did not want that to happen?

A No.

Q Can we just move on to the contact record? We have already looked at large parts of this. Would you go on to page 47, please? We have looked more than once at the entries

G with regard to 17th but, looking at the bottom of the page, the entry for 18th, and I am sorry it is my mistake, is that in your handwriting?

A That is my handwriting.

Q I thought so. Thank you. This is the 18th:

"Reviewed by Dr Barton for pain control via syringe driver. Treatment discussed

H with both daughters."

A

A Yes.

Q That is your record of that having happened?
A Yes.

Q "They agree to the use of syringe driver to control pain to allow nursing care to be given."

B

You record at 11.45 syringe driver commenced. Over the page, still on 18th, is this right:

> "She was peaceful and sleeping, reacted to pain when being moved – this was pain in both legs. Daughter quite upset and angry about her mother's condition but appears to be happy that she is pain-free at present."

C

Now, that is not your note. Does that accord with your ---
A Can I check where I am looking? Am I on page 48?

Q I have moved on to 48. I think it is Nurse Joyce for 18th at 8 o'clock in the evening. You would not have been there at that time I suppose, or might you have been?
A Probably not if I was on in the morning; no I would not.

D

Q That has been recorded at that stage. Then on to 19th, when it appears you would have been back ---
A Yes.

Q The grandson had arrived, we can see nearly half-way down the page:

E

> "Grandson arrived in early hours of the morning. He would like to discuss grandmother's condition with someone – either Dr Barton or Philip Beed later today."

Later on that same day, 19th, in the morning, "Mrs Richards comfortable. Daughters seen. Unhappy with various aspects of care. Complaint to be handled officially by" – the nursing co-ordinator.
A Yes.

F

Q Did you actually see the grandson? I do not know whether I am testing your recollection too far?
A I did see the grandson. I cannot recollect what, if any, discussion I had with him. I think I remember him being there briefly and then leaving.

G

Q In any event, in any contact you had, either with these relatives or with other relatives, did you try to hide things from them or conceal things in any way?
A No, I would have no cause at all to do that. That would be unprofessional.

Q I think that is probably all I need to ask you about that patient. I am going to turn now to two others, and I can take them pretty briefly, and those are the two others you were asked about earlier on. Can I go, please, to Patient D, Alice Wilkie? Do you remember you were asked about that? Can we look, please, with her in her file at page 206?

H

A Yes.

A

Q We can see there a contact record sheet showing a note on 17 August, if you can pick it up at that point, in the morning:

"Condition has generally deteriorated over the weekend."

That is your handwriting?

B

A It is, yes.

Q At 7.45 in the evening:

"Daughter seen – aware that Mum's condition is worsening, agrees active treatment not appropriate and to use of syringe driver if Mrs Wilkie is in pain."

C

A Yes.

Q First of all, does that note record what happened?
A Yes.

Q Would it be right to say or to suggest, as has been suggested, that you on this occasion --- First of all I had better ask you this. Did you at any time --- I am going to interrupt my

D

own question and rephrase it again, I am sorry. I am looking at a transcript of certain things that have been said. Is it right that you had explained to the daughter that a syringe driver was going to be commenced?
A Looking at that, it looks like I discussed that option with the daughter so that it commenced if pain ---

Q It cannot mean anything else, can it?

E

A No.

Q Would that be your normal practice with a relative with whom you were in contact, to explain what you were doing and why?
A Yes, that would be the case in all aspects of patient care, to involve relatives and make sure they were informed and had the opportunity to ask questions and understand what was happening.

F

Q So it would be quite wrong to suggest that a syringe driver had never been mentioned or strong doses of pain relief?
A I would find that very surprising.

Q It has also been alleged by this same witness who observed that her mother, and this is not disputed, was very, very drowsy and unresponsive for a period of time before the syringe

G

driver was commenced. I do not mean for a matter of hours but over a period of more than one day.
A Right.

Q That is attributed by her to her mother being neglected – neglected by the nursing staff. What do you say to that?

H

A

A As far as I am aware that was not the case. We worked very hard on Daedalus ward to make sure that all patients received the necessary care and were looked after as best we possibly could.

Q We can see the next entry, which is four days later, 21 August:

B

"Condition deteriorating during morning. Daughter and granddaughters visited and stayed. Patient comfortable and pain free...."

– and then she died later on that same day. I would just like to pick this up. I think we have already dealt with you about the signing of the prescription chart for diamorphine and midazolam, page 145, and I do not think I need to trouble you with any further matters with regard to that patient. Lastly, please, we turn in this section of the matter to Patient L. Can we look please again at page 1309? We can see there on 21 May at 18.00 a note made about this patient. Is that your note?

C

A Yes, that is.

Q "Uncomfortable throughout afternoon despite 4-hourly Oramorph. Husband seen and care discussed. Very upset."

D

Again, I am sorry to ask you questions in this way but I must so that we can have it clearly from you. When you made these notes, were they accurate?

A Yes.

Q So you discussed her care with the husband. "He agreed", does that mean he agrees to commence syringe driver for pain relief?

A Yes.

E

Q So he knew what you were doing and why?

A Yes.

Q "...at equivalent dose to oral morphine with midazolam. [He is] aware of poor outlook but anxious that medication given should not shorten her life."

A Yes.

F

Q "Father David", who is a Roman Catholic priest, "asked to come and see Mrs Stevens". Is that right?

A Yes.

Q "Daughter, Jane Bailey, called in and informed of situation." Again, does that mean she was told what was happening and why?

G

A Yes.

Q Involving clearly the use of the syringe driver and the use of diamorphine and midazolam?

A Yes.

H

A

Q Again this is not said by way of criticism at all but did you find that some relatives were much better at understanding what you were talking about when you explained what it was you were using and why than others?
A Yes. People are all individual and some would have a greater degree of understanding and obviously a relative's level of anxiety and distress might have a bearing on their understanding of things.

B

Q Then it goes on, after she had been informed, "Message left for 2nd daughter, Carol" and I cannot read the name, at a particular holiday camp for her to contact the hospital.
A Yes.

Q So informing it seems all relevant relatives.
A Yes.

C

Q Then at 19.45 the syringe driver was commenced with that dosage of diamorphine and midazolam in 24 hours?
A Yes.

Q I am not going to go through all the totting up of the Oramorph again but what you were endeavouring to do in this particular case was to work out a direct equivalent?
A Yes.

D

Q To see whether that would control the pain?
A Yes.

Q How did you see it? Mr Beed, perhaps I can just ask you this. Was it your view, and say if you do not agree or you do not think you are qualified to answer, that the administration of subcutaneous diamorphine and midazolam, assuming it was given for proper reasons, might play any part in the decline of a patient in these sorts of circumstances because of their effect?

E

A Yes, they are both mediations which have a depressive effect on the respiratory centre, respiration, so they can affect the patient's decline as a side-effect of their use to control pain.

Q Again, can I ask you this generally? When the husband, Mr Stevens, in this particular case made the point he did not want her life shortened, was that something you always had in mind yourself in terms of the administration of the drugs? Obviously you are following the doctor's prescriptions but, in general terms, was that something you were conscious of, not as it were deliberately shortening the patient's life?

F

A Yes, we would have to be aware of the medication's side-effects, especially strong medication such as opiates and hypnotics, so you would be aware of that when you prescribed them and the overall effect on the patient.

G

Q Bearing in mind your experience and the gathering experience you got in the course of 1998 and 1999, from what you had learned, either by talking to people or your experience on the ward, if you had ever felt the doses that were being administered of diamorphine and midazolam were too high, can we take it you would have said something about it?
A Yes, we would have said something and we would not have administered a dose which we felt to be incorrect because that is part of the procedure for checking and administering medication, any medication.

H

A

MR LANGDALE: Sir, I think, and never trust a barrister when he says this, that is just about all I have to ask Mr Beed. If the Panel was going to take a break at some stage, I wonder if I might just use that time to see if there is anything else I needed to ask him. The alternative, depending on the Panel's wishes, is that Mr Kark re-examines and we then adjourn but I do not want to find myself having to come back with something else to provoke Mr Kark into some further re-examination. It might not; I do not know.

B

THE CHAIRMAN: It might assist us if were possible to have an indication from Mr Kark at this stage about how long he would expect to be in re-examination.

MR KARK: I have got a bit, I would have thought about 10 minutes, but I am also conscious that the witness has been in the witness box for about an hour and a half.

C

THE CHAIRMAN: Yes, indeed, and what is also attracting my attention is the large number of yellow post-its that are appearing on the panellists' papers, which indicates to me that there will be a fair amount of additional questioning from the Panel. As on the last occasion when faced with that situation, we find it very helpful to spend some time in private working out which questions will be asked and by whom so that we do not have duplication.

MR KARK: I am in the Panel's hands. I certainly could re-examine now but it is a matter

D

for the witness, and witnesses are not always very forthcoming in saying that they are tired.

THE CHAIRMAN: I agree. I think the witness in any event should have a beak now. Whilst he does so, the Panel may spend two or three minutes first of all just getting a sense of how much we will have. What I am leading up to is whether we are realistically going to be able to complete today or whether it would be better for us to finish with the questions from the Bar, as it were, and then resume with Panel questions on Monday. I know that would be

E

very inconvenient to the witness but it might be the only way to go until we have had a chance to discuss amongst ourselves. I cannot be sure how much we may have.

MR KARK: I know that Mr Beed was only warned for one day. Perhaps it could be checked with him through you, sir, whether he has further availability.

THE CHAIRMAN: If it were necessary for you to return on Monday, Mr Beed, I would

F

anticipate it would only be for the answering of questions from the Panel and any questions from the barristers that might arise out of the questions from the Panel. In other words, I would have thought it would be half a morning at most. Would that be something that would be possible for you?

A I had anticipated that possibility and I could, if required, do that, yes.

THE CHAIRMAN: That is most helpful. Thank you. What we will do now is rise for 15

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minutes, give you a chance in any event to have a break. The Panel will use part of that time to consider amongst ourselves where we think we are likely to be. Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Langdale, you had reserved your position.

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MR LANGDALE: Thank you for the opportunity. I have nothing further to ask at this stage.

THE CHAIRMAN: Thank you very much. Mr Kark?

Re-examined by MR KARK

Q Just going back again, please, to the file of Gladys Richards, file E, you were asked some questions by Mr Langdale about how patients would sometimes arrive and the previous hospital would suggest they were in a better state than you found them to be. With Gladys Richards, we have a note from Dr Barton at page 30, "Transfers with hoist".

B

A Yes.

Q Can you just explain what that actually means?
A It means we were using a ceiling-mounted hoist and sling to transfer Mrs Richards from a bed to a chair or bed to commode or vice versa.

C

Q This patient I think was certainly meant to be, according to the notes at page 210, in a straight knee splint. Would that affect how she had to be transferred? In other words, would that affect how much help she needed to get out of bed?
A I do not remember Mrs Richards being in a straight knee splint when she arrived on Daedalus.

D

Q Dealing with 17 August – that is what page 210 is dealing with – do you see "Treatment recommendations on discharge: to remain in straight knee splint for four weeks"?
A Yes. I can see that, but I do not remember there being one and I cannot think why you would be in a straight knee splint for hip surgery. It does not quite tally, I am afraid.

Q Is it possible that a patient who requires a hoist to transfer, to get out of bed, would nevertheless then, once she is out of bed, be able to bear her own weight on a zimmer with assistance?
A It might be possible, yes.

E

Q Page 188 was the better copy of the note that you had from the Hasler dated 10 August which indicated to you that she was admitted to E6 ward and:

F

> "She had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a zimmer frame."

I just want to have your evidence clear, as it were. Are you saying that you distrust that note, or are you saying that you accept the accuracy of that note at the time that she left the Hasler and came to you?
A I would accept that at Hasler, if that is what the staff say was happening, it was happening, but in our experience we would have to re-assess patients' mobility as appropriate and we often found it to be the case that patients' mobility had deteriorated during that period of transfer and it may be that it would take us a day or two to get them back to the point they were pre-transfer and that would have been the case with Mrs Richards.

G

Q Does the transfer time make a difference? If somebody is transferring from the Queen Alexandra, that is a rather longer journey, is it not?

H

A

A It probably does, but I think even a short transfer can be quite traumatic for elderly patients with complex pathology.

Q Did you have a zimmer available for Mrs Richards?
A Yes, we would have done.

Q And two nurses to help her get out of bed to use it?

B

A Yes, we would have done.

Q Did that ever happen?
A That would have been part of the assessment when she was admitted to the ward before we determined that we needed at that point to be using the hoist.

Q I understand that, but you have looked through the notes. Did it actually ever happen that she was got out of bed and walked?

C

A That would have been tried on admission.

Q Is there a note to that effect?
A I could not find one when I looked through the notes.

Q Page 41 is the Barthel score.

D

A Yes. That would have included assessing mobility and transfers.

Q How would mobility have been assessed?
A Given that the transfer letter said that the patient could transfer with two and zimmer frame, we would have attempted that the first time the patient required a transfer to see how we got on with it.

E

Q Apart from this Barthel index, would anybody have made a note of that event?
A It would not appear to have been done in the case of Mrs Richards, other than the Barthel record.

Q Dealing with the notes, I think you have accepted that the documentation was poor.
A Yes.

F

Q And you have accepted that there was no note of this patient's pain, justifying the Oromorph.
A Yes.

Q You were asked by Mr Langdale what would happen if you had found that diamorphine was being used to keep a patient quiet.
A Yes.

G

Q I think you said, but I might not have heard you properly, "We would have reported that person." Did you say that or did I misunderstand you?
A Well, it never occurred, so it is a hypothetical question, but if I had felt that was the case, then that would have been dealt with. I would have discussed that with a senior nurse manager so that it could be dealt with appropriately.

H

Q You also told Mr Langdale that there was good handover between teams.

A

A Yes.

Q Could I just ask you about the note making and the importance of note making? Is the reading of notes part of the transfer of a patient between teams?
A Notes could be used for reference when handing over between teams, yes.

Q Would they be an irrelevance, as it were, or would they be an important part of such a transfer?

B

A Yes. They would be useful in handing over and useful for looking back at the care that the patient received.

Q You say useful for looking back at the care the patient has received, so that you can keep an idea, as it were, in your mind as to whether the patient is improving or deteriorating.
A Yes.

C

Q So it is not only important for the handover between teams, but so that you know where the patient is in terms of their recuperation.
A Yes.

Q This is going back a little bit, but could you just go back to page 36? This is jolly difficult to read, I am afraid, but it is a note made on 11 August. Where would this note be made? Is this a Gosport War Memorial Hospital note?

D

A Yes. This is part of Mrs Richards' nursing notes at the War Memorial.

Q In the fifth line down, it says:

> "She has had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a zimmer frame."

E

Is that simply a reflection of what was in the transfer letter, or is this something that happened?
A Given that we know Mrs Richards to be hoisting and that that does not tally with the Barthel, I think that looks to me to be a transcript of what was written in the transfer letter.

Q You told us I think that if you felt it was appropriate, you would yourself challenge a prescription.

F

A Yes.

Q May I ask you this? In the time that you were there on Daedalus Ward, during the period that we are talking about, did you challenge any of Dr Barton's opiate prescriptions?
A No.

G

Q You also told us that the pharmacist would challenge any prescription that she felt was wrong. To your knowledge, did the pharmacist ever challenge an opiate prescription by Dr Barton?
A I cannot remember that ever happening.

Q Did you ever think that a dose should be reduced of opiates that Dr Barton had started?

H

A I cannot remember that happening.

A

Q You were asked about the Palliative Care Guidelines and you quite rightly pointed out that they were guidelines only.
A Yes.

Q Could you help us with this? To what extent would you be attempting to follow them?

B

A Guidelines would help in guiding care, but you also have to take into account patients' individual specific needs and make sure that the patient is receiving the right care. If the right care does not coincide with the guidelines, you have to weigh up the needs of the patient against the guidelines and make professional decisions as to what is appropriate.

Q That is exactly what I was going to go on to ask. If you are going to go outside the guidelines, do you have to take any particular care?

C

A Oh, absolutely, yes.

Q Because the sort of drugs that were being administered, the opiates that were being administered, could actually kill a patient, could they not?
A In high doses, yes.

Q You were also asked about the importance of keeping a patient pain-free, but

D

monitoring the level of consciousness.
A Yes.

Q Would it be important to keep a careful note of the level of consciousness once a syringe driver had been initiated?
A Yes, it would.

E

Q Did you to your recollection ever decrease the level of diamorphine as being too high because a patient had become unrousable?
A I cannot recall having done that.

Q You told Mr Langdale that Dr Barton was very easy to talk to and that she demonstrated sensible, professional judgment and that she found time to talk to relatives.
A Yes.

F

Q Can I just ask you this? Is that something that relatives had to request? We have heard, as you will appreciate, from a number of patients' relatives, some of whom never saw Dr Barton in the entire time that their relative was there. Is that something that a relative would have to request – "Could I have a meeting with Dr Barton?"
A It could happen in a number of ways. It might be a request from a relative or it might be a member of nursing staff saying, "It would be helpful if you saw this patient", or it might

G

be Dr Barton saying, "It would be helpful if I saw the relatives." So it could be in any of those three ways.

Q If a patient is near death, would that necessarily trigger a meeting with a relative, or not?
A Not necessarily.

H

A

Q In relation to Gladys Richards, you have told us now on a number of occasions that it was obvious to you that she was in pain.
A Yes.

Q Otherwise, you would not have started Oramorph.
A Yes.

B

Q Given that Dr Barton's assessment when she saw the patient was that there was no obvious pain and that the Hasler noted that she was weight-bearing and there was no note there of pain, did you consider that anything might have gone wrong with this patient's operation?
A That would be something that would be considered when assessing the patient's pain, yes.

C

Q If the patient is effectively pain-free when she arrives at your hospital, or appears to be, and then you think she is in significant enough pain to prescribe opiates to her, would you want to have examined what had gone wrong, or if anything had gone wrong?
A Yes. That would be part of the assessment of what sort of pain is the patient in and where is the pain.

Q How did you perform that assessment in this case? Other than prescribing Oramorph, what did you do?

D

A Looking at where the pain is, what the nature of the pain is and in particular looking at the site of the surgery to see whether anything looked abnormal there.

Q What did you conclude?
A That there was nothing abnormal with the hip at that time.

E

Q Did you record that?
A I cannot find it in the notes that you showed me.

Q But you remember that now, do you?
A Yes.

Q Are there any circumstances where an injection into the thigh directly might have helped? I appreciate you say you did not do it, but I just want to know.

F

A That could be a route of administering analgesia medication and could be prescribed that way, yes.

Q Directly into the joint?
A Not into the joint. You would give an intramuscular injection into the upper/outer quadrant of the thigh.

G

Q And that might be an effective way of relieving pain?
A Yes.

MR KARK: Thank you very much.

THE CHAIRMAN: Thank you, Mr Kark. The Panel took the opportunity in the break to compare notes, as it were, and to see how much work we felt we had to do together before we

H

A

would be in a position to put our questions. The view is that we would be keeping you here fairly late if we were to embark on that process now. So what we are proposing is this.

We will rise now. Individually we will be considering the issues that we wish to raise over the weekend. The Panel will come in earlier on Monday morning and we will have our own private discussions before we all sit formally. The normal starting time is 9.30. We think if we come in at nine o'clock, we will need a little longer than 9.30, so out of an abundance of caution, we are going to say a 9.45 start on Monday morning. That should cause the least disruption possible to the schedule whilst at the same time ensuring that the Panel have had adequate time to reflect on what their questions should be. So on that basis, unless there is any other business?

B

MR KARK: I think this is the first occasion we have had a witness go not only overnight, but over a weekend.

C

THE CHAIRMAN: Mr Beed, I should remind you that you are on oath now and you will be on oath when you return, so you are effectively in the middle of your evidence and it is absolutely essential that you talk to nobody about any aspect of this case, the evidence that you have given, the questions that you have been asked or what is likely to happen. You can have perfectly normal conversations with people otherwise, but please draw a line about this.

D

THE WITNESS: I understand.

THE CHAIRMAN: Very well; thank you very much indeed. We will see you back again, please, ready to start at 9.45 on Monday.

(The Panel adjourned until Monday 22 June 2009 at 9.45 a.m.)

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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 22 June 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TEN)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

INDEX

Page No.

PHILIP JAMES BEED, Continued

Questioned by THE PANEL	1
Further cross-examined by MR LANGDALE	29
Further re-examined by MR KARK	37

LYNN JOYCE BARRATT, Affirmed

Examined by MR KARK	46
Cross-examined by MR JENKINS	74
Re-examined by MR KARK	87

A

THE CHAIRMAN: Welcome back, everyone. Mr Kark, the Panel are now in a position to ask their questions if that is convenient to yourself. Very well.

PHILIP JAMES BEED, Continued

Mr Beed, I remind you that you are still on oath. We do not require you to take the oath each day. It just continues.

B

As you know, we are now going to the stage where members of the Panel have the opportunity to ask questions of you and, as you had anticipated, there will be a certain amount of that. We are going to begin with questions from Mr William Payne, who is a lay member of the Panel.

C

Questioned by THE PANEL

MR PAYNE: My microphone does not seem to be working.

THE LEGAL ASSESSOR: I am very sorry, ladies and gentlemen. We have a technical problem. That is a learning point for us: we shall see that every new day we will do a quick check of all the microphones before we call you back. In the circumstances we are going to have to break until IT can come in and fix the problem.

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Would you like to return to your various rooms. As soon as we are able to start, we shall let you know. I am very sorry, Mr Beed.

(The hearing was adjourned for a short time)

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THE CHAIRMAN: Welcome back, everyone. I am very sorry for that delay. Everything, I think, is now fixed. Mr Beed, I remind you that you remain on oath. We were just turning to Mr Payne who I mentioned is a lay member. We will see if everything works now. Mr Payne.

MR PAYNE: Good morning to you.
A Good morning.

F

Q I have a few questions. First of all, may I ask if this was your first management role?
A It was my first post as a ward manager, but my previous roles had had large management-type components to them.

Q Right.
A Do you want me to elaborate on that?

G

Q Not too much. Was it your first management role at this hospital?
A At this hospital, yes.

Q And had you transferred from outside of the area?
A I had previously worked in the area in the military hospital, and in a private hospital, and then I had gone up to Oxford to work and returned from Oxford to Gosport.

H

A

Q I remember you telling us that, but this was your first managerial role in this particular hospital?
A It was, yes.

Q You tell us that you had some previous experience working with elderly people, and you had some training before you took up your actual post. During that experience had you experienced the types of prescriptions that Dr Barton was prescribing, with this range of

B 20-200?
A No, I had not seen drugs with that wide a prescription range previously.

Q You never queried those? You told me that you had never queried those?
A No, I did not query those specifically. We had the pharmacist who looked at them and I was happy, understanding that that range meant that you started at or near the bottom of the range.

C

Q That was your understanding but not a direct instruction, for instance?
A No. I would realise. It is fairly self-evident.

Q Did you ever hear of anyone else who perhaps queried the types of prescriptions that were being made? Any of your staff?
A Certainly I can recall one of our staff who joined from another hospital commented on

D it, and it was part of the sort of discussion that nurses would have as part of induction and development. We came to the conclusion – I just said that. Okay, although it was a range of dose, you were actually looking at the bottom end of the range if a patient needed to start on that medication.

Q You had not previously seen this type of prescription and you had had one member of staff who had queried it?

E A Yes.

Q Who had come from outside of the area?
A Yes.

Q Who was not part and parcel of the Gosport War Memorial Hospitals psyche?
A That is correct, yes.

F

Q I want to explore with you the ward. You gave us a breakdown of the ward that you were on, and you said there were so many beds allocated. There were 24 beds. Eight beds were for ---?
A Eight beds were what we termed "slow-stream/rehabilitation".

Q Rehabilitation?

G A So people who had had very dense strokes. Initially in 1998 we had 16 beds which were titled "Elderly continuing care".

Q Which meant what?
A Which were elderly patients who had complex, multiple pathologies and were going to need a long time in hospital to make any sort of recovery.

H Q But no beds that were purely for palliative care then?

A

A No.

Q Of those beds, let me ask you about the eight for the stroke and rehabilitation.
A Yes.

Q Were the eight beds in two confined areas? The hospital near us has four beds in little rooms. I do not know if your hospital is the same. Were the eight beds in two of those little rooms?

B

A No. That was just how the beds were allocated numerically. We had four four-bedded bays, and the rest of the beds in single rooms, but patients could go in any of those beds. There was not a division for patients in different categories.

Q You would not walk into an area and know that all these patients are here for rehabilitation?

C

A No.

Q It could be the individual bed throughout the ward?
A Yes.

Q There is something else I want to touch on, but before I go on from that. I am trying to build up a structure of how I see the ward. How would a nurse know, coming on on shift perhaps on afternoons, what that particular patient was?

D

A I think we used different colours on our ward state boards to denote whether a patient was a stroke patient or a continuing care patient. But also it was in the hand-over that went from shift to shift of why a patient was with us, what was wrong with them and what care they have received and what care they needed to receive. Our ward hand-overs at change of each shift were quite comprehensive.

E

Q It would be in the patients' notes?
A It should be in the patients' notes as well.

Q Should be?
A Yes, yes.

Q You talked to us with regards to the amount of people on the ward, the nursing cover?

F

A Yes.

Q And you always tried to get two nurses per shift covering?
A Two qualified nurses.

Q Two qualified nurses. Were there times when you were not successful in that?
A Yes, there were a lot of times, quite often at weekends or at the end of a late shift in

G

the evening, when we would only have one qualified nurse on duty.

Q How would the distribution of controlled drugs be done there?
A The policy within the hospital was that if only one trained nurse was on duty, that qualified (sic) drugs could be checked by a support worker. However, what I would add is that if it was someone just starting on a controlled drug, we would actually ask a qualified nurse from another ward to come across and actually check that medication with us so that it

H

A was two nurses checking the drug. So whenever possible, we aimed for two nurses, but there was a provision for a nurse and a support worker to check.

You also said that if you could, to make up the nursing contingent that you wished for, you would use bank nurses?
A Yes.

B Q Would there be occasions then when you would have two bank nurses on one shift?
A As qualified nurses? As far as I can recall, certainly on the day shifts we always managed to have our own staff on. There were occasions on night duty when we would have a qualified bank nurse on duty.

Q So there could be occasions when there would be just one nurse, and that nurse could be a bank nurse?
C A At night, there could be. I cannot remember that happening on Daedalus during the day time, although I could not say that it did not ever happen. Usually we would swap shifts or juggle round, or someone would work a double shift to make sure that we had someone. You appreciate it makes a big difference knowing the ward and knowing the patients from bringing someone in from outside who does not know the patients.

Q Yes. I think that has answered those questions. Bear with me for a second please.
D (After a short pause) You talked about the notes accompanying a patient. I think you said that the notes would always accompany the patients – say they came from the Haslar or the other one.
A Queen Alexandra Hospital.

Q The notes would accompany the patients?
A Yes. They should come with the patient on transfer.

E

Q And I think you also said that they were there within 24 hours even if there they did not?
A If they did not accompany the patient, which sometimes happened, we would phone the ward and explain we needed them, and asked them to forward them as quickly as possible, and that would mean they would get to us some time the following morning.

F Q Who would see those notes?
A They would be looked at by the nurse admitting the patient and by the doctor clerking the patient and also by the consultant on the first ward round after the patient had been admitted.

Q I think this is a question for yourself. If you have a patient who comes in, the nursing notes accompany them from the other hospital. Then you have a prescription that allows the
G range from between 20 to 200. What was the effect if someone was opiate naïve and they gave them 200 mg straight away of diamorphine?
A That would have a seriously adverse effect on the patient.

Q And if they give them 80?
A I could not answer that in precise terms.

H Q Sorry, not of diamorphine, but if they did it with midazolam?

A A With midazolam?

Q Yes.
A If you started someone right at the top of a dose range, then I would expect that to have an adverse effect to the patient.

Q Can I ask you questions with regards to Patient E. You did say that you had ---
B A Patient E, did you say?

Q Yes. You did say that you had some memory of this particular patient?
A Yes, yes.

Q Page 188. That letter would have accompanied that patient?
A That is correct, yes.

C

Q I think you made some comments, some references, to other hospitals and what they perceived the patient's situation to be. Can you just remind me what you said?
A Yes. Very often would have reached a certain stage of recovery and rehabilitation prior to transfer. However, when the patient has arrived with us, we would often find that they were not at that level. I think part of that may well have been the actual act of transfer, which we know is traumatic and unsettling for patients. We would need to re-assess the
D patient, to find out what they were able to do and what their needs were.

Q Can I just stop you for a moment? You are actually saying it was the transfer of the patient, as opposed to the high expectations of the previous hospital?
A That would be the only thing. If the transferring hospital had stated the patient was doing something, such as mobilising with a zimmer frame, then I think it would be hard to think why they were not doing that now other than the transfer, because that is the only factor
E that has changed.

Q We had this patient's daughter give evidence. She said that she was there when her mother arrived at your hospital, and she was brought in in a wheelchair. This lady was, I think, 42 years as a nurse, made matron, specialised in working with older people, worked at nursing homes and she said that her assessment of her mother was the same as when she had seen her at the Haslar – what this accompanying letter more or less says, and how she
F found her. She was actually at the hospital before her mother got there and so had come into the hospital, saw the mobility that she had, and she was more or less, I think – I would have to check the actual transcript – but she was more or less in agreement with what they had said. Now, after that, Dr Barton assessed her, wrote out prescriptions immediately for Oramorph. Are you telling me that the deterioration would have been the transfer? The only thing that is wrong is the high expectation of the other hospital or the transfer?
A That is the only factor that I could see which would account for a deterioration in the
G patient's ability, yes.

Q You told us that morphine is only given to relieve pain?
A The management of pain, yes.

Q We have heard about the step situation where you start on step one, and move up to step ---?
H A Yes.

A

Q I want to suggest – is co-codamol step one?
A Yes.

Q And Oramorph would be step two?
A Yes.

B

Q So we have moved straight to step two on the entry to your hospital?
A Yes.

Q That is possibly caused by the transfer?
A Well, yes. A transfer is obviously has had an adverse effect on the patient.

Q You did say on Friday that on the ward there is the BNF?

C

A Yes.

Q There is a copy of that on it?
A Yes.

Q I do not know if you have this in front of you, but it is called C1. Is there one down there?

D

A No, I do not have it.

THE CHAIRMAN: That is Panel bundle number 1. If it is not with you, we will get it to you.

THE WITNESS: I do have it, thank you.

E

MR PAYNE: May I ask you to turn to it. Can you help me with this because, as the Chairman said to you, I am a lay member so I am trying to find out the process. Can I ask you to turn to tab 3? I think you will see the front cover is a photostat of the BNF.
A Yes.

Q If you turn to page 22 – let us see if we are both singing off the same hymn sheet – can you see if there is a conversion table from Oromorph ---?

F

A There is, yes.

Q Dr Barton started this patient on 11 August 1998 on 10 mg. Is that the dose? Looking at this chart, are these doses for adult patients?
A As far as I can see they are, yes.

Q Would you just turn to page 24. Perhaps you can help me with this. It says

G

"Guidelines":

"First always question whether a drug is indicated at all."

A Yes.

Q That is not necessarily a question for you – there is a question there but not for you.

H

This is prescribing for the elderly – you can see at the top?

A

A Yes.

Q

"Reduce Dose: Dosage should generally be substantially lower than for younger patients and it is common to start with about 50% of the adult dose."

Would that be 50 per cent of the adult dose to start with, for someone who has been on co-codamol the day before?

B

A No. That would not be 50 per cent of the dose.

Q And no one every questioned these doses?

A The doses we felt were being used were compatible with the level of the pain that the patient was experiencing, so when a drug is being administered you have to look at whether it is the right drug, the right patient, the right time and the right dose, so you would always look at the dose and in terms of who it was being used for and for what purpose.

C

Q For a layman it seems as though somebody has come in with co-codamol and they are straight on to 10 mgs of Oramorph and this is telling me that you should be starting at least 50 per cent and that is saying to me that that is quite high. In fact on the same day, on 11th, there is also a prescription for diamorphine with a dose range of 20 to 200 and midazolam of 20 mgs to 80 mgs and you never questioned this.

D

A I did not question the range of the dose because my understanding was that we were starting at the bottom of that range.

Q But these dosages are for normal adults similar to ourselves and not elderly patients. Can you tell me how long it takes before Oramorph starts to have an effect?

A That is not something I could answer off the top of my head at the moment, I am afraid.

E

Q Could be variable for different patients?

A Yes, it would be.

Q Would that be the same before it is through the patient's system?

A Oramorph is usually given four-hourly so its effect you would expect to wear off by four hours, but it would depend on how much pain the patient is in and various other factors.

F

Q One final question. I think you were asked about the statement "confirm death" that Dr Barton had occasions to write?

A Yes.

Q You did explain it and probably adequately and I may have missed it, but did you say that that was just an issue of custom and practice?

G

A Yes. The hospital was a community hospital so the patients were looked after by a team – nurses, doctors and therapists – but the people who were there round the clock were the nurses and out of hours there was limited access to medical staff. Because on occasions a patient's condition did change and deteriorate quite rapidly and the fact that a situation could change it was practice that was written in the notes of some patients. That then spared both the patients and the relatives the anguish of us having to call in a locum doctor, say over a weekend or in the early hours of the morning to see a patient they did not know when the patient had clearly deteriorated and the patient had died. The death still had to be certified by

H

A a doctor when they came on duty but I understand that it is common practice within community settings for nurses to be able to confirm that death has taken place and just acknowledge that in the notes. But it did not necessarily mean at the time it was written that there was an expectation that the patient was going to die; it was just a possible outcome.

Q How would a bank nurse on nights on her own know that?

A I would not expect a bank nurse on nights to know that. If we had a bank nurse on

B nights the handover they would have had would have been extremely clear; there was always an F grade senior staff nurse on night duty for the hospital who would have come across routinely to check how the bank nurse was and deal with any problems and overview things, and could have been called at any time should the bank nurse needs support and guidance. So it is not something a bank nurse would probably even come across or had to deal with.

MR PAYNE: Thank you very much for your help.

C

THE CHAIRMAN: The next member of the Panel is Mrs Pamela Mansell, who is also a lay member.

MRS MANSELL: Good morning Mr Beed. Can I go back to Mr Payne and some of the questions he was asking as well? You have talked about when you had a patient transferred to you that there was probably more of an optimistic note within the notes about the patient's

D condition; there was an assumption made that probably it was the transfer that had actually contributed to that. What was the dialogue or communication that was held with that hospital to indicate that there had been this change?

A As in feedback from us to them?

Q To them; or to try to clarify because here you have a patient's condition that does not seem the same – so not making assumptions. So how do you establish what was the dialogue

E with the other hospital?

A Usually once the patient was transferred to us we would take over care so if we had any particular queries about a patient then we would make contact with the ward to clarify things; but we were quite used to patients being transferred to us and not being at the same level that they had been at prior to coming to us. So it was more our practice to accept that as part of the transfer and work with the patient and their relative to try and settle the patient in and then bringing them back to the level they were at, rather than enter into a dialogue with a

F ward who had transferred and you would probably find that the nurse who had seen them last was probably off duty by the time they had come to us. But we could contact them if we had very specific queries, which we would do from time to time.

Q Did that not make it quite difficult for you, though, to just base it on assumptions that it is the transfer that had contributed to the deterioration?

A As well as the fact of that feeling that the transfer … There were other things that you

G could see with patients and relatives settling in and getting to know staff and orientating us to who they could call and what was happening. Often patients arrived and relatives arrived with us in varying degrees of anxiety and so you could actually observe the effect that the transfer had. You are used to looking after patients and picking up various clues as to both their mental and physical state. I do not think it was just an assumption, it was actually an observation based on nursing experience as to what was happening with the patient at that point in time.

H

A

Q So with Mrs Richards do we understand that there was no time with Mrs Richards that actually she was able to walk with a Zimmer frame and aided by two nurses?

A I was not involved in actually admitting Mrs Richards to the ward. But the handover from the staff, from what I recall, is that either she could not or her transfer with the Zimmer frame at that time is what I would term "unsafe" in that it placed both her and the nurses at risk. So initially we were hoisting and that was quite common for patients to be hoisted initially until we could get our physio to assess and look at how best to help the patient to become mobile again.

B

Q I will leave that one at that point then. Can I move on then? We have already talked about "happy to confirm death" and that is on page 30 in the notes here.

A Yes.

C

Q What was the influence on the staff of that sort of note being there?

A I think because we were used to it being there it was not something which – it would be wrong to say we took no notice of it, but we regarded it as it being there and that being part and parcel of the nurses' documentation, but it just signified to us that if a patient's condition changed at some point in the future we would not necessarily have to call in a locum doctor or a doctor who did not know the patient. I certainly did not regard it as an indication that the patient was likely to die at that point and I do not believe my colleagues did either.

D

Q To a lay person looking at this, we have a patient who is coming in for rehabilitation and at the very first point we are talking about happy for staff to confirm death.

A Yes.

Q That seems very incongruent.

E

A Yes; I can understand how that would appear to a lay person and of course I was viewing it through a professional's eyes but when you point that out to me I can see that a lay person looking at that may read that – in fact quite possibly would read that in a different way to the way I had read it as a professional; and there is certainly – possibly a lesson to be learnt in terms of how we write professional notes.

F

Q Because what would you perceive as some of the risks that may have been associated with that, that were there at the beginning?

A Sorry?

Q What would you perceive as some of the potential risks that could be there for you and your staff?

G

A With that statement? I would not have viewed it in that way because I understood the context in which it had been written. I suppose potentially – I was asked the question about if we had bank staff; but, as I said, bank staff usually would not have had cause to refer to the patient medical notes because all the information they would have needed would have been in the handover, and bank staff who did not know the patients in the wards, we would have made strenuous efforts to make sure that they were supported by regular staff who did know the ward and the hospital.

H

Q But I did understand you to say that there could be occasions when a bank staff member may be on the ward alone at night.

A

A Yes, but they would have got a very thorough handover and briefing from the nurse they were taking over from, and there would be a senior staff nurse who would have overall responsibility for all three wards and would come and support that nurse during the shift. So although they would be in charge of the ward and the patients there would be someone senior supporting them and giving them any help and guidance that they needed.

Q So it is your view then that there were sufficient safeguards in place?

B

A I feel so, yes. I can understand how that statement can appear but I did not feel at that time that it actually placed patients at risk in any way because it was written in a particular context and providing that that context was understood – and to my knowledge it was understood by all the nursing staff on the ward – then it did not create a risk; and it had a very specific meaning to it anyway.

Q That you felt was there and everybody understood that?

C

A Yes.

Q Let me move on. Can you tell us what you understand is the purpose of the medical notes, the purpose of the clinical notes, etcetera, because there is a range of different notes. So what is the purpose of those?

A Of the medical notes? Because they were pertinent to that patient they would contain everything that happened to them medically, not only during that admission but in previous

D

admissions and illnesses and outpatient consultations; also, old nursing notes and drug charts. So they were a point of reference for the problems that patients had had, the care that they had received and so on; and they would also contain medical information as to what needed to happen with the patient during their stay on the ward.

Q And the nursing notes?

A The nursing notes would have been kept in a separate file. In fact – I am trying to

E

think at that time – how we kept nursing notes changed over time, but they would certainly be in a file of nursing notes for the patient and a care plan either within that file or by the patient's bed; and they would be an assessment of the patient, their nursing problems, their needs – things like their Barthel and possibly their mental test score – and they would include care plans which would indicate the care that that patient needed, and a contact record where we would summarise the ongoing care that the patient was receiving on a shift by shift basis.

F

Q So in a nutshell the overall purpose of all those notes was to make sure that everyone was fully on board for the care plan and the treatment plan for that patient.

A Yes.

Q I have to say that I have looked through these notes with which we have been provided, and I cannot find the decision that was made that this patient was moving to palliative care. I understand from yourself, what you said previously is that palliative care

G

was the end of life.

A Yes.

Q But I cannot find in here when that assessment and that decision was actually made to move to palliative care. So are you aware of it being in the notes or could you help me to understand how that decision was actually made and communicated?

A I was asked to look through the notes on Friday and I would agree that there things

H

there that I would expect to be in the notes that I was not able to find. I can clearly remember

A Dr Barton seeing the patient and discussing with myself and with family what care the patient was to receive. The only thing I can say is that I think at that point in time we focused an awful lot of our attention on patient care and communicating with relatives and where we had limited time we compromised on patients' note keeping and that is something which, in retrospect, we should have paid far more attention to our note keeping, say.

Q But it is also how was a decision communicated to you? On what basis was a
B decision communicated to you that the assessment is now made and we are moving to palliative care? Because that meant nothing else got attended to – the haematoma or anything like that did not get addressed because we are no longer curing, keeping him until death.
A Yes.

Q So that is a big decision to be made.
A Yes.

C

Q I am not certain I am clear as to how that decision was actually made. I am clear as to how that was carried through with you but now how you knew that that decision was made.
A Without it being in the notes I can only remember from the verbal recollections that the patient had been seen by two of the out of hours doctors and then by Dr Barton as well as X-ray. So there would have been discussion on the ward as to what the plan was for the patient.

D

Q You take me back to what safeguards were actually in place to prevent too speedier moving to that position of care, because you have told me that your safeguards were your notes. So I am not certain at that point then what the safeguards were to prevent you moving to palliative care. You probably cannot answer that.
A I cannot answer that now, I am afraid; I am sorry.

E Q There is just a quickie that I would like to take up, following on from Mr Payne as well. When we actually look at the use of the Oramorph, what is the effect on a patient when it says in Dr Barton's notes "but very sensitive to Oramorph". Again, what are the implications of that for you?
A That Oramorph in this particular patient can have side effects, or the side effects would perhaps be a little bit more pronounced than in some patients.

F Q Sorry, the side effects?
A The side effects could be more pronounced than in some patients.

Q What can some of those side effects be?
A Oramorph can cause – the pain, side effects can be nausea, vomiting, drowsiness, confusion are some of the key ones.

G Q So it is quite a big step to go from co-proxamol, whatever it was, when this lady came in to actually moving on to the Oramorph?
A Yes, it is an increase in analgesia.

Q We are told about the deterioration in these patients from one hospital to another hospital. What contribution could the Oramorph have had on that?
A I think with a patient, if that deterioration was noted before the Oramorph was given
H and the patient was in pain, hence they were given Oramorph, yes, it is possible that if the

A dose was too strong, that could also have contributed towards the patient being more confused or nauseous or vomiting or more drowsy.

MRS MANSELL: Thank you. I think I will leave it there.

THE CHAIRMAN: Before we move on, this is for our visitors today. It is important that those who are here to observe the proceedings restrict themselves to just that. Although there

B have been no spoken words coming from the back of the room today, there have been clear visual comments made in body language, shaking of heads and so on. That is really not appropriate. It does not assist anybody and it is distracting for Panel members who will not take any other notice of it. If I can ask please that that stops now and does not continue.

We turn to Ms Joy Julien who is also a lay member of the Panel.

C MS JULIEN: My question is about how you assess the amount of pain a patient is in and we have heard that there is a lot of communication with relatives as regards decisions to be made about a patient's treatment and care.

A Yes.

Q I have not actually heard what role, if any, relatives play in terms of the assessment of pain, particularly patients who are unable to communicate or are unconscious. Could you

D elaborate on that?

A A relative's involvement in assessing pain?

Q Yes.

A As well as the things we would assess, we would want to know from relatives what is normal for that patient and whether they perceive them to be in pain and what they perceive that level to be. I think we would take into account the fact that the relatives probably, in

E some ways, know the patients better than we do as nursing staff.

Q Sorry if I can interject, does that happen all the time, at each stage you are assessing the amount of pain a patient may be in?

A I would expect it to if the relative was present and available, yes.

Q If the relative is not present and the patient is unable to communicate?

F A If a relative is not available and a patient is unable to communicate and the patient is clearly in pain, then the normal thing to do would be to want to do something to relieve that pain.

Q When you say the patient is clearly in pain; would that be based on your assessment?

A On a nursing assessment of the patient, yes.

G Q I think you did mention it. Perhaps you could reiterate, if a patient cannot communicate with you, how you are making that assessment.

A There would be a range of non-verbal clues. A patient who cannot speak may still make verbal noises, but also facial expression, agitation, body posture and that may change with nursing care to the patient. So actually moving a patient may have an effect on those things as well.

H Q Would you, having made an assessment, then consult relatives further down the line?

A Yes, certainly if a patient was needing regular analgesia or we were starting them on a stronger analgesic, it would be appropriate to bring that to the attention of the relatives at the earliest opportunity and if it was found that that was because of a change in the patient's condition, it would be normal to make contact with the relatives and maybe talk to them on the phone or even ask them to come into the hospital so they were aware of what was happening with the patient so they could be involved in the decision making and just put their minds at ease that things were being observed and dealt with appropriately.

Q What form would that communication take? If I were a relative, what would you be expecting from me?
A I would expect to talk to you about what I observed and what the plan was, and then allow you the opportunity to ask questions and discuss it and together come to a consensus on what is an appropriate course of action or treatment to deal with the problems.

Q So it would be a consensual arrangement?
A Yes.

Q If you felt my relative was in pain and I felt that she was not, how would you be able to resolve that? Would you be able to come to a resolution? How would you deal with that?
A I would hope so. I would want to have the relatives on board and yes, we would come to an agreement. I would be very reluctant to move forward with a course of action with which a relative was particularly unhappy about or not in agreement with.

Q What happens in those circumstances?
A I cannot think of a specific example of it happening, but I would aim to come to some sort of compromise that we would maybe review things or ask someone else to look at the situation, or try to find a course of treatment we could agree on and then review things at a later time.

Q Would a note be made of that discussion?
A I would expect to make a note, yes.

Q Of the nature of the discussion or the conclusion?
A The nature of the discussion and the conclusion.

Q So it would be noted that there was disagreement between you?
A Yes.

Q Has that appeared, or have you found when looking in the notes any examples of that?
A The notes we are looking at here, which I was asked to look at on Friday, I could not find that. I can think of other patients where I know that I have recorded things where we have not agreed, and in fact some of these cases were a learning experience for me.

Q Is it something you would expect to see in the notes?
A I would, yes.

Q In terms of priority, because I know you have said that sometimes you are busy and care needs to take priority.
A Yes.

A Q Would that be something you may not do immediately, but would aim to do as soon as possible? Would it be a high priority?
A Yes, it should be something that is done and I think in 1998 I can see now looking at the notes that that was not always the case, but yes it should be a high priority and should be done.

Q Slightly moving on but still related to that, you mentioned that relatives sometimes

B have unrealistic expectations. Would that mean that part of your role would involve or did it involve managing their expectations?
A Yes. Regularly patients would have arrived on Daedalus Ward with relatives thinking, or having the idea as far as we could establish that two or three weeks on Daedalus Ward and patients would be returning home. Quite clearly, even without the deterioration, without the defective transfer, the patient was going to need a longer period of rehab than that and it would be quite complicated. So part of the assessment and discussion with relatives

C would be around how long rehabilitation might take, what some of the problems might be and how we might deal with them, and often we found we were having to help patients and relatives come to terms with the fact that their stay on the ward was likely to be more complicated than they had envisaged from the information they had at the transferring hospital.

Q How did they take that information generally speaking?

D A I think it really varied, but if someone has an expectation of three weeks in a community hospital and they will be well enough for home, and then someone is telling them it might not be that, I think most people would be disappointed and might find that difficult to take on board. That would temper how you actually gave that information because you would not just say, "Actually it is going to be eight weeks" and so on. You need to be gentle with people and helpful and supportive with them.

E Q Did any of them complain about the difference in the information they had received?
A Sometimes they were not surprised at all, particularly with relatives of elderly patients who they knew had been having problems for some time, perhaps, but some were very surprised and were not happy that they were being told something different from what they either had been told or thought they had been told by the transferring hospital.

Q Again, is that something that would appear in the notes, the conversation regarding

F the expectations?
A Again, yes it should. Whether it always did I do not know and I am sure there are notes where that conversation or a good recording of that conversation probably was not there. It should be there, but I think there are probably cases where that conversation was not there.

MS JULIEN: Thank you very much.

G

DR SMITH: Good morning. Just some general points first. Dr Barton was the doctor who came pretty much every day, and you saw her, went round with her, I think you said, once or twice a week because of shift patterns.
A Yes.

Q Then other nurses would go around with her in the same frequency.

H A Yes.

A

Q How well did you know each other?
A Myself and Dr Barton?

Q Yes.
A I knew Dr Barton relatively well as the doctor managing the ward. Our relationship was limited to clinical manager and doctor, so I did not know Dr Barton outside that.

B

Q In a professional capacity?
A In a professional capacity I felt I knew her very well.

Q Would that be the same with the rest of the staff? That is to say, would the whole relationship be very much a team?
A Yes. I mean, many of the staff had been working on the ward for a much longer period than myself and knew Dr Barton very well, so I think we all felt we knew her professionally very well.

C

Q Would you say there was a mutual understanding of each other's points of view?
A Yes, I would.

Q The ward itself, we have heard before a description and Mr Payne took you into that. I just want to go a little e bit further into that because even though I am a doctor, I sometimes find some of the titles difficult to understand. I think I can understand "Slow stream/rehabilitation" – very disabled people you are trying to get into some kind of a state, not necessarily up and walking but some kind of a state.
A Yes.

D

Q What is "continuing care"? Can you try and help us with that?
A Yes. Continuing care in Gosport, Portsmouth was the title given for the care of elderly patients who had complex needs and were going to take a long time to make recovery and that recovery was expected to be limited. Probably in that category the patient may never be well enough to return home so they may need ongoing hospital, nursing home or rest home treatment, more likely nursing home. Or if they were to return home, they would probably need a very complex care package and these would be patients who were dependent with very restricted mobility and a range of other problems as well.

E

F

Q This was in 1996. I cannot really remember, but you were there, you were working in it. At that time were some of those patients permanently in hospital, would not go home?
A At the time I arrived on the ward in 1998, there were a small number of patients who had been on the ward for I believe 12 months or more. We were working towards getting them home or discharged, but it was not looking terribly hopeful for them because of the length and extent of their illness.

G

Q Nevertheless, the ethos of the ward was to do what you could for patients and then move them on to the most appropriate place.
A Yes.

Q In such a ward – again it has been gone over but I want to look at it from a slightly different angle – how was patient prognosis communicated? Who would decide what the prognosis is first?

H

A   A   Patients arriving with us would be for active treatment to improve them, but if things changed then that prognosis would be dealt with by either Dr Barton as our medical assistant doctor on the ward or by a consultant at the ward round. So it would be conveyed to nursing staff on duty who would then convey it to the rest of the team.

Q   So you have given us one flavour for active treatment. What other kinds of labels might be used?

B   A   I think if a patient's condition was deteriorating and they needed palliative care, then that would be conveyed from medical staff to nursing staff, and then to other members of the team.

Q   What kinds of words would be used? What kind of technical professional words would be used?

A   I am struggling to think, actually.

C

Q   Might you say, "End of life"?

A   "End of life" might be used, but also sometimes if a patient's condition was deteriorating, that they were to be kept comfortable and had to receive sufficient pain relief.

Q   It is passed on by word of mouth?

A   I would expect it to be in the notes, but also communicated verbally as well, yes.

D

Q   It should be in the notes?

A   Yes.

Q   We have heard and we have seen three statements. Dr Barton's statement, "I am happy for nurses to confirm death", written early or immediately on admission. Another one was, "keep comfortable", and another one was, "For TLC". Were all these three there as a

E   matter of custom and practice?

A   I believe they were, yes.

Q   Mrs Mansell said that a lay person might read it as something quite different. You said, "No, as a professional I take it to mean what we generally felt it to mean". I am a doctor, and I find it difficult to take a different view to Mrs Mansell. As a doctor I am fairly worried by a statement that a patient who has just come in, said to be mobile with a zimmer

F   frame and two nurses, can have their deaths confirmed. Can you explain what it is, the feeling in the team, that makes you comfortable with that statement, with the statement that Dr Barton has written in the notes?

A   At that point in time it was something that we would have been used to, so our understanding of it was as I explained, that it was something that was there and we understood it to mean that if things changed and the situation deteriorated. So yes.

G   Q   Had you ever seen it before in another hospital?

A   I had not worked in a community hospital before so that was not something I was familiar with.

Q   It could be misunderstood, could it not?

A   I would agree that it could be misunderstood, yes.

H   Q   By a bank nurse at night.

A It could have but I would not anticipate a bank nurse to be referring to the medical notes to direct them in patient care, and I come back to the fact that the bank nurses were well supported by a senior staff nurse as well as their handover from the nurse passing the shift on to them.

Q If a patient was in pain at night and the bank nurse referred to the admission note where the prognosis is written?
A I would expect them to refer to the senior staff nurse if they wanted to, if they were concerned about the patient.

Q These three statements are not a code that you all understood?
A No.

Q They are not a code?
A No.

Q For "We are not going to do anything more for this patient"?
A No.

Q You were pretty dogmatic that opiates were never given except to control pain?
A Yes.

Q You also said – and I think more than once – that once a syringe driver had started, the dose was never reduced?
A Yes.

Q Yes?
A Yes.

Q This rendered patients unconscious. At least in many of the patients that we are looking at this rendered these patients unconscious?
A Yes.

Q One of those patients rendered unconscious had pain from a haematoma in the hip. Would you agree that a haematoma in the hip is not a terminal condition?
A Yes, I do.

Q What is the objective of the syringe driver?
A The patient was not just in pain from the haematoma, but the patient's overall condition had deteriorated significantly as well as the fact they were in pain.

Q So it is not for pain?
A Pain was one of the symptoms that the patient was demonstrating, but there was also an overall deterioration in their condition.

Q Why not reduce the dose and see if the pain has gone away?
A I think the feeling at that time was that actually reducing the dose would cause the patient to be in pain when the dose was reduced.

Q Is that a reasonable professional view?

A That was certainly the view held amongst myself and my colleagues at that time.

Q That suggests, does it not, if you have a bad pain you are going to become unconscious and you are not going to come out of that. That could be suggested, could it not?
A I think it needs to be viewed in the context of the patient's overall condition, not just the pain they were in.

Q So a frail old lady gets severe pain – you are not going to reduce the dose and see if the pain has gone away?
A At that time with syringe drivers, it was considered that the dose would be continued and the patients monitored. In fact, in this case Mrs Richards was continuing to be in pain when we were delivering nursing care to her. That was the factor that was deciding whether that analgesic was finished. So when she was being turned or washed, even though she was unconscious, there were indicators that she was still in pain at that time.

Q And midazolam was added – a further sedative – and that was not reduced either?
A No.

Q And no hydration was given?
A No.

Q This is terminal care?
A Yes. I think the decision had been made at that point that the care Mrs Richards was received was palliative care.

Q And hyoscine – what does hyoscine do?
A Reduces secretions.

Q So if hyoscine is prescribed, if you like before the terminal state, before the very end, is that not anticipating that it is going to happen?
A Yes.

Q That death is near?
A Yes.

Q You said to Ms Julien that when a syringe driver was started you asked permission, and you elaborated on that that it was a consensual thing. You discussed and it was consensual?
A Yes.

Q Did you ask the relative's permission in an explicit way or was it always implicit?
A As far as I am aware it was always explicit.

Q She would say, "So is that all right" – having described what you are going to do, what might happen?
A Yes.

Q "Is that all right"?
A Yes.

A

Q Once the syringe driver was started the dose was never reduced?
A Yes.

Q So what would you do if a relative said, "But this is going to hasten his death/her death"? What would you say to that?
A I felt that the use of a syringe driver was keeping the patient comfortable. It was not my opinion that it was hastening death, but it was keeping the patient comfortable at a time when their death was anticipated. If they had that concern, I would have talked to them about it and the effects of the syringe driver. If there were real concerns, I did have the option of asking a more senior member of staff to come and review the situation and discuss things with relatives.

B

Q And the relative, the husband, says, "I do not want my wife to have something that will hasten her death". What do you say to that?
A That would be a cause for me, having talked to the relative, if we did not have consensus, it would be to ask the senior nurse to come and review and look at the situation.

C

Q But we know either that the husband was mistaken and never asked that, or that if he was not mistaken ---
A Sorry?

D

Q --- the senior nurse was not involved.
A You are talking about a particular ---

Q Maybe it was not a patient you were involved with.
A Right.

E

Q But in Mrs Richards' case her daughter says that she asked for the dose to be reduced so that she could speak to her mother and have some last words, so she could make some arrangements.
A I have no recollection of that being asked of me by Mrs Richards' daughter.

Q I may be mistaken in the specific, but in the general if somebody asked that what would your reaction be?

F

A I would be concerned about the patient being in pain if the dose was reduced, but I would be quite happy to discuss that with the relative and, as we discussed with starting analgesia, to look at the dose that the patient is on. If I was not happy, then I would actually ask a more senior nurse to come and look at the situation with me.

Q And that would be a normal situation?
A I have no recollection of any relative ever asking.

G

Q I apologise. If I have the specific wrong, I apologise.

A SPEAKER: Mr Farthing.

DR SMITH: Mr Farthing.
A Yes.

H

A

Q I do apologise.
A That was not on the ward that I worked on.

Q Nevertheless, to crystallise it, would you resist that, or would you go along with it?
A I certainly would have been. I would be happy to consider that. If that is what a relative was asking, it needs to be looked at very carefully and very properly, to make sure that between myself and the medical staff and the relatives, that we are making the right decision. It is hypothetical because I cannot recall it having been asking of me, but I think if it was asked of me, my view would probably be that I would be in agreement to do that and see what the outcome was because that situation could always be reviewed again and the dose increased if a patient became in pain. So yes, I cannot comment on what someone else has done, but what I do ---

B

Q I would not ask you to do that.
A --- in that situation would be to reduce the dose.

C

Q Just one other general point. We have heard that the pharmacist came once a week and the pharmacist would review the controlled drugs register?
A Yes.

Q But some patients might have died in the meantime. Would the pharmacist check over the prescriptions for a patient who had died?
A Probably not, because the patient would be no longer on the ward and the notes would have been sent away. So no, the pharmacist would have looked at the drug only for patients who were actually currently on the ward receiving treatment at that time.

D

Q Can you remind me, and certainly inform the lay members of the Panel, does the controlled drug register indicate the precise dose given each time?
A Yes, it does. It records the dose, the time it was given and the nurses who checked that prescription.

E

Q The pharmacist, in looking at the control drug book, would see what dose has been given?
A Yes, yes.

F

Q Without seeing the notes?
A Yes.

Q That is helpful. Finally, let us just move to Patient E, Mrs Richards. I think you have agreed that on her first admission, when she came – and this is when she came from Haslar walking with a frame plus two in Haslar – she was given what I think you conceded is quite a large dose of Oramorph, 10 mg?
A Yes.

G

Q And I think you conceded that that should perhaps have been 2.5 mg. You did not say that specifically, but would that be right?
A Sorry. Can I ---

Q Can we go back to the BNF?
A Yes, right.

H

A

Q A starter dose would be 5 mg in a so-called adult.
A 5 mg rather than 10 mg.

Q But for some strange reason elderly patients are not adults any more.
A Right.

B

Q Which worries me now. That would be reduced?
A Yes.

Q To 2.5. So 10 mg is a pretty big slug?
A Yes.

Q Then she was found on the floor?

C

A Yes.

Q Is that a surprise?
A In which context?

Q She has just had 10 mg of Oramorph?
A I could think of a number of reasons why she might have ended up on the floor. I do

D

not know that I would necessarily relate that to having the Oramorph, but it could perhaps, I agree, have been a factor.

Q You are an experienced nurse. If I gave you 10 mg of Oramorph now, what do you think you would feel like?
A It certainly would have a degree of sedative effect.

E

Q Would that be equivalent to a pretty good dose of alcohol?
A Possibly so, yes.

Q Just finally – and this is difficult. This is difficult. If somebody asked me this question, I would find it difficult to answer. I just wondered. I will just clarify if I can, crystallise, that statement that you made that the Wessex ladder is only a guideline. Just take us to that again. Just try and help us understand what you mean by that?

F

A It was a protocol and we subsequently did have a protocol in the hospital that would specify precisely what steps would be taken, and when, and you would usually adhere very rigidly to the protocol, where as the Wessex guidelines gave you a framework for what you would usually do for any given patient, but there is a degree of scope for operating outside those guidelines within certain situations.

Q What is the general rule if you break a guideline? What do you do?

G

A I would expect to have some clear documentation as to the reasons why you did not follow the guideline.

Q You would cover your back?
A So that you can refer back to it.

Q You would write it down?

H

A Yes, yes.

A

Q There are not any notes.
A No. I agree with that.

Q When I was a medical student I was taught if it is on the notes it did not happen. What do you say to that?
A I would agree that our documentation at this time did leave something to be desired in certain areas.

B

Q I am wondering how you defend actions afterwards ---
A Yes.

Q --- in an inquiry as serious as this if there are no notes.
A It makes it very difficult. All I can tell you is what my recollection is of things at that time, of decisions we made and why we made them, and things we did and why we did them.

C

Q You mentioned a protocol and a guideline. Can you take us to the protocol? Is it ---
A No, no. The protocol was introduced later on from 1998.

Q Right. It is this thing – Drug Therapy Guideline? That was later.
A Sorry – which?

D

Q It is in the big folder 1, behind tab 5. It is called the Portsmouth Hospitals Drug Therapy Guideline, 1998. I am just wondering if that is what you are telling us about? 1998 is when Mrs Richards was a patient in your care. It is behind tab 4.
A Yes , yes.

Q Is that it?
A No, no. That is not. Some time, I believe in 1999/2000, there was an analgesic protocol which particularly covered syringe drivers but also for analgesia which was introduced into the Department of Elderly Medicine, which included Daedalus and Dryad ward, but that was post the period we are talking about here. But that protocol was much more structured in the way that syringe drivers particularly were managed.

E

Q Do you think the Wessex handbook was in place in August 1998?
A We had the Wessex handbook in August 1998, yes.

F

Q Was any other protocol in place?
A Not that I was aware of. That protocol that I was talking about was developed specifically because of issues that had been highlighted with the difficulties that had been associated with syringe drivers.

G

Q Your only other guideline at that time was the BNF that was current?
A Yes, yes.

Q 1997?
A Yes, and advice from other colleagues that I was working with.

DR SMITH: Thank you very much.

H

A THE CHAIRMAN: Mr Beed, I am conscious of the fact that you have been giving evidence now for more than an hour and a quarter. We are down now to me as the final member of the Panel, but if you feel that you would need and would welcome a break now, I can ask questions of you later. If you prefer just to continue we can do that, but it is in your hands.

THE WITNESS: I am happy to continue, if that is what you would like to do.

B THE CHAIRMAN: Very well. We will attempt to do just that. I am the last of the lay members, and so you will have to bear with me on occasion, I think. My role really is to try to cover any matters that still remain outstanding, and generally to pull things together. It seems to me that the evidence that you have given to us today and last week is of a ward with staff functioning strongly as a team, trusting each other, having confidence in each other, getting on well with each other and, indeed, knowing each other. One clear area of weakness, you have candidly conceded, has been in paperwork and notes. I think if it was not before, it C is very clear to you now, the importance of good quality notes, not just for those involved in care at the time but for those such as us, coming in and taking a forensic approach to often very elderly notes. I am not going to say anything more about that, but there are a few areas that I might ask you some questions on.

First of all, there is the business of the notes that would have come over to the hospital when somebody was being transferred, for example, from Haslar. You have told us that those notes D would be seen by the admitting nurse, by the doctor clerking and probably by the consultant involved. Would any other nurses routinely see those documents?
A Certainly any member of nursing. They would be accessible to any member of nursing staff and the usual pattern would be for the admitting nurse to go through them and pull out the pertinent and key issues but if you had concerns or issues with the patient, and you needed to refer back, then it would be common practice to get the notes out and refer back to them if it was appropriate.

E

Q Certainly every one of your senior regular nurses would be aware of the fact that those documents were there and would be ale to refer to them as and when they wished?
A Yes.

Q The reason I ask is because we have heard from one such nurse that so far as she was aware, the only document that ever came over was the simple transfer letter, the referral F letter.
A Was this with Mrs Richards?

Q I am not talking about a specific patient; this was a general answer to a general question. Her response was, "No, all we got was this referral letter and that was why we often were not able to tell more about the patient's previous treatment."
A It was not uncommon for notes not to accompany the patient by mistake; but also in G 1998 Haslar, as a military hospital, was still using its own nursing notes – medical notes. They were subsequently merged into one department. So the practice for Haslar was that the notes came to us; the military notes, the Haslar notes remained until the consultant ward round and a consultant would then summarise the information and they would be returned. Staff at Haslar were not used to the principle that their notes had to accompany the patient when they came to Gosport. So if notes were going to be forgotten or missed for being sent with the patient that was a more common occurrence from Haslar than it was from Queen H Alexandra, which was actually part of the same department within the hospital system. So

A the notes did come but I think possibly with the time lag people are confusing the fact that there were instances where actually notes quite often did not come, it just was a letter and then we had to chase up the notes and get them at a later date.

Q Indeed, that was the evidence that you have given before; that if they did not come then you and your staff were assiduous in chasing them up.
A Yes.

B

Q It may not have any great significance but there would appear to be a difference in experience and understanding on this point as to the availability of notes between yourself as the ward manager and one of your senior nursing staff.
A Yes.

Q It is no more than that; it was just something that stood out. If we can look briefly at

C the transfer of patient E. This was a patient who came in on a low part of the ladder and promptly went on to opiates, and you indicated that in general the reason that this sort of change will usually occur is because of the effect of transfer, and even a short distance in transfer is still capable of having a very major effect on a patient – the confusion that can be involved and the distress of moving from a bed that they know to a bed that they do not and nurses that they do not know, and I am sure we all understand that very clearly.

D However, this specific patient was brought to your attention by Mrs Mansell, I think, because it was an occasion where, on the face of it, that would not appear to be the answer. You will recall she put to you that when the patient left Haslar she appeared to be in good condition and when she arrived her daughter was waiting for her and has given evidence that she was in pretty much the same condition on arrival as she had been on departure. Again, this is a case where the clerking doctor, Dr Barton, had also on admission noted that the patient was apparently pain free. Your own nursing staff later on also noted that the patient appeared not

E to be in pain.

So the usual reason for going up the ladder – the unfortunate and sometimes almost inevitable effect of transfer – does not appear to have been acting in this case. Is there any other reason that you are aware of from custom and procedure and your experience on that ward as to why that patient or such a patient would be nonetheless started on opiates?
A The only reason normally for starting on opiates would be pain. Why the patient's

F condition deteriorated between admission and the time they were started on the opiates at this point I cannot see what particular reason there would be for that, no.

Q Not only that, but there does not appear, does there, from the record to be any note of deterioration. From what we can see, both from what the daughter told us but also from what the notes tell us, there is a complete absence of any indication that there had been a deterioration before the start on Oramorph. You have no explanation?

G A No, other than that the patient clearly had deteriorated.

Q There is no reason why you should have. What is clear though is that once the Oramorph was started a deterioration did begin to manifest itself and you have conceded that although neither you nor any of your staff ever queried the starting doses the BNF does make very clear that the appropriate starting dose for this patient would have been two and a half milligrams, whereas in fact I think I am right in saying that she started on ten.

H A Yes.

A

Q So that is four times the appropriate dose. You were asked by Dr Smith what would be the effect starting you on ten – which I take to be the appropriate dose for a person in your health and age – you indicated that there certainly would be an effect.
A Yes.

Q Can I ask you to conjecture what four times that dose would do to you?
B
A The effect would be possibly increased.

Q Would it make it likely that, among other things, if you were to remain there having been given this dose you might fall off that chair?
A I would suppose it might be a possibility.

Q Would it be a reasonably foreseeable possibility?
C
A Yes.

Q We have also heard that putting somebody onto a dose of Oramorph may have a number of side effects and you have indicated that one of those might be confusion. Putting a patient on to four times the appropriate starting dose, how would that work for confusion? Would it be likely to result in confusion or not?
A Yes, that might well result in some confusion.
D

Q Of course, a confused patient is going to generate a reduced Barthel score, is that correct?
A Yes, that would be correct.

Q And a low Barthel score has what consequence within the way that your ward was operating at that time?
E
A Barthel was just an indicator of the patient's level of dependence or independence and was just used to guide nursing and medical staff and thereby aid staff in planning patients' care.

Q And it would be a useful indicator for those that have to make the unhappy decision to change somebody from continuing care to palliative care; would that be correct?
A No, it would not be used as an indicator for palliative care.
F

Q It would not be a part of the picture?
A No.

Q It would be irrelevant.
A We had lots of patients with a Barthel of one, two or even zero who I can remember remaining with us and actually being discharged; so no, I would not agree with that.
G

Q Thank you; that is very helpful. You have talked to us about the consensus on action that you and your colleagues routinely sought in a ward where there were patients' relatives available to consult. You said that you were not comfortable moving forward when a relative was not on board and that you would do what you could to bring a patient on board. As I understand it, that really means making it very clear to them what the true clinical position is.
A Yes.
H

A

Q So in the case of Jean Stevens, for example – Patient L, Jean Stevens – if I could ask you to look up page 1309, I think this was a patient in whose care you were involved.
A Yes.

B

Q We have a note on this page that the husband on the patient came and spoke to staff and he agreed to commence syringe driver for pain relief and he was aware of the poor outlook but he was anxious that medication should not shorten her life. What actions did you take to give effect to that caveat that had been placed on the permission given by the husband?
A We had explained, we had talked with the relative about his wife's condition and explained that the use of the syringe driver and the pain relief was principally aimed at controlling pain and keeping his wife comfortable, and that although the expected prognosis was that she would pass away, that the syringe driver was not altering the duration of that process but just making it more comfortable for her while it occurred.

C

Q That was not strictly speaking accurate, was it? Once you put her on that syringe driver with that combination of opiates you were not going to be in a position – because she would be unconscious – to keep her hydrated at that time.
A No.
Q So as a direct consequence of that dehydration her death would be hastened, would it not?

D

A Given her condition, even if she was not on a driver she would not have been receiving hydration at that time, so the hydration and the syringe driver I would regard as separate issues.

Q Let me understand that. If she were not on the syringe driver and was conscious she would not be receiving hydration.

E

A Unless she could take fluids orally and from the notes and my recollection this lady was very poorly and was taking either no or very little oral fluids.

Q That is something I am sure we can all look at individually at a later stage. But your recollection is that although conscious prior to going on to the syringe driver she was in effect not being hydrated.
A No.

F

Q You have indicated that you made it clear to the patient's relative that in effect once started on a syringe driver the patient was not going to come out of it.
A Correct.

Q And in your experience, once started on syringe driver in these circumstances with these doses of opiates patients did not come out of that.

G

A Not usually, no.

Q I think you told Dr Smith that that was an indication that the decision to move to palliative care had been taken ---
A Yes.

Q ... and indeed it was one of the actions of palliative care. You will have gathered form I think every member of the Panel that we have been struggling to understand from the

H

A notes where the decision to move to palliative care was taken and how it was evidenced. You made it very clear to us early in your evidence last week that that is the decision of the doctor and you made it clear that in this case or in the cases before us the doctor concerned would have been Dr Barton.

A Yes.

Q We have already discussed the importance of note taking and of recording key decisions. I am sure you have gone through all of these notes with the care that we have and it is right, is it, that there is no indication anywhere in the notes of a decision taken and noted by the doctor herself of "decision made; we now move to palliative care"?

A Is this in Mrs Steven's notes?

Q This is in Mrs Steven's case but we could widen it, if you like, to any of the cases on which you have had an opportunity to review notes.

A I think that would probably be a correct statement.

Q Would it also be true that in respect of all of those notes that there is nowhere recorded in terms, using those words, by any member of staff, "Decision taken; see change; we are now moving to palliative care with this patient." It is never expressly said, is it?

A I do not believe it is, no.

Q There was some questioning, particularly from Dr Smith, about the significance of certain phrases – phrases that of themselves might not seem particularly significant but which he asked might have significance to your staff as people who were members of the team and familiar with the custom and practice of that particular ward in that particular hospital. I think he asked you whether these were in effect a code. The first collection of words were the ones that appear beginning with the word "happy" – "happy for nursing staff to confirm death", and you were asked if that was a code and you said no because it did not necessarily mean that the patient would die.

We have heard evidence from one of your colleagues already and she was asked whether she could recollect any occasion – any occasion in her entire experience on that ward when a note reading "happy for nursing staff to confirm death", whether any patient had ever recovered and left the ward, and she was not able to recall a single one. Are you able to recall a single occasion when that happened?

A I would not be able to specifically say that I can recall that, but at the same time it would not surprise me to go back through notes of patients who are discharged and find that there because I am fairly confident that it was written on occasions when actually patients make good progress and actually it became an irrelevant comment which probably should no longer have been there in the notes.

Q What about the next phrase "patient to be kept comfortable". In your experience – you have already indicated that that was an indication of an end of life prognosis – once that appeared on a patient's notes were there ever patients who recovered and left the ward well?

A Again, I would have to look through notes to find ones. Yes, I would agree that it could be used to indicate that patients were entering a palliative stage and were to be kept comfortable; but it could also be used for patients who were very poorly and need to be kept comfortable but nevertheless would, once comfortable, stabilise and plateau and if not make a recovery then at least their condition would stabilise.

A

Q Rather dangerous, is it not, to have on a ward a system where a particular choice of words could mean palliative care, terminal, end of life or it could mean just what it says?
A Yes, I agree that that could be confusing.

Q But other than these key phrases we have not been able to find, as a Panel, any direct reference to palliative care; would it be fair to say that that just did not happen, it was never overtly recorded in records?

B

A I certainly know it was recorded in records but again I would need to go through notes of various patients to find it, and I would agree that it would be much better if it had been recorded to give us a clear indication of the type of care patients were receiving.

Q The phrase, "TLC" – tender, loving care – is in the same category, is it not? It could be interpreted as meaning just that, or it could be interpreted as meaning "End of life".
A Yes. I think "TLC" is very commonly used as an "End of life" term, not just in

C

Portsmouth but quite widely so. That is a term I had encountered before I came to work in Gosport.

Q Dr Smith asked you to tell the Panel how the change to palliative care would be conveyed to staff. In the absence of those phrases I have referred to, we as a Panel are struggling to see where this would have happened. It appears that you were too. In fact, that is the word you used. You said, "I am struggling" – I think the complete sentence was, "I am

D

struggling to think of ways in which that decision was conveyed".
A Right.

Q Yet it was conveyed as a matter of practice routinely, was it not, by definition? A large number of these patients were never going to be leaving alive simply by reason of the conditions they were suffering from.
A Yes.

E

Q But you were not, when the doctor asked you, able to think of the way in which this would have been conveyed to you.
A It would have been conveyed verbally. My understanding of "conveyed verbally to me", was that it would have to be clear and I would have sought clarification if it was not.

Q What the doctor said was, he put to you an example of a phrase, "End of life", and

F

you accepted that. You said, "Yes, that might be used", although that is a particular phrase that we certainly have not come across, so far as I am aware, in any of the records before us. It was then that he put to you another phrase, "Patient to be kept comfortable", and that was one to which you responded, "Yes". So the only phrases that are appearing repeatedly in these records are phrases that, with the exception of "Happy for nursing staff to confirm death", at the very least you do seem to accept are the sorts of phraseology that would be understood by your staff, routinely but not necessarily always, as meaning the change.

G

A Yes.

THE CHAIRMAN: I do not think I have any further questions. There is now the opportunity, I am afraid, for the barristers to come back and ask questions that arise from those asked by the Panel. Before I ask them to come back, you have now been giving evidence for a fair bit – you are coming up to one and three quarter hours – would you welcome a break now or would you wish to continue?

H

A A break now would be appreciated, thank you.

A

THE CHAIRMAN: We will return at quarter past twelve. Of course you need still to consider yourself on oath, in the middle of your evidence, and therefore you must not discuss this case with anyone.

(Short adjournment)

B

THE CHAIRMAN: Welcome back everyone. I hope that was sufficient for you to refresh yourself, Mr Beed. We are now going to turn to Mr Langdale and ask if he has any questions arising out of the questions asked by the Panel.

Further cross-examined by MR LANGDALE

C

MR LANGDALE: Mr Beed, I do have further questions arising out of what you have been asked this morning. I am going to try to avoid going over old ground, but some of it may be repetitious. Dealing with one matter you were asked about in terms of bank staff and the situation where there might be, although you try to avoid it, a lack of staffing resources meant there might be a bank nurse on duty at night alone on Daedalus. Right?
A Yes.

D

Q You were saying that there was always available a senior member of staff who could be consulted or seen by that nurse if necessary.
A Yes.

Q Is that somebody we think of as in effect a night sister covering the wards?
A It was an F Grade senior staff nurse who would be on duty on one of the other two wards but would also have responsibility for overseeing all three of the elderly care wards. So it would not be sister level but it would be senior staff nurse level and very experienced both in working terms and with working in the hospital.

E

Q So that is the person who would be available if some drama occurred or something completely out of the ordinary run of things.
A Yes, and not only be available but would routinely visit the two wards she was not covering to make sure that all was well and to anticipate any problems, if you like.

F

Q You were asked about the question of nursing staff confirming death – I may have to come back to that in a moment – but perhaps we can turn up in File 1, Tab 9, what are the guidelines from the Portsmouth Healthcare Trust with regard to community hospitals. Let us just remind ourselves what it says in the first part of that.

> "It is not the duty or responsibility of the Nurse to confirm a death when a Doctor can reasonably attend to do so, during daytime hours the patient's Doctor should be contacted and asked to certify the death immediately".

G

Correct?
A Yes.

Q "However in Small Hospitals" – is that what we are talking about in terms of the Gosport?

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A That would be Gosport War Memorial Hospital, yes.

A

Q "...without resident Doctors, where medical staff are on call for emergencies, during the night or at times when Doctors are unable to attend any qualified Nurse who is competent to do so, may verify death".

A Yes.

B

Q Was that occurrence something which did occur from time to time?
A Yes, because quite often patients would die, either during the night or during the weekend or even early in the evening, so yes, that was a quite regular occurrence.

Q What would the position be if a doctor had not indicated that he or she was happy for nursing staff to confirm death if that happened? A doctor would have to be summoned, would they?

C

A It would be normal to contact a doctor if a patient's condition was deteriorating so they would see them at that time, but if that had not occurred, then yes, if that had not been indicated by a doctor, we would have called a doctor even if it was out of hours.

Q You have already told us and told the Panel specifically that the fact that Dr Barton had written in the case of Gladys Richards, "I am happy for nursing staff to confirm death", was not a sort of signal or code to the effect that there was nothing more that could be done

D

for this patient.
A No, it was not.

Q I would like to look back with you, please, in the light of some of the questions that have been asked, at that note made on admission, back to page 30 of the file relating to Patient E. We must remember, of course, that this lady was suffering from dementia.
A Yes.

E

Q As Dr Barton recorded, "Frail, demented lady". We also have noted, "Not obviously in pain". Right?
A Yes.

Q "Please make comfortable. Transfer with hoist".

F

May I deal with that first? If this lady on admission, in the hands of the nursing staff, had been capable of moving from the wheelchair to the bed with the aid of a Zimmer frame, would that have been done?
A Yes.

Q What I am trying to get at is, would you have used a hoist unless you had satisfied yourselves that a hoist was necessary?

G

A We would not have used a hoist unless we felt it was necessary.

Q That indicates, obviously, that she had been, as it were, got into bed by the nursing staff before Dr Barton saw her. Correct?
A I could not say whether she was in bed or in a chair at that time.

Q "Transfer with hoist", what does that signify?

H

A That a patient either is not able to mobilise with a frame or that mobility is actually unsafe.

Q At what stage would the Barthel Score be established with this patient?
A That would usually have been done on admission.

Q If we look at page 41 in that same file, we see there that the total is, I think, 3. It is not a very good copy.
A It looks like 3, yes.

Q The date at the top is certainly the date of admission although it does not give a time.
A That is right.

Q Normally speaking that test would have been carried out before any medication or drugs were administered.
A Yes.

Q You told the Panel, when you gave evidence about this in answer to questions from Mr Kark, the gentleman across from me, that where Dr Barton had written, "Please make comfortable", you said it means what it says: make sure she is not in pain.
A Yes.

Q In the case of this patient, was that carrying any message or signal so far as you were aware, "Well, there is nothing more we can do for this patient", or anything like that?
A No, not with this patient.

Q You told us that in some cases you had known – please correct me if I am wrong – that "Please make comfortable" in relation to some patients in the circumstances in which they were, might be an indication that the palliative care routine was what was going to be done.
A Yes, that is correct.

Q In some patients, but not in the case of this patient.
A That is correct.

Q May we just deal with the administration of Oramorph. I know you have been asked about this more than once, but in the light of certain questions that have been asked I would like you to help us with certain things. We see that Dr Barton had noted, "Not obviously in pain", on the page we have just looked at.
A Yes.

Q If we go to page 63 we can see what she prescribed.
A Yes.

Q She says in the prescription note, which is an "as required" prescription, so it would depend on the judgment of the nursing staff as to whether it should be administered at any particular time, it says, "Oramorph".
A Yes, 10 gms in 5mls.

Q Then the dose underneath that is what?

A	A	It is 2.5 to 5 mls.

Q	We have, for me anyway, this ghastly business of translating millilitres and milligrams, but 2.5 mls would be what?
A	That would be 5 mgs.

Q	So 2.5 is the lowest dose, 5 mgs. Right?
B	A	Yes.

Q	Up to a maximum of what?
A	Up to 10 mgs.

Q	Looking at the dose, I want to make sure I am reading it right. The 2.5 --
A	It is 2.5 to 5 mls.
C

Q	To 5 mls. So turning it into milligrams, would be what?
A	It would be 5 to 10 mgs.

Q	Thinking about the physical side of it, as it were, the minimum dose, the 2.5 mls is about half a teaspoon, very roughly.
A	Yes.
D

Q	And obviously that is about the smallest quantity you can sensibly give of Oramorph, is it not?
A	We use a syringe or a medicine measuring pot to make sure we were giving the dose as accurately as possible.

Q	Obviously the 10 mgs would be the equivalent of a teaspoon full, more or less.
E	A	Yes.

Q	You have told the Panel already in your evidence, before you were asked any questions, that although it is not recorded, the patient obviously was in pain otherwise you would not have administered any Oramorph at all.
A	That is correct.

F	Q	And in sufficient pain to justify the administration of that opiate.
A	Yes.

Q	We can see that that was carried out by you at 2.15 in the afternoon. Right?
A	Correct.

Q	You were using the higher dose of the range.
G	A	Yes.

Q	Can we take it, although you may not be able to remember, that you did that for a reason?
A	Yes, I did.

Q	I want to ask you one further matter about Oramorph before I continue with the
H	history of it. You were asked about what the effect would be of 10 mgs of Oramorph on you,

A we hope a perfectly fit individual and all the rest of it, if you were asked to take it and what the effect might be. Is that something that is sensible to compare with what the effect would be on an elderly lady in pain, in sufficient pain to justify the administration of Oramorph, which is a rather different situation?

A Yes. It is not a terribly straightforward comparison, particularly given somebody being given a completely effective analgesia when someone is in pain is different to when somebody is not in pain.

B

Q That is what I wanted to ask you. Is this right, in general terms, that the pain of the patient is in a sense absorbing the effect of the opiate.

A Yes, that is correct.

Q Therefore is this right, that there is a greater tolerance?

A Yes, that is correct.

C

Q Is there any other way you would like to put it? I am putting it in layman's terms.

A When patients are in a great deal of pain they can receive quite strong doses of analgesia without it having any significant effect and Mrs Richards is not a good example, but people with cancer who are on strong doses of morphine still continue to drive cars, for example, quite safely, because it does not have the effect it would have on someone who was not in severe pain. I could not describe the pharmacology of that.

D

Q I am not going to ask you to. I think that will probably assist us with what the basic situation is. In other words, with a patient as this lady was, with dementia and all the rest of it, and in such pain that Oramorph was warranted, it is not the same as an opiate naïve perfectly well person, is it?

A That is correct.

E Q Perhaps I can just deal with one further thing about analgesia because you were asked some questions by the Panel, about the BNF. Perhaps you could go back to File 1, please. The relevant BNF extracts are at Tab 3 and I wonder if you would turn up, please, first of all page 22, which a member of the Panel asked you to look at and speak to. Looking at the equivalences, as they are described at the bottom part of the page, is the heading of that, just above the actual figures and columns,

F

> "Equivalent doses of morphine sulphate by mouth (as oral solution or standard tablets or as modified-release tablets) or of diamorphine hydrochloride by intramuscular inject or by subcutaneous infusion.
>
> These equivalences are approximate only and may need to be adjusted according to response."

G Is that something you were aware of?

A Yes.

Q Then we can see the oral morphine every 4 hours, every 12 hours and the diamorphine being administered either intramuscularly or by subcutaneous infusion, 4 hours and 24 hours. We have looked at the figures more than once. Would you just note, please, on page 19 of the same tab, there is a section half way down the left hand column headed "Pain". All right?

H A Yes.

A

Q

"Analgesics are more effective if started at the earliest stage in the development of pain that if used for the relief of established pain."

A Yes.

B

Q Is that something you were aware of?
A Yes, it is. Yes.

Q That is the case of Patient E, Gladys Richards, and still on page 63, the drug chart that we were looking at a moment or two ago, you were asked some questions about the effect of Oramorph in a slightly different sense. I would just like to look through the history of what happened with this lady. First dose of Oramorph, 2.15 is on the afternoon of the 11th?

C

A Yes.

Q Correct?
A Yes.

Q And although it is not you, the next date we have agreed, I think, should be 23.45?
A Yes.

D

Q In other words, in the evening, another 10?
A Yes.

Q That is all on the 11th. Then on the 12th at 6.15 in the morning, 10 mg - right?
A Yes.

E

Q And then no further Oramorph that day.
A Right.

Q And indeed the next administration of Oramorph is on the 13th at ten to nine, 20.50 hours in the evening?
A Yes.

F

Q You were asked about people falling off chairs and so on, in relation to Oramorph, and I would just like to see what the nursing care plan, and so on, and the history shows us with regard to that. Would you look back, please, to page 46.
A Yes.

Q On 13 August at one o'clock ---
A Yes.

G

Q It may not have been precisely when it happened but this lady was found on the floor?
A Yes.

Q Having apparently fallen off her chair?
A Yes.

H

A

Q If that timing is more or less right, that event took place nearly a day and a half after the last administration of Oramorph?
A Yes, it did.

Q In your view would any Oramorph that she had consumed in the period of time we looked at have had anything at all to do with her falling out of the chair?
A I would have expected the effect of the Oramorph to have worn off within four hours.

B

Q I think that follow from what you said to us earlier on.
A Yes.

Q We can see, just following that through in the note – we were just looking at it –

C

"Found on the floor, checked for injury ... none apparent at time. Hoisted into safer chair."

Then at 19.30, 7.30 in the evening:

"Pain [right] hip internally rotated."

D

Then Dr Brigg was contacted and he said, in effect, this must be x-rayed but the following morning?
A Yes.

Q And said she should have suitable analgesia during the night?
A Yes.

E

Q And that is exactly what happened, because we can see back on the drug chart on page 63 – is that right?
A Yes.

Q That night, at 20.50 hours on the 13th, she was given 10 mg?
A Yes.

F

Q Then on the 14th we can see the times and the other doses. I am not going to go through all that, and the Oramorph progressing when she comes back on the 17th and 18th. I am not going to go through the other records which are there in relation to this period of time in the nursing notes but we have already looked at those. I want to turn to just two more matters, I think, please, Mr Beed. You were asked to look at the notes with regard to Patient L, Jean Stevens. You remember the entry you looked at was in relation to her husband, indicating he did not want the opiates that were to be administered to shorten her life?
A Yes.

G

Q We can go back to it if necessary, but I do not think it will be. Is that an example of you having a discussion with a relative about the situation?
A Yes, it is.

Q And taking into account what the relative was saying?
A Yes, it is.

H

A

Q And obviously having to make a sensible decision in the light of that?
A Yes.

Q I would like to ask you about a situation which you were referred to or you were queried about, where a patient – perfectly properly in your view as a nurse – is having diamorphine and midazolam administered by means of syringe driver, subcutaneously. All right?

B

A Yes.

Q And a patient who is plainly, as it were, on the palliative care route?
A Yes.

Q And a relative says – I am not using the precise words but in effect says – "I want this relative of mine taken off the syringe driver so that they can recover consciousness fully enough to be able to speak to me." Who, in terms of the nursing or medical staff, would be the appropriate person to make that decision? To take a patient off subcutaneous analgesia in the sort of situation we are talking about in palliative care?

C

A Really it would need to be a medical decision ---

Q So if it came to it ---
A --- to stop the prescription.

D

Q If it came to it. I appreciate this is not a situation you have had to face.
A Yes.

Q But the proper course for the nurse would be to contact a doctor or, I suppose, a consultant?
A Yes.

E

Q Because it would be a medical decision?
A Yes.

Q As to whether that treatment should be stopped or not?
A As a nurse, the responsibility for giving medication is not only to make sure patients do not receive incorrect medication, but also to make sure that they do receive medication that has been prescribed for them, so a nurse, in stopping medication or not giving medication, would have to have very good reason for doing so and it would be appropriate to get medical advice on that as soon as practical.

F

Q Because the consequence if you do do that is the patient is going to be subjected to a return of pain?
A Yes. That would be the major concern.

G

Q The pain having been sufficient in the first place to justify the subcutaneous analgesia earlier.
A Yes.

Q One further question. I am sorry – I should have asked this slightly earlier. You were asked about the Oramorph dosage that was given to Gladys Richards the first time she had it administered to her by you on that afternoon, the 11th. She was apparently on transfer, and I

H

A

will remind you what the transfer letter says. You do not need to turn it up. She was, leaving aside anything else but in terms of opiates or analgesia, on co-codamol, two co-codamol, as required?

A Yes.

Q In what way would you take that into account in terms of making any kind of assessment and what sort of jump, 2.5 or 5.0 ml of Oramorph would be?

B

A You need to look at how regularly she had been receiving that, and whether it had been effective in controlling the pain.

Q Because co-codamol is a step one drug?

A Yes.

Q Yes?

C

A Yes.

Q The transfer letter does not appear to be indicating when she had last had any co-codamol?

A No.

Q And with a demented patient, it may be rather difficult to establish when on admission at Gosport?

D

A Yes. The only thing, we would have had to refer to the drug chart from the transferring hospital. That would be the only way to establish that.

Q Would that normally comes, or sometimes not come?

A It should come, but it is the factor I discussed earlier, and whether it had arrived with Mrs Richards, I would not be able to say.

E

Q I am afraid, to be frank, I have forgotten whether we have seen it, but I will not trouble with that. That is a factor you take into account if you were trying to work out a precise conversion?

A Yes.

MR LANGDALE: Thank you, Mr Beed. That is all I have to ask.

F

THE CHAIRMAN: Thank you, Mr Langdale. Mr Beed, it is now the turn of Mr Kark.

<u>Further re-examined by MR KARK</u>

Q I am probably going to be the last one asking you question, you will be relieved to know, but I cannot promise you. I want to go back to some of the questions that Mr Payne

G

asked you first of all. I want to ask you about verbal handovers because I think you have agreed already that the notes are not quite what they might have been?

A Yes. I agree to that.

Q Is that fair?

A Yes.

H

A

Q I just want to ask you about verbal handovers. You have, say, 18 to 20 patients on the ward generally?
A Yes.

Q You have night staff taking over from staff, and day staff taking over from night staff?
A Yes.

B

Q What does the handover actually do? Do you go and sit in a room and discuss each patient? Do you go round the beds? Do you just discuss the problem patients?
A Handover would take place in the ward office. It would be allocated, as long as it was needed, but typically it would be anywhere from 20 minutes to half an hour. If there was one trained nurse on duty, they would go through all the patients. If there were two, we would probably divide it up and talk about the patients we had had responsibility for for that shift, and we would go through every patient.

C

Q Right?
A And make sure they were clearly handed over to the next shift.

Q So you have an average of 18 patients from the ward?
A Yes.

D

Q Is that fair?
A Yes.

Q You would verbally discuss 18 patients, would you?
A Yes. Every patient would be handed over.

E

Q That is what I am trying to get out of you. When you say "every patient would be handed over"?
A Yes. We would discuss each of them individually and talk about the care that they were in with us, the care they have received, the care they needed to receive, and any specific issues and problems.

Q And would notes be being made or would they be relying on the notes that were already in the patient notes?

F

A The nursing notes should have been written up prior to the handover and then could be used during the handover, if necessary, to refer to, as well as nurses on shift would carry their own written copy of what they needed to know for that particular shift.

Q You are an experienced manager. You have been at these handovers presumably?
A Yes.

G

Q And you have had patients handed over to you?
A Yes.

Q Did you ever have any difficulty remembering which one of 18 patients had a particular problem?
A The practice among nurses is usually to keep a written note of all the handovers they get, so you would have the patient's take-over sheet, patient's name and you would jot down the important key things you needed to know to help you with that.

H

A

Q And those notes would be kept where?
A That would be my crib sheet for the shift, if you like, so that would be used for that shift, and then a new one on the next shift I came on. It would not be comprehensive. It would just say patient's name, fractured neck of femur and things I needed to know for the next seven to eight hours.

B

Q If there was any doubt about it, you would go to the nursing notes, would you?
A Yes.

Q And hope that they revealed what you needed to know?
A Yes.

Q You have mentioned bank staff. Mr Payne asked you about bank staff, but I do not really have a sense of how often bank staff were used. Are you able to help us at the relevant time?

C

A Quite regularly. Typically we would be filling gaps where support workers have gone off sick. Sickness rates amongst support workers were higher than rates amongst qualified staff. I could not tell you quite why. It would probably be not unusual for at least one or two shifts during the 24-hour period to have a bank support worker on. Qualified nurses less frequently – more importantly so on nights when there was only one qualified nurse on. Because it is difficult to get qualified bank nurses it would be more common if we were short of someone qualified. That someone would swap their shift or work a double shift.

D

Q Right.
A That would often arise if there were two nurses due to be on a shift. One of those nurses would end up swapping a shift, so would end up with only one qualified on when, as I said, two qualified nurses is a much more desirable situation.

E

Q Yes. I understand that. You might get a qualified nurse with a support worker. Did it ever happen you had a bank nurse and a bank support?
A I cannot remember that happening. If that was likely to happen, you would be more likely to bring a regular member of hospital staff across from another ward who would at least know the hospital, and may have worked on the ward previously. I cannot think of any occasion when none of the staff on the ward were familiar with the ward at all.

F

Q You might be bringing a nurse of from a different board to come and deal with patients who would be foreign to her, as it were, but she would know the ward at least?
A Yes, yes. I would anticipate that on any given shift, depending on which shift, the majority of staff would be regular staff who knew. We did have bank staff who actually worked regularly enough that actually they knew the ward as well as some of our part-time staff.

G

Q You were asked by Mr Payne again, I think, what the effect of giving an opiate-naïve patient – an elderly patient – 200 mg of diamorphine, and you used one of those expressions, "You would expect it to have an adverse effect". There are all sorts of adverse effects in life.
A Yes.

Q Are you able to say what you mean by an "adverse effect" in giving 200 mg to an elderly patient who had never had opiates before?

H

A

A I am not sure that I can really answer that question. I know that is the top of the dose range. It is a very high dose. I would expect it to have a severe effect. I have never experienced a patient being given that dose and I do not have the pharmacological knowledge to tell you exactly what effect it would have. It is quite obvious to me that a dose that high would have effects on a patient. Whether it would make them unconscious or semi-conscious or what it would actually do, I am afraid I could no more than hypothesise on that.

B

Q You were giving evidence about the stepped process, and Mr Payne put to you, and you accepted I think, that co-codamol would be step one, and then morphine would be step two?
A Yes.

Q Can I just take you to tab 4 of the Panel bundle 1, just to explore that with you for a moment. Would you go to the printed page 5 and it is page 6 of the internal numbering?

C

A Yes.

Q We actually have the analgesic ladder set out for us. If you look underneath the ladder, you can see a paragraph starting, "The WHO analgesic ladder has been adopted to emphasize that it is essential to use an analgesic which is appropriate to the severity of the pain;"

D

Then, underneath that, do you see the various steps?
A Yes.

Q Is this the same ladder that you were referring to when you were speaking to Mr Payne?
A No, that would not be because that is indicating co-proxamol and co-co-codamol to be in step two.

E

Q That is why I draw your attention to it. Which ladder are you referring to, which starts off with co-codamol? You have gone past paracetamol or aspirin or anything like that.
A Yes.

Q You have gone straight for the co-codamol, co-proxamol; what is that based on?
A I think I possibly misunderstood the question I was being asked. I thought

F

I was answering the question in co-codamol in relation to Oramorph.

Q I entirely understand that; that is why I want to clarify it with you. I understand that Oramorph comes after co-codamol, but does that make co-codamol step one on the analgesic ladder?
A No. Clearly co-codamol is step two on the analgesic ladder.

G

Q And you would start off, if it were appropriate, with aspirin or paracetamol?
A Depending on the level of pain the patient is in, yes.

Q Staying with that bundle, tab 3 – back to the BNFs, please – I want to ask for your assistance in relation to how these drugs actually come. If we go to page 9 – I do not think it really matters which version we use; this is the '97 version of BNF – we can see on the right hand side of the page, two-thirds of the way down, "Oramorph", which is a registered

H

trademark, apparently. Do you see that?

A

A Yes, I do.

Q It is described as an oral solution of morphine sulphate, ten milligrams in five mls. So what form does that come in? Is it a bottle, a phial?

A It comes in a bottle, usually in a 250 ml bottle.

Q So ten mgs in 5 mls is an indication of the concentration, is it?

B

A Yes.

Q Again, this may sound like a silly question but I want to have it absolutely clear. You can give any amount within that range, as it were, underneath 5 mls; so you can give 2.5 mls?

A Yes, you can.

Q You could give 2 mls, I suppose, until it gets to a point where it is almost ---

C

A I think one of the Wessex Guidelines suggests not giving odd figure doses ---

Q You are quite right, it does.

A ... to avoid confusion; so it is usually given in regular steps.

Q So are you saying that the lowest you would give of Oramorph of 2.5, or would it be normal to give less than that on occasions?

D

A I have never experienced a patient being given less than 2.5 mls.

Q So if you are going to start with Oramorph you are effectively going to be starting with 5 mgs of morphine?

A Yes.

Q You were asked by Mrs Mansell about the effect of transfer upon patients.

E

A Yes.

Q And you said that you were used to patients being transferred and coming to you in a – it is my précis but it is an "iller state", a more poorly state than when they left the previous hospital, and that, you say, is sometimes the effect of the transfer itself.

A Yes.

F

Q Did patients who came to you and who had suffered ill effects from the transfer sometimes recover and get back to where they were?

A Yes. The majority of patients, given a few days of recuperation, would recover.

Q So if a patient has suffered an adverse effect, as it were, from a transfer, would you normally give them a period of time to see how they recovered, as it were, or did not recover after the transfer?

G

A Yes, we would.

Q If you would just give me a moment because I am going to come on to Gladys Richards but I want to make sure that I have dealt with everything else first. (After a slight pause) Dr Smith asked you about the words "keep comfortable", "TLC" and "happy for nursing staff to confirm death".

A Yes.

H

A

Q You indicated, as I have understood it, that it was not an indication for palliative care for every patient.
A I did not regard it as that, no.

Q But in some cases it might be.
A Certainly the expression TLC is commonly used amongst nursing and medical staff to indicate palliative care.

B

Q Let us put TLC to one side for the moment. "Keep comfortable", let us concentrate on that; is that sometimes an indication of palliative care or not?
A Yes, sometimes it can be. I did not regard it as being that in this situation.

Q "Happy for nursing staff to confirm death"; is that in a different category or the same category?

C

A No, that was a different category; that was custom and practice within the ward that we were working on and was used to aid us if a patient's condition deteriorated out of hours. But it did not indicate palliative care.

Q Does that mean that you would expect to see that on every patient's form?
A No, what factors determined whether it was written I would not be able to say, but it certainly would not be on every patient but perhaps those who had multiple pathologies or who were particularly frail might have that written.

D

Q The decision obviously is not yours but that of, in this case, Dr Barton?
A Yes.

Q Leading on from that, we have also seen in one patient's notes from another hospital "not for resuscitation" or "not for 555"; do you know those expressions?

E

A I do know those expressions.

Q Let us start with TLC. If you see "for TLC" on a patient's notes and they then suffer a significant event would you read "for TLC" as meaning "not for resuscitation"?
A Yes, I would.

F

Q Would you read the words "keep comfortable" – if that patient then suffered a significant event would you regard that as being a signal for non-resuscitation?
A Yes, I would.

Q If you saw the words "happy for nursing staff to confirm death" and if that patient suffered a significant event would you regard that as a signal for non-resuscitation?
A Yes.

G

Q Still sticking to the general questions you told us – I think it was to Dr Smith – that there were no other guidelines of which you were aware at the time. I just want to draw your attention to tab 5 of the same bundle – and I am not going to test you on it, as it were, you will be relieved to know, but I just want to know of your state of knowledge about this document. Just have a look at it and see if it triggers any recollection. It seems to have been printed in 1998 and is entitled *Compendium of Drug Therapy Guidelines*. Did you know of the existence of this document and, if you did not, just please tell us?

H

A

A I cannot remember. You will appreciate that an organisation as bit as a Trust had a number of documents referring to all sorts of aspects of practice and whether I was aware of this in 1998 I honestly cannot remember at this point in time.

Q Then please put that away. I want to turn, if I may, to Patient E. Could we go to page 188 first of all? You were asked some questions – and I will not keep trying to record which panellist asked you these questions, although I think it was Ms Julien. At page 188 this is the transfer letter?

B

A Yes.

Q We can see that this patient is described as fully weight bearing and walking with the aid of two nurses and a Zimmer.

A Yes.

C

Q Can I ask you this in respect of that patient: once that patient is put on to Oramorph – as we know she was – would you make attempts when the patient is under the influence of that amount of Oramorph to walk them with a Zimmer?

A Yes, it would still be practical to try and in fact if a patient had severe pain and that pain was then controlled then it may well be that the patient is more mobile having had Oramorph than having not had Oramorph, but of course it does depend on the individual patient and the cause of the pain and various other factors as well.

D

Q Below that you will see the words:

> "Gladys is continent. When she becomes fidgety and agitated it means she wants the toilet."

A Yes.

E

Q If we go to Dr Barton's note at page 30 – and I am not going to read all the way through this, we are all getting pretty familiar with it – would you expect a nurse to read Dr Barton's note?

A Yes.

Q A nurse taking over the care of this patient the following day, say, on 11, 12 or 13, would they necessarily read the transfer letter?

F

A Probably not because they would have the handover from the nurses on the shift before to give them the information they needed.

Q How would you expect a nurse taking over from the previous shift to know that if Gladys got fidgety and agitated it meant that she wanted the toilet?

A We would include that in the handover.

G

Q Is that going to be part of the verbal ---

A That part of the verbal handover – that was quite a clear piece of information and that is one of those clear things that I would expect to be handed on from shift to shift as well as being in the nursing notes.

Q So when you hand over your 18 or 20 patients you would say, "This one, if she gets agitated means she needs the loo"?

H

A

A Absolutely; and that is not something that is untypical for a patient with dementia anyway, so it would be something we would expect and anticipate as qualified nurses and our experienced support workers as well.

Q Page 243 is the Haslar drug sheet and we can see that the patient was on I think co-codamol and haloperidol. Can you help us; I am just trying to see when that finished? The co-codamol this sheet certainly finished, I think on 7 August.

B

A That looks to be the case here, yes.

Q If a patient had remained on co-codamol what would be the signal to go up a stage to the next analgesic level?
A If the pain was not being managed by that analgesia.

Q Would that be a significant event?

C

A It probably would, yes.

Q Would you yourself normally make a note of that?
A Yes.

Q If we go to page 67, Mr Langdale pointed out to you that the Oramorph had stopped a good while before the patient had her fall. Is this your administration of the drug – page 67 of the E file?

D

A I have just haloperidol.

Q Who was giving that haloperidol; is that your initial?
A I do not think that is my initial.

Q I am sorry, I thought it was. Could you help us, was that given at one o'clock on 13th?

E

A It looks like it was given at one o'clock, yes.

Q 30 minutes before the patient is found on the floor; is that right?
A That would be according to the times given, yes.

Q I am not criticising the administration of that drug but does haloperidol sometimes have an effect on the coordination of the muscles?

F

A That I do not know, I am afraid.

Q Finally, can I turn to Mrs Stevens? I only have one matter about which I want to ask you. Please take up Patient L's file and there are two pages I want you to look at. The first is 1309. I think we were all having a bit of trouble making the conversion there. The second is 1342. Do you have that?
A Yes.

G

Q At 1309 we have the husband saying he does not want her life to be shortened.
A Yes.

Q Then we have this note,

> "Agreed to commence syringe driver for pain relief at equivalent dose to oral morphine with Midazolam".

H

A

A Yes.

Q The oral morphine she was on we can see at 1342. She had 15 mg the day before, on 20th. Is that right?
A Yes.

B

Q It is 5 mgs and then somebody changed it to millilitres but the essence is that she had 15 mgs and 5 mgs on the morning of the following day.
A Yes.

Q If we tot all of that up it would be 20 mgs.
A Yes.

C

MR LANGDALE: I am sorry to interrupt but you are talking about the previous 24 hours.

MR KARK: Yes. Have I got it wrong?

MR LANGDALE: I may be wrong, and I am even worse than Mr Kark is on the figures, but when you tot it up for the previous 24 hours to before 6 o'clock on 21st, I think it is 50 mgs in total.

D

A I think if I remember rightly there was another page where it was given four-hourly.

MR KARK: Because it was being given not as a PRN.
A Yes. There is page 1342 where it was on the PRN side and to make sure it was given regularly, on 21st, it was given as a regular four-hourly dose.

E

Q Thank you. And the effect of adding Midazolam to that, are you aware of the effects of adding Midazolam?
A Yes.

Q What would the effect be then?
A It is given to calm and relax the patient, but it would also have an additional sedative effect.

F

MR KARK: That is all I wish to ask.

THE CHAIRMAN: I think that really is the end. The Panel are very conscious of the stress and strains that coming before us can give rise to, and you have spent a considerable time answering questions from all of us. We are extremely grateful to you for the measured way in which you have stuck with us. You are now free to go with our thanks.

G

(The witness withdrew)

THE CHAIRMAN: I think we will break now, Mr Kark, and return in one hour.

MR KARK: Perhaps I can fill you in after then on the witness arrangements.

THE CHAIRMAN: We will return at 2.15.

H

A

(Luncheon adjournment)

THE CHAIRMAN: Welcome back everyone. Mr Kark, I have been asked by a Panel member whether there is any possibility of assistance from you in respect of two documents that are difficult to read in Bundle E. It may be that what we have is the best we can get, but if it is possible to improve on pages 41 and 43 that would be greatly appreciated.

B

MR KARK: Can I make sure what they are. Bundle E, page 41 is Gladys Richard's Barthel.

THE CHAIRMAN: Page 43 is a lifting/handling risk calculator form.

MR KARK: Can I ask Mr Fitzgerald to have a look at those? While we are looking at that bundle, I did make some copies earlier. If you go to page 64 it should be headed, "For nursing use only. Exceptions to prescribed orders". That is very difficult to read and I do have a better copy of that and was going to pass it round. It is not a document we have concentrated on.

C

THE CHAIRMAN: One never knows when an individual panellist reading alights on a particular page that no one has yet looked at.

MR KARK: So a new page 64 to replace the old version. (Document handed) We will see if we can do better on the other two documents.

D

THE CHAIRMAN: If you can it will be great. If not, we understand that not all the documents can be improved upon.

MR KARK: There is not a lot of point in my going through the whole witness schedule, but it may have become apparent rather as we imagine my patterning, once we got to the nurses that we are slipping behind. We will produce for you tomorrow a refreshed version but we are trying to change the order somewhat.

E

THE CHAIRMAN: I have to say that having reached Day 10 without slippage is something of a record anyway and you are to be congratulated for keeping us to it.

MR KARK: I think it was fairly obvious that we were going to get some slippage at this stage so we are just doing what we can. At the moment there may be a matter that I am going to have to raise in relation to one of the witnesses who wants to be anonymised, but I prefer to do that at the end of the day and get on with the evidence now. So may I please call Lynn Barratt?

F

MS LYNN JOYCE BARRATT, Affirmed
Examined by MR KARK

G

(Following introductions by the Chairman)

MR KARK: Is it Lynn Joyce Barratt?
A It is, yes.

Q I think you are a registered nurse.
A I am, yes.

H

A

Q Can you tell us a little bit, please, about your background and experience in nursing? When did you qualify?
A I qualified in November 1972. I then did two years ENT nursing. That was in Hull in Yorkshire. I left Hull and came down to Hampshire because I got married, and I worked at the Portsmouth Royal Hospital on the children's ward. I then left to have my family, my eldest son. When I went back to work it was in Plymouth and I worked on what they call the "Nurse Bank", which is just doing shifts as and when I am needed.

B

Q We have heard of that.
A I worked then on various specialities. I then came back from Plymouth to Gosport and I worked in the private sector in private nursing homes.

Q Can I stop you for a moment? I think in 1980 you were working for a company called the Thalassa Nursing Homes Group. Is that right?
A Yes.

C

Q How long did you work for them for?
A From 1982 to 1987 I think it was.

Q Then I think you started work at the South East Area Health Authority working in something called the Northcott Annex
A It was the Northcott Annex. It was an annex of the Gosport War Memorial Hospital.

D

Q Is that still there?
A No, it closed, and I moved over to the Redcliff Annex, which was another annex for elderly patients of the Gosport War Memorial.

E

Q The Redcliff Annex we know also closed and moved to the main building.
A Yes.

Q Tell us the sort of patients you were dealing with in the Redcliff Annex.
A We dealt mainly with what we called long-term elderly patients, which meant that they came into us and stayed with us for a long time and usually until they passed away. We also had shared care patients, which were patients that were looked after so many weeks at home and then they came into Redcliff to give families a rest.

F

Q Respite care.
A Yes, like respite care.

Q When you were working at the Redcliff, did Dr Barton begin working there?
A Yes, she did.

G

Q Were you already there when Dr Barton came in?
A Yes, I believe I was, yes.

Q Can you remember when the Redcliff Annex closed?
A I have got to be honest and say no, I cannot remember what year it closed.

H

A

Q By the time we are going to be dealing with, which is 1997-98 onwards, the Redcliff would have closed and the patients would have moved over.
A Yes, I believe it had.

Q When you moved to the Gosport War Memorial Hospital proper, the main building, did you move to a specific ward?
A Yes, I did.

B

Q Which ward was that?
A Dryad Ward.

Q Help us please with the sort of patients you had on Dryad Ward and how many beds you had?
A We had 20 beds. Initially we had patients again that were long term. They stayed with us for quite some time. We also again had respite care patients. We used to have occasionally patients that were what we would call "Slow stream rehab", but we were basically there to look after just the elderly patients really.

C

Q Was there much rehabilitation that took place on Dryad ward?
A Not an awful lot, no.

D

Q What seniority were you when you were on Dryad?
A I was a staff nurse.

Q Staff nurse? Forgive me for not knowing, but is that one below sister?
A No. That is two below sister.

E

Q That is two below sister?
A Yes.

Q There is a hierarchy in everything.
A Oh yes.

Q Above staff nurse is what?
A Senior staff nurse, and then sister.

F

Q Are you still working in nursing?
A No, no. I have had to retire because of ill health.

Q I ought to say, I think you have a medical condition. If at any stage you need a break or you need to stop, you only have to ask.
A Thank you.

G

Q We will allow a break, I am sure.
A Thank you.

Q Tell us a little bit about the staffing on Dryad ward please. Who was the sister in charge when you started?
A On Dryad it was Sister Hamblin. She was our day sister. Then there was a senior staff nurse. We had two or three senior staff nurses due to people leaving, and things like that.

H

A Then there were the staff nurses like myself. We also had enrolled nurses and we had healthcare support workers.

Q But the senior manager, as it were, for the nursing staff would have been Gill Hamblin?
A Sister Gill Hamblin, yes.

B Q How many beds did you have on Dryad ward?
A We had twenty.

Q Was that a mixture of patients?
A Yes.

Q Tell us a little bit about the layout of Dryad ward, please. What did you have there?
C A Let me think. As you went in the main ward door, to the left was a four-bedded unit. To the right were two single beds, two single rooms. Going on further down there was another two single rooms.

Q Is it a mixture of single rooms and four-bed wards?
A We had three four-bedded units and eight single beds.

D Q Apart from the nursing staff, can we just examine for a moment what other staff you had. Did you have any physiotherapists, either on the ward or who used to visit the ward?
A We had a physiotherapist that used to visit the ward but we did not have many physiotherapy hours available to us.

Q What about a pharmacist, because we are going to hear quite a lot about controlled drugs?
E A We had a pharmacist. I am trying to thing of the dates now. It was not until towards the end of my stay on Dryad that we used to get a pharmacist that actually came to the ward to check stocks and see what we needed. The nursing staff would check the cupboards to see what we needed and it would be ordered on a pharmacy form, put into a locked box, and it would be taken to the Queen Alexandra Hospital and then delivered back to us a little bit later on in the week.

F Q Just to give us an idea of timing, when did you finish on Dryad ward? When did you leave?
A I finished on Dryad, I think it was 1984. Sorry! 1994.

Q I think you are decade or more out.
A 1994. No – not 1994 either! What am I talking about?

G Q It is all right. Might it have been 2004?
A I completely finished in 2006 and I left Dryad 2004. Sorry about that.

Q When do you think the pharmacist started to come onto the ward? If you are unsure about dates, just say so.
A I would say a good couple of years.

H Q Before you left?

A Before I left.

Q You know that part of this case, at least, is examining the use of syringe drivers and diamorphine, and you were spoken to by police back in 2004, I think, so not part of the initial inquiry but the later part of the police inquiry. You made a number of statements to them – is that right?
A Yes.

Q And you were being asked questions. You were not being interviewed under caution, but you were being asked questions about the use of syringe drivers?
A Yes.

Q Yes?
A Yes.

Q And the extent to which diamorphine was used?
A Yes.

Q And more recently, I think, you gave evidence at the coroner's inquest?
A I did.

Q You were asked questions there, again about diamorphine and the extent to which syringe drivers were used?
A Yes.

Q Your view, I think, when you were asked questions about whether patients were being administered diamorphine in excess of their needs for pain relief was, in short, that that was rubbish?
A Yes.

Q Your view is that patients under your care were not being administered excessive amounts of diamorphine. Is that right?
A Yes.

Q Does it follow – I do not know – that you are saying that they were not put on syringe drivers unnecessarily?
A Oh, no. Most definitely not. No.

Q And so far as Dr Barton is concerned, I think you have described her as being used as a scapegoat?
A Yes, I did.

Q All right. I understand that. I want to ask you please about the use of diamorphine and syringe drivers?
A Uh-hum.

Q Having made your views clear. We know that syringe drivers were used on both Dryad ward and Daedalus ward?
A Yes.

A Q I want to ask you a bit about the authority for their use. All right? Dr Barton, we know, was prescribing variable doses?
A She was, yes.

Q So far as you are concerned, in order to administer a variable dose when it had been written out by Dr Barton what was needed? What more, if anything, was needed before a nurse could set up a syringe driver and insert it into a patient?
B A It had to be written on the drug chart.

Q Right?
A The dosage had to be written so that it was legible and clearly stated what the doctor wanted.

Q Yes. Who then would make the decision to use the syringe driver?
C A It was always done in conjunction with the staff, Dr Barton, and the family when possible. It was usually a big sort of conflab between everybody.

Q Could it happen, or did you ever begin a syringe driver on the basis of a prescription but not having discussed it with Dr Barton?
A No. No. It was always a doctor's decision to commence a syringe driver.

D Q In terms of the dosage that was used in that syringe driver, because we know they could be loaded up with various doses, whose decision was it as to the dose that was used?
A Dr Barton, or whoever the doctor was prescribing the syringe driver.

Q Let us just examine that for a moment. We know that Dr Barton wrote out variable doses?
A Uh-hum.

E

Q And there comes a point where there is a conflab, a discussion you say, and a decision is made to use a syringe driver on a particular patient?
A Yes.

Q Whose decision is as to the dose that goes into the syringe driver?
A The doctor.

F

Q If Dr Barton was not present what would be done?
A Another doctor would be called if. Dr Barton was not available then we would call whoever was on call for the ward at the time.

Q In your experience we know that Dr Barton was going along every week day?
A Yes.

G

Q Unless she was on leave or ---
A She used to come in in her own time as well.

Q She used to come in on her own time as well. So how often would she be coming into the ward?
A She came on a regular basis, Monday to Friday, once in the morning. It would then
H depend if we had new admissions coming in, she would come in again later on in the day and

A she very often used to pop in on her way home from surgery to see if there was anything that we needed or to check on patients.

Q We have heard that her GP surgery was not very far from the hospital?
A No, it was not. No.

Q Did you find it easy or difficult to get hold of her if you needed her?
B A Very easy.

Q Very easy?
A Very accommodating like that.

Q And if you needed her to attend the hospital – let us ignore week-ends and nights for the moment – but if you needed her to attend the hospital, did you ever have any difficulty in
C getting hold of her?
A No. We just used to ring the surgery and we would have a word with her, and she would tell us what time she was coming in.

Q What about the other GPs of her practice. How often did you use those? How often did you need to use those?
A Whenever Dr Barton was not available.
D

Q I have understood that.
A I know. It varies. Obviously if Dr Barton was away, then they used to take over her duties, but they did not do the morning rounds like Dr Barton used to do. We only got the doctors in when it was necessary.

Q If Dr Barton was working – so it is a weekday and she is not on holiday?
E A Yes.

Q How often would you have used one of the GPs in her practice?
A Only if it was after five o'clock in the evening when Dr Barton finished her duty.

Q Was that common, or a rarity? Can you put any ---?
A It was not rare. It was not every single day. Possibly maybe once or twice a week
F

Q Let me turn to the issue of increasing the dose after the decision had been made to use a syringe driver. After the decision had been made as to the initial dose, whose decision would it be to increase the dose?
A Dr Barton.

Q How would that work if she was not there?
G A We would ring her. Whoever was in charge of the ward at the time would ring her at the surgery, say we had some concerns. She would then come in and visit.

Q And would she actually have to come in, or could that be done over the telephone?
A Occasionally, very occasionally, she would give permission to increase it over the telephone but it would have to be done to two nurses and then she would come in personally to sign the drug chart. But it very rarely happened. She nearly always came into the ward.
H

A

Q What was your understanding of the rule or the guideline, or whatever you want to call it, as to the degree of increase?
A The dosage could only be increased fifty per cent in 24 hours.

Q And so if a patient is getting, say, just to keep the figures simple, 50 mg on day one ---?
A Yes.

B

Q --- you could increase up to 75 on day two?
A Up to, yes.

Q Up to?
A Up to.

C

Q Did it ever go beyond that?
A No. Not without good reason and permission.

Q Hydrating patients. We have heard some evidence in this case about hydrating evidence once a person has gone onto a syringe driver. Can I just ask you about your experience, please. Once a patient goes on to a syringe driver what is done about hydrating the patient or not hydrating the patient?

D

A Our normal procedure would be if the patient was unable to swallow, which is one of the big reasons that the syringe driver was usually started, then subcutaneous fluids would be introduced.

Q And how would they be introduced? Where would they be?
A Almost like the syringe driver, just by a little tiny needle under the skin in a fleshy area of the body.

E

Q What would be going into that?
A Normal saline usually – just to keep the patient hydrated.

Q Hold on. I just want to understand this. Did you ever do this yourself?
A Yes.

F

Q You did?
A Yes.

Q And you insert the needle where on the body?
A In the abdomen. Wherever there is a fleshy part because it just goes underneath the skin so that the fluid can go in slowly.

G

Q Was a decision ever taken not to hydrate a patient who is on a syringe driver?
A Not that I can remember, no.

Q So your recollection is, if a patient is put onto a syringe driver that you always hydrate them?
A The ones that I can remember, yes. Yes.

H

A Q Finally this, I think, before I move on to the individual patients: the analgesic ladder – I am not going to call it the Wessex guidelines because some people have heard of the Wessex guidelines and others have not heard of the Wessex guidelines – but have you heard of the analgesic ladder?
A Yes.

Q What is your understanding of how the analgesic ladder works?
B A The analgesic ladder is a series of steps of analgesia, starting with the very simple ones, something like paracetamol. The next step up is something with codeine in it and then up to the weak opioids and then up to things like diamorphine, which are the opioids.

Q What would it be that brought about the initiation of opioid analgesia to your mind?
A If the patient was not being settled on anything else that they were being given.

C Q What does that mean – the patient not being settled on them?
A When you are nursing a patient in pain, hopefully they are able to tell you if that pain is being settled by the analgesics that they are being given. If they cannot, then as nurses we have to observe what we call "non-verbal indicators". It is just the patient – if the patient is restless or grimacing when they are being moved. Anything out of the ordinary would be made a note of and passed on.

D Q Passed on to whom?
A Dr Barton, or whoever the doctor was.

Q Were opioid analgesics used in your experience to deal with anything other than pain?
A No. The syringe drivers and opioids that I used were for pain control.

Q So if a patient was agitated but it may have been for a reason other than pain, are you
E saying you would not use an opioid?
A No, I am not. Yes, I have used an opiate for agitate on doctor's instructions.

Q Right. In what circumstances? What sort of degree of agitation?
A Very severe agitation where there is nothing that we can do that can calm them down and other methods have been unsuccessful.

F Q Would you ever initiate a syringe driver in those circumstances?
A Syringe drivers can be used for other things than opiate, other than ---

Q Oh yes, I understand. I am sorry. You are quite right.
A If I had a patient that was very agitated and we could not settle them in any other than a syringe driver with a sedation may be used.

G Q You are quite right to pick me, but I meant really would you ever use a syringe driver with opioids?
A Oh, no.

Q To deal with agitation?
A No, not just agitation. No.

H

A

Q We are going to look at your dealings with a number of the patients that we have been dealing with. I am going to ask you on each occasion to indicate to us whether you can remember the patient. I think there is one patient you can remember, but not surprisingly perhaps, given the amount of time that has passed ---
A The others....

Q --- you do not remember ---

B

A No, I do not remember the others.

Q --- much about the others?
A No.

Q Then I am not going to ask you a huge amount about those, but could we start, please, with a patient called Leslie Pittock. To your left you will find some files. Can you take up

C

the file with an "A" printed on it. Just to help you, and to remind the Panel, this patient had been reviewed by Dr Lord, having been admitted to Mulberry Ward back in December 1995, reviewed by Dr Lord on 4 January 1996 and this patient was suffering from chronic depression and ulceration of his buttock and hip. Yes?
A Yes.

Q And he was admitted to Dryad ward, so your ward?

D

A Yes.

Q On 5 January 1996 and I think you were asked about this patient in the coroner's inquiry?
A Yes.

Q And you were asked about this patient by the police and is it fair to say you do not

E

recollect the patient?
A No.

Q There is no criticism of you for that. Can I ask you to go to page 209 of his notes? It is really to identify on occasion where you have made an entry. If you want to, you can look at the beginning of these nursing notes, if you go back to page 205 just to orientate yourself. Does the layout of this ring bells for you? Do you recognise this document?

F

A I recognise the documentation, yes.

Q I do not think you were the named nurse, were you, for this patient? If we look at page 205 is it Staff Nurse Rigg?
A Yes.

Q And the consultant is shown as Dr Tandy.

G

A Yes.

Q If we go to page 208, just to read ourselves back into these notes, the first entry is not made by you, it is made by is it Gill Shaw?
A Freda Shaw, Staff Nurse Freda Shaw.

H

A Q

"Transferred from Mulberry Ward at lunchtime. Appears to have settled well. Wife and daughter visited this afternoon. He has a sore on his right buttock which is being treated and similar on his left buttock. The skin on his scrotum is broken."

If we look to the bottom of that page, 15 January, we can see just above that Mr Pittock appeared to be distressed apparently and there were problems with the catheter.

B A Mm hmm.

Q Then we can see on 15 January that Dr Barton had commenced the use of a syringe driver.

A Mm hmm.

Q Prior to that we know that the patient had been on Oramorph.

C A Mm hmm.

Q And he was commenced on 15 January with the lowest dose that Dr Barton had prescribed, which was 80 mgs.

A Mm hmm.

Q Can I just ask you this: did you know anything about the conversion rate from oral

D morphine to subcutaneous morphine?

A To be perfectly honest with you, I would have done at the time; but now I cannot remember the ratios.

Q If you ever saw a prescription or a use of a drug that in your view contravened any of the basic guidelines, would you have done anything about that or would you have just administered it?

A Oh no, I would have said something at the time.

E

Q Can you remember ever challenging Dr Barton about her use of opiates?

A I cannot remember ever doing it but I am sure I would have done if I had felt it was necessary.

Q If we go to page 209, so the following page, do we see a note by you?

A Yes.

F

Q Is that on 16 January?

A Yes.

Q Can we just go to 13.00 hours, or is it the whole day?

A 13.00, yes.

G Q So it is half way down page 209. Can you read us your note, please?

A 13.00 hours:

"Previous driver dose discarded. Driver recharged with diamorphine 80 mgs, midazolam 60 mgs, hyoscine 400 micrograms and haloperidol 5 mgs given at a rate of 52 millimoles hourly. Visited by daughter (not Sister Wiles) who is now aware of poorly condition. All nursing care continued. Right ear found to be blistered along

H

A upper edge. Please nurse only on back and left side. Marking very easily. Please turn one and a half to two-hourly."

And it is signed by me.

Q After that it is not your note, I think.
A No.

B

Q But we can see:

"Condition remains poorly. All care continued. Syringe driver running satisfactorily."

A Mm hmm.

C

Q I think you previously made one note back on 9 January, which I am not going to bother with at the moment. But just dealing with this scenario here, you have come along to do what for this patient?
A To check the syringe driver and, if necessary, it looks as though I have changed it.

Q What would you be checking about it?
A Normally when a patient is being administered medication via a syringe driver we check the needle site; we check the driver to make sure that the fluid is actually going in. Just to make sure that everything is comfortable really for the patient. Then obviously if it is time for it to be changed to make sure that it is on time and changed at the time.

D

Q If the patient had been conscious or saying anything at this stage would you remember it or make a note about it?
A If the patient had spoken to me I would make a note of what was said.

E

Q Are you able to tell from this whether the patient was awake or unconscious?
A Not really. The only thing I can say is it looks as though he is obviously very poorly at this point because he was being turned on a very regular basis. His position was being changed on a very regular basis; so he was obviously unable to do it himself.

F

Q Can we go over the page, please, to page 210. We can see again at the top not your writing.
A No.

Q We may come across your writing later on.

"See by Dr Barton. Medication increased 09.25 as the patient remains tense and agitated. Chest very 'bubbly'."

G

Is 08.25 a time when you would expect Dr Barton to be coming round?
A Yes, she used to come round very early in the morning.

Q If we just cast our eye further down the page we can see that there is are various entries about further deterioration.
A Mm hmm.

H

A

Q Little change and poor condition on the night entry.
A Mm hmm.

Q Have you made the next note?
A Yes, it is me.

B

Q "Poorly condition. Continues to deteriorate. All nursing care given."
A Yes.

Q What does "continues to deteriorate" really mean in these circumstances?
A It means that his poorly condition was continuing to get worse; it was not getting better, it was getting worse.

C

Q How do you tell?
A The colour of the patient and how much more nursing care they required; how often the position was being changed.

Q The colour of the patient would indicate what to you?
A That the blood supply was not circulating properly.

D

Q What would you put that down to? If you just see this note what does that actually tell you?
A That the patient was dying – close to death, possibly.

Q Would you know from this note what was causing that?
A Not from reading just that, no.

E

Q How much of the previous notes would you read?
A Sorry?

Q When you come to perform a particular action, as you did with this patient, which was recharging the syringe driver by way of example, how much of the previous note would you read?
A We would read what had been written by everybody else.

F

Q Everybody else?
A Whenever you came on duty you would read what had been previously written, as well as having an oral handed over report.

Q I just want to know how much of it you would read. Would you read the last entry, the last couple of entries, all of the notes?
A If I had come on duty at, say, where it says here 14.30 hours, if I came on duty just before there I would read what had been done in the morning and possibly what had been said at night as well. Or maybe go even further back if I had not been on duty the previous day.

G

Q Would you ever take a decision to decrease the dose or increase the dose on your own?
A No.

H

A

Q We know that there was a change, as we can see at the top of the page, with the medication being increased.
A Mm hmm.

Q On this occasion that is being done by Dr Barton.
A Yes.

B

Q Should we take it that you would follow the medication that had been provided previously, unless ordered otherwise?
A Yes.

Q The sort of note that we have been looking at – when would you make that note?
A Something like changing a syringe driver or what I would call an important entry I would do at the time or very close to the time; but like a general overview of how the patient had been during the day I would take it from notes that I had made – because I used to carry a little pocket book and I would make general notes in that pocket book and then write the notes up before I went off duty.

C

Q So not necessarily made immediately at the time, but made ---
A Things like changing syringe drivers and doctors' visits and things like that were normally written at the time or very close to the time. I am not saying that it happened every single time but we used to like to try and do those things as close to the time as possible.

D

Q Could you go over the page again, and if we look on 19 January, do we see an entry of yours at 15.00 hours? Sorry, there is one at the top as well.
A There is one right at the top as well, yes.

E

Q "Wife has visited for most of the day. Appears comfortable in between attention. Oral suction given with some effect."
A Mm hmm.

Q So that would be a note relating to 18 January; is that right?
A Yes, because it carries on from where I have left off.

F

Q Then 19 January:

"Marked deterioration in already poorly condition ..."

This is not your note, is it?
A Yes, it is.

G

Q It is your note?
A It is my writing, yes.

Q You have not signed it?
A No, because it goes further down. It goes from there (indicating) to half way down the page.

H

Q Thank you very much. So:

A

"Marked deterioration in already poorly condition. All nursing care continued. Position changed strictly two-hourly. All pressure areas intact except for small discoloured area at the base of the big toe."

A Yes.

Q What is the next word?

A "Mouth care performed at each position change."

B

Q "Breathing very intermittent. Colour poor."

A Mm hmm.

Q For whatever reason I suppose that the note is obvious in what it means – breathing very intermittent?

A Yes. Very intermittent, and it is shallow usually.

C

Q And pausing for a period between each breath.

A Yes.

Q Then we can see that you recharge the syringe driver.

A Mm hmm.

D

Q With 120 mgs of diamorphine and 80 mgs midazolam and then we can see a note about Mrs Pittock.

A Yes.

Q Does that finish your note?

A It does, yes.

E

Q The next note we see on 20 January, I do not think that is yours.

A No.

Q But we can see that there was a verbal order taken to double Nozinan and stop haloperidol.

A Yes.

F

Q Just in relation to that, was that the sort of thing that would occur from time to time?

A Occasionally, yes.

Q But Dr Brigg would have telephoned in.

A Yes.

Q And then as we have heard from him, visited later.

G

A Yes.

Q Again, if we go over the page to 212 I think you have made a further note. Is it your note on 22 January.

A Yes, it looks like my writing.

Q Can you just read it for us?

H

A A "Poorly but very peaceful. All care given today. Daughters have visited and spoken to Sister Hamblin. At 15.50 driver recharged with diamorphine 120 mgs, midazolam 80 mgs, hyoscine 1,200 micrograms and Nozinan 100 mgs at a rate of 43 millimoles hourly."

Signed by me.

B Q "Poorly but very peaceful", would that indicate that the patient was unconscious?
A Yes, usually; not always but usually.

Q And "poorly" in the way that you have described – skin, colour, breathing.
A Yes.

Q I think that is the last note that you have made in relation to this patient.
C A Yes.

Q We have seen with this patient that there was an increase in the diamorphine.
A Mm hmm.

Q And you told us that in your experience, did you say that it was very rare to increase by more than 50 per cent?
D A Yes.

Q Did you ever know it to happen?
A Not in my experience, no.

Q If it had happened is that something you think you would have challenged, or not?
A I would have asked why.

E

Q In any event with this patient any decisions to increase were not yours?
A No.

Q We can put bundle A away. You have made a statement about Patient C and I hope my learned friends will not object if I just deal with one or two brief entries that I want you to help us with. If you take up the bundle for Patient C.

F

THE CHAIRMAN: That is the one where the bundle has still not been distributed, so I suspect it will not be at the witness's table either.

MR KARK: Sir, I am sorry; I thought that they had all been distributed.

THE CHAIRMAN: It was the only one and the reason it was not distributed because you
G were still waiting.

MR KARK: I hope it has been sorted out.

THE CHAIRMAN: Mr Kark, the witness has been up for just about an hour now; perhaps whilst we are sorting this out it would be a convenient moment for a break.

H

A (To the witness) We have a little break whilst a file is found and it has to be given to everybody else as well. So we are going to take a break now for 15 minutes, which should give you the opportunity to get a little refreshment, and our Panel assistant will assist you now.

(The Panel adjourned for a short time)

B THE CHAIRMAN: Welcome back everyone. Mr Kark, we have now received into evidence Bundle C. We previously agreed that it would be marked Exhibit C4, so perhaps everybody could mark it. May I ask if the bundle is now complete or if there is more to come?

MR KARK: It should be complete.

THE CHAIRMAN: I know, for example, that in common with others it does not have a
C death certificate.

MR KARK: That is correct. We have been trying to get the death certificate. We have asked the police for their help but they have not been forthcoming. Mr Jenkins on Mr Langdale's side may be more successful than we were but we will continue trying.

THE CHAIRMAN: Given that we are mid-witness, as it were, I am not going to ask that we
D take what has become our customary course of acquainting ourselves with the contents first, but perhaps you would bear in mind that this is a first hand viewing. That would be helpful.

MR KARK: I will. In fact there are very few documents that I am going to refer to. Can I also mention something else in relation to timing? Because this witness was not expecting to be here tomorrow – I do not want to embarrass the witness – we have had to arrange for a prescription for her, but she will have to pick that up this evening.
E A Sarah is picking it up for me.

MR KARK: Hopefully we will be able to get that. The representative of my instructing solicitor is going to deal with that now so if there are any problems we will find out in good time, in case we have to rise early.

THE CHAIRMAN: We are most grateful to you for being here today and do apologise that
F we have not been able to get to you as soon as we would have liked.
A These things happen.

MR KARK: We were about to turn to Patient C and we can do it relatively shortly. Patient C, if we go to the chronology at the beginning, was admitted to the Queen Alexandra Hospital following a collapse. Then she was in fact discharged back to the residential home in which she was living. In 1998 she was readmitted to the QAH on 6 February 1998, and
G this was with a diagnosis including,

"probable carcinoma of the bronchus and depression".

Then we see that on 19 February 1998 she was transferred to Charles Ward under Dr Lord, and on 27 February she came over to you at Dryad Ward.
A Yes.

H

A

Q She was reviewed by Dr Barton. We will find Dr Barton's clinical note at page 304. It is dated 27 February and I am going to do my best to read it. It says,

> "diagnosis of carcinoma of the bronchus made on x-ray on...Generally unwell. Off legs. Not eating. Bronchoscopy not done".

I am afraid I need help with the next word,

B

> "Needs help with eating and drinking. Needs hoisting. Barthel 0. Plan get to know. Family seen and well aware of prognosis. Opiates commenced",

and we know the rest I think. Really that was for the Panel rather than you, as I think you appreciate. Turn, please, to page 174, which is the nursing note. Do you see your name there as the "designated nurse".

C

A Yes.

Q Is that any different to the "Named nurse"?
A No, it is just another name for it.

Q What does that mean for you?
A When a patient is admitted it just meant that I was a point of contact for the family and other members of staff to find out what had been going on with this particular patient.

D

Q If we go to page 178, is this your writing?
A It looks like it, yes.

Q It is nice and clear:

E

> "Can make her wishes known".

A Yes.

Q Then what does it say?
A "Quite well. Does as she is asked. Helps all she can. Pain? Yes, on movement. Skin: dry, friable, paper thin. Client/Carer preference: Not discussed".

F

Then she is given a Pegasus mattress which I think is to relieve pressure sores.
A A pressure-relieving mattress, yes.

Q She is on a urinary catheter.
A Yes.

G

Q "Pain on movement": we have seen that quite often. Did you use pain scores at the Dryad?
A Towards the end of me being on the ward, we did, but it was not something that we used on a regular basis at the beginning.

Q It is not something we have seen in any of these notes. Looking back on it now do you have any recollection of this patient?

H

A None at all. The name does not even ring a bell.

A

Q These are your notes.
A Obviously it is my writing, yes.

Q I will not spend very long with this. If we go through the notes, I think we go to page 180 where we can see,

B

"Requires assistance to settle at night. To maintain comfort and promote restful sleep. Transfers with 2 nurses".

What does that actually mean?
A It means she needs two members of staff to help her into bed, out of bed, into a chair, to rise from a chair; to do any kind of movement, really.

C

Q Can we tell from this whether she is able to help herself at all?
A If I read that as just somebody coming in who read it, I would think that she was not really able to do much for herself, not in the way of movement anyway.

Q If we go to 272, which is the beginning of the drug chart, I am afraid it is just to ask for your assistance as to whether you have administered any of these drugs so we can identify your initials in the future.

D

A No.

Q None of those?
A No.

Q Over the page.
A At the bottom.

E

Q At the bottom of page 274, is this lactulose?
A Yes, lactulose 10 mls.

Q Where are your initials, 1800 or 9.05?
A They are at 9.05 and then on 1800 the following day.

F

Q Is that the following day?
A It looks like it, February/March. It looks like I have written at 9.05, which is my initials on 28 February, and then it is my initials on 1 March at 1800.

Q Page 278?
A No, they are not mine.

G

Q You have no recollection of this patient at all, do you?
A No. The name does not even jog my memory.

Q Then I will not spend any more time going through those. Could you take up Bundle F, please, which is Mrs Lake? Again, we are going to deal with Mrs Lake quite shortly. Does that name ring a bell with you or not?
A I recognise the name, but in all honesty I could not put a face to it.

H

A

Q This lady had a fall. She went to the Haslar. She was transferred to the Dryad Ward on 18 August. If we go to page 373, I think you will find a Barthel score. I do not know if this is your writing or not.
A I do not think it is, no.

Q She has a Barthel score of 9. We know that there is a maximum of 20, so how does that compare to the majority of patients on your wards?

B

A Compared to the majority of patients, that was very good.

Q A Barthel score of 9, how would you translate that into reality? We can see she can groom herself, which means presumably brushing her hair, brushing her teeth.
A Yes. She was able to transfer with just one member of staff.

Q Could we have a look, please, at the following page, page 374? There is no named

C

nurse on there.
A No.

Q If we go to 381, I think this is the nursing care plan and you are shown as the named nurse there.
A Yes.

D

Q Do we see your writing, which is nice and clear, on this page?
A Yes.

Q Again, unless you have got any recollection of this patient, I am not going to take you through it.
A I recognise the name, but I could not put a face to her.

E

Q All right. If you go to pages 376 to 377, would you just remind yourself a little bit about this patient, because I just want to ask you one matter? You will see on page 377 there is a note that she has small ulcerated areas.
A Yes.

Q Whose writing is that?
A That is mine.

F

Q "Mrs Lake has small ulcerated areas on both lower legs".

One small area on her right and two on her left.

"Desired outcome to dry and heal them".

G

This is dated 18 August, is it not?
A Yes.

Q Look underneath, "Nursing Action". Read that through to yourself and I want your assistance with the word "sloughy". Have you read that through?
A Yes.

H

A

Q We can see that you make a note of,

"Apply layer of zinc and castor oil to good skin and then aserbine to sloughy area".

A Yes.

Q Aserbine is what?
B
A It is a de-sloughing agent; it is quite a powerful de-sloughing agent.

Q Is "slough" dead skin?
A It is dead tissue.

Q That can be necrotic tissue, presumably.
A Yes.

C

Q Is it always necrotic tissue?
A Dead tissue is necrotic tissue.

Q Sorry, you are absolutely right. You get areas of dryness on the skin and that is dead tissue.
A But that is not necrotic. It is dry skin.

D

Q Right. Just looking at those notes again, how significant a problem does this lady have in terms of ulceration? Are you able to help us?
A Just by looking I would say that the right leg was not very bad at all because all I have applied is Paranet, which is a very gentle dressing. It is good; it heals, but it is very gentle. The left leg would seem to be a little worse because I have had to use Aserbine to the sloughy area.

E

Q Page 394, please. Also dealing with 18 August, we can see the note made at the top when she was admitted, and that I think is not your writing.
A No, it is not.

Q But underneath that,

F

"PM: Seems to have settled quite well. Fairly cheerful this pm".

A Yes, that is me.

Q That is you.
A Yes.

G

Q Do you still have no recollection of this patient?
A No.

Q At 1150, complains of chest pain,

"Not radiating down arm. No worse on exertion".

H

A Can you just help? I appreciate that is not your note, but as a nurse does that mean anything to you?
A To me it would indicate that it was something that could be quite serious because chest pain radiating down the arm is quite indicative of a heart attack.

Q Quite. This actually says, "not" radiating down the arm.
A If it was not radiating down the arm, then obviously the nurse who wrote it, that is the
B first thing she has obviously checked and found that it did not radiate but that this lady was obviously still in pain.

Q Then we can see in the next entry that diamorphine 20 mgs, and the midazolam were commenced via syringe driver.
A Yes.

C Q You took no part in that decision.
A No, that is not my writing.

Q Or the administration of it.
A No.

Q If we can just go to the drug chart, 368, I think you will find a, b, c and so on. I want
D to go to 368e. Do your initials appear anywhere on this drug chart?
A No.

Q We can see, I think, that on the 19 August, even with the better copy it is rather difficult to read – she was provided with 20 mgs of diamorphine and 20 mgs of midazolam. Do you see on 19 August and on 20 August she is given 20 mgs and 20 mgs?
A Yes.

E

Q Then on 21 August – just confirm; does your writing appear anywhere on there?
A No.

Q She is put up to 60 mgs.
A Yes.

F Q On my maths that is three times the previous dose.
A Yes.

Q Is that something if you were administering you would have queried, or not?
A Yes, I would.

Q Why?
G A Because it is not the 50 per cent increase.

THE CHAIRMAN: Sorry, Mr Kark, to interrupt, but I too, in common with the witness, at the time you first referred to the diamorphine, was on page 368b. In fact it was Oramorph that was referred to on that page and it is specifically the diamorphine and the Midazolam that you are now referring to.

H MR KARK: Yes. It is 368e, which is one of the inserts.

A

THE CHAIRMAN: That is OK, but on the 19th it is clear that Oramorph was also administered.

MR KARK: Yes.

THE CHAIRMAN: Thank you.

B

MR KARK: Again, just on that issue, if you are setting up a syringe driver would you normally check when a patient was last given Oramorph or would you just take the doctor's instructions?

A No. If I was setting it up I would check to see when it had last been given.

Q From what you have seen of the nursing notes, and the nursing notes that you made – we can go back to them if you want – can you see why this lady was started on a syringe driver?

C

A I cannot see.

Q All right. If we go to page 612 do you recognise those notes?

A No.

D

Q So again, just going –

A That is Ward E3.

Q Which is where?

A Am I on the right page?

Q Yes.

E

A That is E3. That is at QA.

Q Just give me a moment, please. We were looking at 614. You are absolutely right. In fact that finishes on page 614 when on 18 August she is transferred over to you.

A Uh-hu.

Q I apologise. We can move on. Again, having looked at any of those notes do you have any recollection of the patient?

F

A No.

Q Just one other matter to help us on that one – I am sorry – page 368 please. Would you go to 368e again – I am sorry to go back to it. Do you see on 20 August three is a note that something has been destroyed?

A Yes.

G

Q Can you just talk us through that, please?

A If a patient is having medication by syringe driver and the constituents of the syringe driver have been changed for any reason or the dosages have been increased or decreased, or something has been added, or something has been taken away, then the previous dose that they were receiving would be destroyed and a new dose would be started.

H

Q You cannot add to the same syringe driver?

A A No. We do not do it like that, no.

Q So you get rid of the old syringe driver?
A Yes.

Q And a note is made that it is destroyed, as we see here?
A It is made. A note is made in the drug chart to say that it has been destroyed, and in
B the drug record book.

Q If this patient was being hydrated where would there be a note of that?
A She should have a dietary assessment, and if she had a Barthel of 9, I would presume that she was drinking and eating.

Q While on the syringe driver?
C A On her own, yes – with a Barthel of 9.

Q She would be able to, would she?
A She would be able to. According to the Barthel it says she was eating; she was feeding herself.

Q That is on her admission?
D A That was on admission.

Q Of course. If she has a syringe driver going into her at these sort of rates, is she going to be able to eat and swallow?
A Yes.

Q She may be able to?
E A Yes, she may be able to. Yes.

Q If she was able to take oral morphine can you think why this patient would be on a syringe driver?
A I cannot. I cannot answer that at all.

Q In any event, again, just to make your position clear, you do not recall this patient?
F A No.

Q Could we turn, please, to Patient H, Mr Wilson. Again, I have a very limited amount to ask you about Mr Robert Wilson. Can we remind ourselves, please, because sometimes it is a bit difficult to keep everybody in mind, I am afraid. He had an alcohol problem and he was brought to your hospital on 14 October 1998?
A Uh-hum.

G

Q Do you have any recollection of Mr Robert Wilson?
A No.

Q Can we go to page 267, please? Perhaps that should be 266 and 267. I think you are going to find – just to make it more complicated – a 266A and 266B, but we can at least read those. Do you have 266A?
H A Yes.

A

Q Again, just cast your eye over these notes. Do you see your --?
A No, I do not see my writing.

Q --- writing on 266A?
A No.

B

Q Or 266B?
A No, not on B either.

Q And on page 267 "pm", I think we see you?
A Yes.

Q

C

"All care has been given. Oral suction has been required and performed. Condition continues to deteriorate."

Oral suction – why would that be required and how is it performed?
A How is it performed, did you say? Sorry?

Q Yes.

D

A It is to clear the mucus from the back of the throat and to make the patient more comfortable. It is a thin tube that is on the end of a suction machine. It uses gentle suction to remove the secretions at the back of a patient's throat if they cannot cough them out themselves.

Q So a nurse would be inserting a tube into the patient's mouth?
A Yes. We try not to do it too often.

E

Q Why would a patient be needing that?
A If they were poorly, if they were unable to cough or if they were unable to get rid of the secretions themselves. It can get quite distressing for them because it obviously makes it difficult for them to breathe properly so we have to remove it that way.

Q Is that something you found when the patients are on a syringe driver?

F

A I found it with both patients that are on syringe drivers and not.

Q Again, just looking at this note, I do not think you have made many other notes for this patient. I might be wrong, but if you go over to page 278 and 279 you will see that Shirley Hallmann was actually the named nurse. Please cast your eye over 279 and 280. If you have any recollection of this patient, please let us know. I do not think you have made any notes on 279, have you?

G

A No, I have not. No.

Q I am sorry, I have a wrong reference. I have page 96 for the nursing care plan but that is wrong. I think it will be 279 and 280. Again, did you have anything to do with the writing up of this patient?
A No.

H

A Q Very well, I will leave it then. I am going to turn very briefly to the drug chart again, please, just to see if you made any entries or administered any drugs. Page 263, please. It is sometimes difficult to identify nurses' initials?
A No. Mine do not seem to appear there, no.

Q Let me move on. I am going to turn to a patient that I think you do have some recollection of; that is our Patient K, Elsie Devine. I see you smile. Do you have a
B recollection of Elsie?
A Oh yes!

Q I should call her Mrs Devine – I am sorry. Tell us before we turn up our notes why you remember Elsie Devine?
A Because she gave me a black eye, basically.

C Q Tell us what the circumstances were?
A She scratched me, and I ended up with a big bruise on my shin. I came on duty one morning. I usually got there about five past, ten past seven. I walked onto the ward to find Elsie in the middle of the corridor opposite the nurses' station grasping one of my colleagues by both her wrists, trying to push her up against one of the wall bars. I tried to persuade her to let go of Debbie, my colleague, and hang on to me but she would not. She was getting really quite agitated, upset. She was shouting and screaming at us. She was kicking out at
D us. She then hit me and knocked my glasses across the ward. We eventually got her into the day room because it we were trying to get her into the day room out of the corridor because it was upsetting other patients as well. We eventually got her into the day room but she refused to sit down. She was still shouting and screaming at us, and she was getting really quite beyond herself really.

Q Let us have a look, please, at page 223 and see if we can put some dates on this
E incident, or a date on this incident. This was the lady who is under the care of Dr Cranfield, just to remind the Panel again, who found insufficient evidence for a diagnosis of myeloma. She went into the Queen Alexandra Hospital on 9 October with an episode of acute confusion. Then she came over to you at the Dryad ward on 21 October 1999. If we look at the top of page 223, we see that she is –

F
> "admitted this pm with increasing confusion and aggression. The aggression has now resolved. Still seems confused …
>
> Needs minimal assistance"

is it?
A Yes.

G Q
> "… with ADL's. A very pleasant lady. Her appetite on the whole is not good and can be a little unsteady on her feet.
>
> Quite cold"

is it?
H A Yes, yes.

A

Q
"... on admission and both feet swollen.

[Seen by] Dr Barton. See treatment chart for drug regime."

B

Let us keep a finger where we are and go to page 279C. I think we can see that there are some prescriptions written by Dr Barton on 21 October. Is that right?
A Yes, yes.

Q And indeed, the page before, page 279B, can we see that Oramorph was written up?
A Yes.

C

Q It is quite difficult to read. Temazepam, Oramorph, thioridazine, is it?
A Thioridazine, yes.

Q Hyoscine – no. That is later, I am sorry. Over the page, thyroxine?
A 100 micrograms.

Q Then back to your note. If we go to page 223 again, at the bottom of page 223, 19 November 1999 whose note is this?

D

A That is Sister Hamblin's.

Q Can you help us whether this refers to the incident that you just referred to?
A Yes, that is it.

Q Can you just read through the note for us please?
A Yes.

E

"Marked deterioration over last 24 hours. Extremely aggressive this a.m. refusing all help from all staff. Chlorpromazine 60 mgms given I.M. at 08.30. Taken 2 staff to special. Syringe driver commenced at 09.25 with diamorphine 50 mgms and midazolam 50 mgms. Fentanyl patch removed. Mr Devine – son – seen by Dr Barton at 13:00 and situation explained to him. He will contact his sister, Mrs Reeves and inform her of Elsie's poor condition. He will visit later."

F

Q Were you part of the conflab that you spoke about earlier, about starting a syringe driver with this patient?
A Not that I remember, no.

Q This was an occasion when effectively your evidence is she had attacked members of staff?

G

A It was very unlike her. Yes, she attacked me and she had got hold of Debbie, but it was very unlike her. She had not done anything like that since she had been on the ward.

Q There is no indication here, or is there, that she was in pain?
A Not that I can see, no.

Q She had been on a fentanyl patch. Did you know about fentanyl patches?

H

A I know of them. I have used them in the past.

A

Q And what was the effect of those?
A What – in general?

Q Yes.

Q Well, in general I did not particularly think they were very good, but for some patients they did work.

B

Q If we to page 279B – keep a finger where you are – we can see chlorpromazine which is referred to on the page that you have just been talking about at page 223?
A Yes.

Q It prescribed chlorpromazine?
A Yes, chlorpromazine.

C

Q What is that used for?
A Sorry

Q What is that used for?
A It is a sedative.

D

Q It is a sedative?
A Yes. It is used a lot in psychogeriatrics. Well, it was. Not so much so now.

Q And that is an injection?
A Yes.

E

Q 50 mg?
A Yes.

Q Can we tell from this when the fentanyl patch was taken off? We can see the note at the top of page 224 – syringe driver commenced?
A Uh-hum.

F

Q Would a syringe driver be commenced while the fentanyl patch was still on?
A Not normally. it would be taken off first.

Q Did you say "not knowingly"?
A "Not normally".

Q Not normally.
A The patch would be taken off.

G

Q Would you have known how long fentanyl remains within the system after a patch is removed?
A Offhand? I think it is about six hours. Four hours. I am not sure to be quite honest.

Q So this patient has had a patch on. She is given chlorpromazine and she is started on a syringe driver about 9.30?

H

A	A	Uh-hum.

Q	Yes?
A	Yes.

Q	With 40 mg of diamorphine and 40 mg of midazolam?
A	Yes.

B

Q	Do you know why that was done?
A	I cannot say.

Q	And you were not part of the conflab that made that decision?
A	Not that I remember, no.

C	Q	Apart from this incident of you getting a black eye do you remember much else about the patient?
A	Just odd things. I remember that she was quite a little tiny lady and she used to go rummaging around in other people's lockers and take their sweeties and biscuits and then we would have to persuade her to put them back, but apart from that I cannot remember an awful lot more about her.

D	MR KARK: Thank you; would you wait there, please.

Cross-examined by MR JENKINS

MR JENKINS: Mrs Barrett, do you remember I asked you some questions at the inquest?
A	You did, yes.

E	Q	Can I ask you some questions about where patients came from during the time with which the Panel here are concerned. Did you get patients coming from their own homes?
A	Occasionally.

Q	Were they often transferred to the War Memorial from other hospitals?
A	Yes.

F	Q	Was that the main way in which they came to you?
A	Yes.

Q	Did you get some transferred from nursing homes or rest homes as well?
A	Some but not an awful lot.

G	Q	Would this be fair, that the overwhelming majority of patients that you were dealing with were post operative patients from surgical units?
A	No.

Q	No?
A	No; we did not get an awful lot of post operative patients – we got some but not an overwhelming amount.

H	Q	Dr Barton started there in 1988.

A A Mm hmm.

Q Do you know if you were there then?
A I started in '87.

Q So were you working at the War Memorial when Dr ---
A I was at the Redcliff Annex in '87 until we moved up to the main building.

B

Q So you were nursing with Dr Barton in Redcliff.
A Yes.

Q And you moved up with her to the main building?
A Yes.

C Q Can I ask, over the time that you were doing the job until Dr Barton resigned in 2000 were the patients and the condition of the patients the same or did they change over time?
A They changed actually.

Q In what way?
A When we were at Redcliff we went through a stage where we got really quite poorly patients that were transferred to us from other hospitals and we were not given the chance to get to know them or their families. When we went up to the main hospital we went through a period where they kept changing our remit; first of all we were a long stay unit, then we were slow stream rehab and then we were something else. And each time the name of the ward changed the patients sort of changed. Basically we used to get patients that nobody else seemed to want. Sorry, am
I allowed to say that?

D

E Q Of course you are allowed to say that. What does that mean for someone like yourself who was nursing that kind of patient?
A We used to get a lot of patients – am I allowed to use the word that we used to use? We used to call them being "dumped" on us because the hospital beds at the QA, which were usually the acute beds, could not cope with long term patients. There was nowhere else to send them and so we used to get them and we used to take all kinds of patients.

F Q Tell us why nobody else would have wanted those patients?
A Because elderly people can take an awful lot of nursing care and an awful lot of nursing hours and on an acute ward they do not have the time to care for them like we could.

Q So for the time with which this Panel are concerned – really 1996 through to 1999 – would it be fair to say that a lot of the patients were very dependent?
A Oh, yes! Yes.

G

Q It will be obvious that that creates pressures on nursing staff.
A Yes.

Q And should we have a picture that the level of dependency of the patients had grown worse over time? They had been more dependent over time?
A Yes, they were. Occasionally, as your colleague said about the lady that had the high
H Barthel, we occasionally got patients like that but a lot of the patients that we had on the ward

A had Barthels of zero or one or two. We thought ourselves quite lucky if we got a patient with a high Barthel.

Q Again, when Dr Barton started the patients had not been like that, or not as bad as that?
A When Dr Barton started I was down at Redcliff and most of our patients at Redcliff were dependent and with us for a long time – and I do not mean just months, I mean years

B sometimes. So they were quite dependent, even at Redcliff.

Q I understand. Of the patients that were transferred in a number of them will have been transferred with the view that they should undergo some form of rehabilitation.
A Some did, not many.

Q I think that was an answer you gave to Mr Kark when he asked you questions. You

C said that there was not a lot of rehabilitation on Dryad Ward.
A No.

Q Why was that?
A As I said, our remit kept changing and we kept being told that we were this and we were that, and Daedalus was actually the stroke rehabilitation ward for the elderly, so they used to get an awful lot of rehabilitation obviously because of their remit. But because we

D were not sort of continuing care we only got it if we needed it; if we had a patient that they thought had a little bit of potential then we used to maybe get a half an hour, an hour a week or something like that. It was quite scarce.

Q So half an hour or an hour of what – physiotherapy?
A The physiotherapist used to come, yes.

E Q The Panel have seen medical records of one of the patients who was treated at one of the other hospitals, the QA or the Haslar, where they were seen day after day after day by physiotherapists. Did you have that facility at the War Memorial?
A No.

Q Can I take you to the sort of patients that you might have been nursing, if there were patients towards the end of their life? Patients may clearly arrive at the end of their lives in

F various ways. Some of them may just be involved in an accident or have some cardiac event and they drop dead. You would not treat those people clearly; they would not get to your hospital?
A No, they would not get to us, no.

Q But of those who might be approaching the end of their lives might there be some patients for whom there would be a lengthy decline – weeks, months?

G A Oh, yes!

Q Yes?
A Yes.

Q And as a nurse who has looked after such people for years can you tell us how do those patients deteriorate over time?

H

A

A It is a slow process usually. They stop eating, they stop drinking; they will not mobilise; they do not want to interact with other people. It is just a slow decline really.

Q As the end approaches are the various systems breaking down?
A Oh, yes; yes.

B

Q You have told us about reduced eating or drinking. Does the quality of the skin deteriorate?
A Yes. Most elderly people have got very dry skin, friable skin anyway, so it is something that the nursing staff on an elderly care ward would take an interest in from the very start anyway.

C

Q We saw with Patient A some notes – we do not need to look at them now – and you were making entries saying that the skin was marking.
A Yes.

Q What does that mean?
A A normal person like ourselves, we would move quite regularly and so the blood supply to our skin would be okay – it would not be interrupted. But with an elderly patient they sit for long periods of time; they are not very happy about standing and they have to be encouraged, so their skin starts to mark and you get red areas that can very quickly turn into ulcers.

D

Q And you talked about the colour of the patient.
A Yes.

E

Q As something that can help you as an experienced nurse.
A Yes. If they do not eat or drink and they start sort of just withdrawing from everybody it is just ... I do not know how to describe it. When you have been looking after these people for a lot of years you look at them and think, "Oh, dear; you do not look very good; you do not look very well." It is just the case that they sometimes get very pale. I do not how to describe it; it is just something that you know really after years of experience.

F

Q Would it be fair to say that for someone experienced like yourself, although you cannot describe it you would recognise it?
A I would recognise it immediately.

Q You would recognise the signs of someone deteriorating.
A Yes.

G

Q Or the signs of someone who may be terminally ill.
A Oh, yes.

Q Or dying.
A Yes.

H

Q I have asked you about patients who may have a lengthy decline – weeks, months, longer. Is it also in your experience the case that for some patients, particularly the elderly, there may be quite a rapid decline ---
A Oh, yes; yes, I have seen it a number of times.

A

Q For relatives of those patients where there may be quite a rapid decline is it your experience that the relatives may be completely shocked at the speed of it?
A They find it very difficult to understand why they have declined so rapidly, yes, and they are quite shocked.

Q We have heard that there may be patients who have a number of medical conditions.
A Most elderly people have numerous problems.

B

Q Is it your experience that for a patient who may have a number of medical problems, if there is a decline suddenly all those problems can come to the fore at once?
A Yes. They all sort of reach a pinnacle and that is it, everything goes wrong at once.

Q For patients – and you have nursed them – who may be a day or a few days from the end of their natural lives, do they sleep for long periods? Can they?
A They do sometimes, but not always.

C

Q Are there some patients where the mental state will fluctuate?
A Yes. On Dryad especially we used to get a lot of patients with confusion problems; they were confused and ... Could I just possibly take a bite of my Mars bar please?

D

Q Of course you can. If you need a break you must say so.
A No, I am fine; I am okay, just so long as I can take something because I can feel myself shaking. (Short pause)

THE CHAIRMAN: Would it help if we got you a hot drink?

THE WITNESS: No, thank you; I am not a big fan of hot drinks.

E

THE CHAIRMAN: If there is anything you need at any time?

THE WITNESS: No, I have my water, thank you; that is very kind.

MR JENKINS: If you need a break, say so.
A No, I am fine.

F

Q Can I keep going?
A Yes. I am okay.

Q Again, for patients who may be within a day or two of death may they drift in and out of consciousness?
A Yes.

G

Q Patients who are on no medication at all.
A Yes. I have known it happened; yes. We have had patients that have been admitted to the ward and died on the same day – it can happen.

Q I think that is bad for staff morale.
A The particular time that I was thinking of, when I was speaking with your colleague, at Redcliff we had about ten months where we got particularly poorly patients and they were

H

A passing away within days of actually coming to us; and on two occasions that I remember – I am sorry I cannot remember their names – the patients actually died on the same day that they were admitted, and the morale on the ward at Radcliff was quite low at that point because when you work with elderly people it is nice to be able to get to know them and also to get to know the relatives because nine times out of ten you are going to be looking after these people for weeks and months, and we just could not do that when they kept coming in and passing away within days, and it was quite upsetting for the staff really.

B

Q When patients are transferred to you there is obviously a named nurse system.
A There was at the time; I do not know whether that still is there.

Q Let us deal with the late 1990s. There was a named nurse system.
A Mm hmm.

C

Q Would the named nurse take the lead in talking to relatives?
A Yes, I suppose you could say that. It was just like a point of contact. Personally, if I was the named nurse of the patient admitted I would make it my job to introduce myself to the relatives and tell them who I am, and maybe show them around the ward and tell them a little bit about the ward, what happens. But also say to them if I am not here please do not think that you have to wait for me to come back – anybody on the ward would be able to answer your questions. It was just a point of contact for relatives and for other members of staff really as well.

D

Q Was it clear that where you were able to build up a relationship with the relatives of the patient that things went better?
A Yes.

Q Because in a sense are you not looking after the relatives as well?

E

A Yes, because we used to get some of these patients for months and we used to consider a lot of the relatives; we used to consider it like an extended family really because we got on first name terms and they used to come in on a daily basis or wherever they came in; and we used to get to know them quite well. Even though our remit kept changing so drastically and we were supposed to be getting patients that were going to be able to go home or go to nursing homes, nine times out of ten we ended up with patients for four, five and six months at a time.

F

Q But was it clear that where you were able to build up a relationship with the relatives - --
A We liked to.

Q ... that the decision-making was easier?
A Yes, because they felt that they were involved in anything that went on.

G

Q Was it also the case that where there was a deterioration in the patient's condition, perhaps where the patient died on the ward, that having a continuing discussion, dialogue with family members made it easier for them
A If you have a relative that is poorly and no matter how long you have been waiting and people keep saying, "She is not going to make it," it is still a shock when that patient passes away, no matter how you have been waiting for it and thinking that it is going to

H

A happen. If you have a relationship with the relatives you can help them through that horrible time

Q What you have said is that in cases that there may have been where a patient died very soon after arriving on the ward ---
A You were not able to do that.

B Q You could not help the relatives or the patients.
A No. You could try but it was not the same.

Q After Dr Barton left was she replaced by a full time doctor who was there Monday to Friday, nine to five?
A Yes, she was.

C Q Did that make it easier for the relatives of the patients nursed and taken care of after that doctor arrived for there to be ongoing discussion between the doctor and the relatives?
A I would not have said easier because Dr Barton was always very good about coming in to see relatives. Obviously it made it easier in the fact that the doctor was always there, but she had her other duties – she could not just drop everything.

Q Indeed, but what the Panel has heard is that in at least a couple of cases there were
D relatives who went to see a patient who never saw a doctor there – they did not ask to see one, it is fair to say, but they never saw one because there clearly was not a doctor there.
A I cannot comment on that because obviously when I wanted a doctor I used to call for them.

Q I understand. But do you agree that if the situation was as it was after Dr Barton had left, that there was a doctor there 9 until 5, five days a week, there would be a doctor there for
E relatives to talk to?
A Yes. If they asked for one there would be one.

Q Can I come back to the terminal stages of patients? If they are in the process of dying, was there occasionally or commonly a restlessness, an agitation in the patients?
A Quite commonly.

F Q Were patients often in pain as well?
A Oh yes.

Q You were asked right at the start of his questions by Mr Kark whether, in your view, patients were ever overdosed with medication.
A Yes.

G Q Your answer was, "That would be rubbish".
A The same as last time, "Rubbish".

Q Why do you say that it was rubbish?
A Because we would not do that. We were there to give the best of care that we could for these patients and we would not overdose them. They would only be given the medication that they required.

H

A

Q Did you like your job?
A Towards the end, no; I have got to say no.

Q Why was that?
A Am I allowed to say? Because of what was going on with Dr Barton a lot of the time. It made it very difficult when you went out with some of the relatives that were particularly not very happy about things.

B

Q Can I interrupt? There was a police investigation and a lot of publicity. Is that what you are referring to?
A Yes, it just made things horrible.

Q But before there was any talk of a police investigation?
A Before that I enjoyed my job very much. I used to enjoy going to work.

C

Q What can you say about the standard of care that you were able to give the patients that you were nursing?
A Excellent because Sister Hamblin expected nothing but excellent care.

Q Was she a first class sister?
A Yes.

D

Q What about Dr Barton?
A Am I allowed to say? I have been thinking about this. Am I allowed to say what I feel?

Q You should.
A I have the utmost respect for Dr Barton as a doctor and as a person. She gave of her time when she was off duty. We knew if we needed somebody she would be there. She was always available for the relatives whenever the relatives wanted a word. She would always make sure she made time for them. The patients used to refer to her as either, "The tall lady doctor" or, "The nice lady doctor" and the relatives have referred to her like that as well. Whenever she spoke to relatives she was always very honest.

E

Q Would you be there?
A Yes, there would always be a nursing member there. One of the trained staff would always be there.

F

Q When you say, "honest", why do you put it in that way?
A Because sometimes people do not want to hear bad news. I have been in with some doctors who have flowered it up and said, "We can do this. We can do that". Dr Barton would say, "This is what is happening. This is what we are going to do. This is what we are going to try". She would always be very honest in what she said to the relatives. She was always very respectful and I have got nothing but good to say about her.

G

Q If the doctor has not met the relatives before, and the first meeting with the relatives is a meeting where the doctor is giving what may be bad news.
A Yes.

H

Q How was Dr Barton handling that, from what you saw?

A She would be very respectful. She would always introduce herself, tell the relatives who she was and then go into a conversation with the relatives about the patient that they wanted to discuss.

Q Because sometimes, if you have not met the other people before like the relatives, it is difficult to judge how they are going to take it.
A Yes. I think I have to say that Dr Barton was quite a good judge of character. She knew just how much information they would accept in one conversation, but she was always very good. She was always available to have these conversations with relatives.

Q I understand. Let us come back to the patients. As a nurse you would be involved with giving basic nursing care to the patients you were dealing with.
A Yes.

Q That would mean you were involved with feeding them, if they needed assistance.
A Yes.

Q Assisting them with toileting.
A Yes.

Q You would be washing them.
A Yes.

Q Sometimes helping them to sleep or settle for sleep.
A Yes. It was the night staff. Obviously you could not do it just within meeting them the first day, but over a couple of days, over a couple of nights, they would find out how the patient liked to sleep – for instance, they might like to sleep on their side – and they would get the pillows and things right and do everything they could to make sure they were comfortable when they went to sleep.

Q You would be changing the sheets, the bed clothes.
A Yes.

Q Was that daily?
A Yes.

Q If there were medical conditions that needed nursing care, you would be dealing with that?
A Yes.

Q Pressure sores or bed sores?
A Ulcers we actually call them now. I was actually the wound care link nurse for the hospital for a time so that was my interest really.

Q If patients were liable to bed sores or ulcers, would you be making sure that they moved and their position was adjusted?
A They would be assessed when they came in, what they call a Waterlow Score would have been done.

A

Q We have seen the charts. I think we saw with Patient A, who did have some ulcers, you making notes to say that he should be moved, or his position should be adjusted at a certain hourly rate.

A Yes, depending on how thin the patient was. You had to assess the patient as a whole, especially if they were poorly or unable to move very much themselves, which we used to get quite a lot of patients who were not able to move themselves in bed an awful lot. They would be given a special mattress and the nursing staff would go in and assist them to roll over in bed or whatever they wanted to do.

B

Q Perhaps the answer is obvious, but if you are dealing with a patient in all those various ways – toileting them, changing their sheets, dealing with pressure sores, feeding, giving medication – would you have had a very good impression as to their level of agitation?

A Yes.

C

Q Their level of pain?

A Yes, you get to know them quite well.

Q How many patients would you be responsible for dealing with at any one time on the ward? Perhaps I put that badly. There were a number of staff on the ward.

A Yes, there were usually five or six of us.

D

Q If there were 20 or so patients on the ward, would you deal with each of those patients during the day, or would you concentrate on a limited number?

A You would be given a particular number. If I was in charge of the shift, then I would delegate who would do it. As I say the ward was split into two – not literally, but into 10 beds that side and 10 beds this side for the workload. I would say to people, "You do that four beds" and that is how we would do it. So you would do possibly three or four patients a day.

E

Q That is, each nurse would be concentrating on three or four patients.

A Yes, just for the morning to get them up and washed and dressed and ready.

Q So again, for nurses dealing with specific patients, would they know very well how their patient was coping?

A They would know immediately if there was anything sort of out of the ordinary.

F

Q Because what we have heard is that when medication was given, there would be two nurses involved in doing that.

A Yes.

Q So the nurses had their own professional obligations so far as patients are concerned.

A Yes. We have got our accountability and duty of care.

G

Q If your patient or one of the patients you were focusing on, was prescribed medication that you did not think was appropriate, you have already told us that you would speak out.

A Yes. I would speak up.

Q Leaving aside your professional obligations to do so, you would want to.

A Yes.

H

A

Q You are in the caring profession after all.
A It even came down to the fact that if I did not really know an awful lot about a drug or medication that one of the patients was taking, I would ask Dr Barton what it was because she was quite happy to tell us. So I would definitely speak up if I thought something was being given inappropriately.

Q We know that Dr Barton would be there in the mornings.
B
A Yes.

Q On weekdays. She would see patients then.
A She would see them all.

Q Doing the ward round
A Yes.
C

Q But for the other 23.5 hours in the day, other than the occasional day when there was a ward round by the consultant or some other doctor, is it right that there would not be another doctor dealing with that patient on the ward?
A Yes.

Q So where would Dr Barton get her information from other than her own assessments
D
on a weekday morning?
A The nursing staff would give it. Sometimes the night nurses, if they were still on duty when Dr Barton came, they would actually go round with her and say what the patients had been like during the night. If not, the information given from the night staff to the day staff would be passed on by whoever went round with Dr Barton.

Q Let us look at a typical day. What time would you arrive to start a day shift?
E
A I usually got on to the ward about five past, 10 past seven, but my shift actually started at 7.30.

Q I understand. Would the night staff leave at 7.30?
A No. Their shift was officially supposed to finish at quarter to eight, but the nurse in charge was very often there until 8 o'clock and gone 8 o'clock sometimes.

F
Q So if there was handover, would that be 15, 20 minutes or more?
A More normally, depending on how many patients we had got obviously. It used to take between 20 and 30 minutes.

Q Tell us when that would start roughly?
A At 7.30. Whoever had been in charge of the night shift would go into our room – we used to have a little room we used to go into and have our handovers – and the person who
G
was in charge of the night staff would come in and give us a report while the other night staff stayed on the ward and made sure that everybody was all right.

Q Dr Barton, I think the Panel have heard, would get to the hospital about 7.30 on a weekday morning.
A Yes. It was usually between 7.30 and 8 o'clock, yes.

H

A

Q She would go and do a ward round. There were two wards, Dryad and Daedalus Ward.

A Yes.

Q Would she sometimes be there for handover?

A Sometimes, yes. If she got there early enough she would be there for handover.

B

Q *She would be there for 40 minutes or so?*

A Yes, sometimes longer.

Q So if you were full, that would be about two minutes a patient if one were to split the time up.

A Yes, but it did not work out like that because she would stay as long as she was needed, and she would make sure that she spoke to every patient and asked about each one.

C

Q If there were blood results or urine tests that had been sent off to the laboratory for analysis, would she see the reports in the morning?

A Yes.

Q Would that be part of what she did?

A Yes. She usually used to do a ward round and at the end of the ward round she would look at any results or anything like that. Sometimes, especially if Sister Hamblin was going round with her, she would take them with her.

D

Q What you have told us is that if there were any new patients admitted to the ward, Dr Barton would come back during her lunch hour.

A She used to just appear. We would ring and say, "Mrs So and So has arrived", and she would say, "I will be there", and she would just appear.

E

Q She would come in the evenings, I think in her own time.

A Very often, and at weekends as well. If she was on duty, if she was say on-call for her surgery, she used to very often pop into the ward as well.

Q So not part of the time that she was contracted to be there.

A No.

F

Q She would come back and often relatives may be there.

A Yes.

Q And that was a chance to see them.

A She quite often made appointments in her own time to see relatives, because sometimes that would be the only time it was available for them as well.

G

Q Would it happen that sometimes the nursing staff would ask for Dr Barton to come in and see a relative?

A Yes. It was usually 50-50 really. The relatives would probably say, "Is it possible to speak to the doctor on the ward?" or we would actually offer, "Would you like to speak to doctor?"

H

A Q Would it sometimes happen – we have seen an example or two in the notes – that Dr Barton said she would like to see the relatives?
A Yes. Then she would give us a little list of times and days that she was available for to try and coincide with the relatives to make sure it was convenient for them.

Q Would it be fair to say that Dr Barton's understanding of the patient's condition was heavily dependent on the feedback she got from nursing staff?
B A Yes, but she always knew things about the patient because she was always reading notes and things like that, so she would read what other doctors had written about them as well, especially on a morning when she would want to know what had happened during the night, and obviously the day before as well as in the evening shift, if anything relevant had happened then.

Q Was it clear that Dr Barton was eager to know how the patients were doing and
C getting the information that she needed to do her job properly?
A Yes.

Q You have made it clear that it was easy to contact her during the day.
A Yes. We would just ring the surgery.

Q On her mobile phone I think.
D A I think she did give her mobile phone number to me and to Sister Hamblin, but she did not give it to everybody.

Q I understand. Can I ask about syringe drivers?
A Yes.

Q Had you had training in syringe drivers?
E A When I first started using them, I would not call it formal training. I was shown how it worked. I then had to go and observe on several occasions when they were being set up, and then I had to do some where I actually did it but I had somebody observing to make sure that I did it properly. Then I believe I started an interest in terminal care and things like that so I went on several study days and what have you to do with it.

Q Was that doing that off your own bat?
F A We used to get a list on the ward of what study days were available. I would ask if I could go to the ones that I was interested in.

Q Do you know if all the other nurses on Dryad were given training in the use of syringe drivers, or were there some who found themselves dealing with syringe drivers before they had been trained in the use?
A No, because a syringe driver is something quite important. They would speak up,
G "I have never done this before so I need to know what I am doing". So they would not do it until they had been shown what to do.

Q Is it right that there were only a small number of syringe drivers, three or four?
A Yes. I think by the time I left Dryad, I think we had three and we thought we were really quite lucky because we had had one donated by a relative.

H Q I think they cost a lot of money.

A — A Then they were about £600 or £700 and are probably even more expensive now.

Q There was a limit on the number of syringe drivers, was there not?
A Yes. As I say, we only had three because one of them had been donated by a relative and the other two were actually provided by the hospital, but we very often used to have to lend them to the other wards.

B — Q I understand. Is this right? The picture the Panel should have is that it was unusual for there to be a patient on a syringe driver?
A It was not the norm, no.

Q You did not have enough of them and it was not necessary?
A It was not the fact that there were not enough. It was that they were only used if it was necessary.

C

Q Of course. You have told us that there was subcutaneous hydration?
A Yes.

Q I just want to ask whether you think that was in place when Dr Barton was there.
A Yes.

D — Q I am going to suggest that it was not there at that stage. It may have been brought in later.
A It was used more after Dr Barton left but we did do it when Dr Barton was there; I am sure we did.

MR JENKINS: Thank you very much. That is all I ask.

E — THE CHAIRMAN: Mr Kark, the witness has been giving evidence this side of the break for one and a half hours. I am wondering whether we should trespass upon her patience very much longer today given that, even if you are short, there is still the matter of the Panel's own questions.

MR KARK: I only have one question, and if the Panel are going to take time to consider their own questions it may be helpful if I put it now, as it were. (To the witness) Then you are finished so far as the barristers are concerned at least – if you can bear it.

F

THE WITNESS: Yes, yes.

Re-examined by MR KARK

Q You told Mr Jenkins that you had no formal training?
A Uh-hum.

G

Q But really you learned effectively ---
A On the job.

Q On the job?
A Yes. At the time I do not think there was actually formal training.

H

A

Q I understand that works in terms of setting up the syringe driver itself and how you fill it up and how you insert, is it, via a cannula?
A A needle, yes.

Q Put a needle into the patient?
A A little tiny needle.

B

Q But who taught you about dosages?
A We had a pharmacist that came in, and we had a lecture from one of the pharmacists, I remember.

Q When was this?
A I honestly cannot remember when it was. The dosages and everything were always on the drug chart and we had to stick to that drug chart.

C

Q At what? The minimum dose?
A Yes. We always started at the minimum dose.

Q I see.
A Unless we were told otherwise.

D

MR KARK: Thank you.

THE CHAIRMAN: (After a short pause) I am sorry – I just wanted to make a note of your last answer. As I indicated earlier, you have been on the stand for some considerable time now – in fact longer than we would normally ask a witness to endure, even when they are in the very best of health.

E

It is clear that although we have reached the end of the questions from the barristers, there is still the matter of questions from the Panel. Being realistic, we are not going to manage that today. I understand that the matter of staying over has already been canvassed with you.

THE WITNESS: Yes.

THE CHAIRMAN: That is going to be possible.

F

THE WITNESS: Yes.

THE CHAIRMAN: We are most grateful to you for agreeing to that.

THE WITNESS: No problem.

G

THE CHAIRMAN: It does make it much easier for all of us. I should, however, remind you that you remain on oath overnight.

THE WITNESS: Yes, I do realise.

THE CHAIRMAN: That means two particular things. One, you must not discuss this case with anybody at all, even if your daughter is here supporting you.

H

A

THE WITNESS: I do not have one!

THE CHAIRMAN: If you have somebody here. A sister, is it?

THE WITNESS: That is my sister.

THE CHAIRMAN: You look too young to be her sister! If you have ---

B

THE WITNESS: I will stay here as long as you like!

THE CHAIRMAN: The other point is that this is a case that attracts a certain amount of press publicity. It is very important that you refrain from reading any newspapers that may be reporting on today's proceedings.

C

THE WITNESS: I can honestly say that I have never read anything in the newspapers, or watched the television. I will not do it. That is even from the start, when it all started.

THE CHAIRMAN: Excellent, because I was going to ask you not to do so, but that is clearly not going to be a hardship for you.

THE WITNESS: No. It is not going to be a problem for me.

D

THE CHAIRMAN: Very well. The next thing I need to do is to see whether we can give you a little lie-in tomorrow. That will depend on how long the Panel feel they would need before we would be ready for you. I am very quickly going to take some soundings from the other members of the Panel. (The Chairman conferred with members of the Panel) The general consensus seems to be that ten o'clock would work well for us, so that would mean we would be hoping to start at ten. Could you please be in the building a little bit before, but we will not ask you to be here as early as no doubt you were this morning.

E

THE WITNESS: It was only about nine o'clock this morning.

THE CHAIRMAN: Of course, the same remains for everybody else. The Panel will be in effect in camera first thing tomorrow morning, but we aim at 10 o'clock to resume for business. Thank you very much, ladies and gentlemen until ten tomorrow, then.

F

(The Panel adjourned until Tuesday, 23 June 2009 at 9.30 a.m.
and parties were released until 10.00 a.m.)

G

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5

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 30 June 2009

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY SIXTEEN)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

INDEX

	Page No.
DANIEL REDFERN, Sworn	
Examined by MR FITZGERALD	3
Cross-examined by MR JENKINS	16
Re-examined by MR FITZGERALD	22
Questioned by THE PANEL	22
RICHARD REID, Affirmed	
Examined by MR KARK	27
Cross-examined by MR LANGDALE	67

A THE CHAIRMAN: Good morning everybody. Mr Kark, a quick bit of housekeeping, if I may. This Friday a member of the Panel needs to be away by about 3.30 in the afternoon. If there is any danger of that impacting negatively on the schedule, then the Panel would be perfectly prepared to sit longer hours in the run up to, and I will be guided by you as to when and if that is required.

MR KARK: First of all, I am sure in terms of overall impact that is not going to have a
B significant effect at all. It is a timely point at which to mention next week and Professor Ford. Today we have a fairly full schedule. Mr Fitzgerald is going to be calling the first witness Mr Redfern, and I may slip out of the room at that time while that is done. Then we are going to be hearing from Dr Reid. Dr Reid is a fairly substantial witness. You will recall that he was one of the consultants. Then tomorrow we may still have Dr Reid to finish. I do not know how long we will be with him. Then we have got Dr Tandy and others. Now, so far as Thursday is concerned, we certainly may start Professor Ford on Thursday, but you
C have heard Mr Langdale's suggestion, which I fully support. Mr Fitzgerald has done a huge amount of work on the chronologies and the defence are going through those at the moment. They have done some of them but not all of them, and are adding some details, I think, to those they have seen. Next week we have one, as I understand it, non-sitting day, which is Wednesday, because we are being moved out of here because it is required, I think, for a Council meeting. Then I ought to mention that Thursday, my current instructions are that Professor Ford is not available. He has some prior commitment. I have known about that for
D some time and perhaps I should have revealed that earlier. I am sure there will be other things that we can do and read, but we are losing two days in the middle of next week. Professor Ford is available, I think, until Monday the 13th. So we have got Friday, Monday and Tuesday of next week, Friday the following week and Monday the week after that, so we have got five full days to deal with Professor Ford's evidence, and, although he is a very substantial witness, I am reasonably confident that we will be able to finish in that period.

E MR LANGDALE: May I just mention one other thing which may affect the order of events. At some stage before Professor Ford gives his evidence my learned friend I know is going to put in evidence the statements made by Dr Barton, which include a general statement of her position and individual statements with regard to each one of the patients. I am not suggesting that he calls a policeman, or whoever received the statements, to read them all out, but it is going to be very important for the Panel, before hearing Professor Ford, to have in mind the content of Dr Barton's statements, because, apart from anything else, I shall be
F putting certain matters from them to him. He, of course, has read them all, but I just think we ought to allow, in terms of the timetabling, for that to take place. It is not a matter of a half hour read.

THE CHAIRMAN: You are absolutely right, Mr Langdale. One of the unusual features of this case so far has been that we have not had the sort of gaps that often occur and which enable a Panel to keep up with its reading. I know there is a general feeling that we would
G welcome some reading time, just keeping up with the transcripts themselves. Normally, Mr Kark, it has to be said that GMC scheduling is not as efficient as yours has been, and your team are to be congratulated on that because you have kept it coming with no real gaps.

MR KARK: Well, perhaps there is advantage to inefficiency sometimes.

THE CHAIRMAN: Sometimes.

H

A

MR KARK: One of our difficulties is that because we have known of Professor Ford's time slots, as it were, we have had to keep things moving to get to the point where we can call him. Thereafter, I suspect, we can if necessary slow down a little because we still have a long time before the scheduled end of the case, but we will just have to deal with Professor Ford as best we can. I entirely accept Mr Langdale's point. You will need, I would suspect, at least half a day realistically reading Dr Barton's statements.

B

THE CHAIRMAN: It sound as though towards the end of this week that time is going to be available to us. Even if we were to start the Professor a little later, at least we would be properly prepared for him, and I think Mr Langdale is absolutely right, we need to be in a state of readiness or else the first wave washes over us and we have not really taken it on board in the way we should, if I can mix the metaphor.

MR KARK: I accept that.

C

THE CHAIRMAN: Good. Thank you. So, Mr Fitzgerald, you have a witness.

MR FITZGERALD: Sir, I do. Just before he is called, could I hand out, please, copies of the revised chronology for Patient I, Enid Spurgin, which is the patient the next witness deals with. (Same handed)

D

THE CHAIRMAN: Mr Fitzgerald, we will just add these to the patient bundle without the need to give it a separate exhibit number. It will simply go in at the beginning of the bundle.

MR FITZGERALD: Thank you. This is the revised and agreed version which sets out almost all, if not all, of the relevant entries from the notes.

THE CHAIRMAN: I can see you really have done a great deal of work and we are most

E

grateful for that. Thank you.

MR FITZGERALD: Certainly, sir. The next witness is Daniel Redfern, who is a consultant orthopaedic surgeon, who reviewed the notes relating to Enid Spurgin and provided an opinion. He did not deal with her himself. What I was going to suggest is that maybe the most efficient way of dealing with this is for he and I, and therefore the Panel, to go through this document briefly when he is called and familiarise the Panel with it in that way, rather

F

than giving time at the outset for the Panel to just review it.

THE CHAIRMAN: We are in your hands absolutely.

MR FITZGERALD: Thank you very much. Could I just explain something about the chronologies in terms of the colour coding. The colour coding has only been used in terms of the drugs prescribed and administered. For example, if one looks at page 12 at the top, one

G

can see that there is an entry on page 12 relating to Oramorph and co-dydramol. Entries in red relate to prescriptions and entries in blue relate to drugs administered. So that is designed to be helpful. Could I call then, please, Mr Daniel Redfern.

H

A

DANIEL REDFERN, Sworn
Examined by MR FITZGERALD

B

(Following introductions by the chairman)

Q Is your name Daniel Redfern?
A It is.

Q Is it Mr Redfern?
A Mr Redfern.

C

Q You are a consultant orthopaedic surgeon at the Royal Preston Hospital?
A I am.

Q You have been in that post since 1999, is that right?
A Yes.

D

Q Just a little more about your background: you qualified originally from Oriel College, Oxford, is that right, in 1980?
A Yes.

Q Where did you do your further medical training, please?
A St Bartholomew's Hospital Medical College in London until 1988.

E

Q What qualification do you hold, please?
A An MA, MBBS, FRCS and the FRCS Orthopaedics.

Q So a Fellow of the Royal College of Surgeons for Orthopaedics?
A Yes, two Fellowships: one is the standard Fellowship, and then there is the intercollegiate Fellowship, which is taken at the end of training.

F

Q You did your basic surgical training at St Mary's Hospital in London?
A Yes.

Q Then moved on for higher surgical training to the Hammersmith and Charing Cross Hospitals?
A I did.

G

Q Then, as you say, you have been a consultant surgeon, orthopaedic surgeon, in Preston from 1999?
A Yes.

Q Is it right, Mr Redfern, that you were asked in 2006 by the Hampshire Police to provide an expert report into the care provided, from an orthopaedic point of view, in relation to Enid Spurgin?

H

A Yes.

A

Q You produced a report dated 22 January 2006, having been provided with the medical records and reviewed them, is that right?
A Yes.

Q Would you find it helpful in giving your evidence to the Panel to be able to refer to your report?
B
A Yes.

MR JENKINS: There is no objection.

MR FITZGERALD: Sir, I am sure that for large parts of Mr Redfern's evidence he will not need to do that, but there may very well be points where it would be helpful, so I am grateful for that.

C

THE CHAIRMAN: In the absence of objection from the defence I see no difficulty with that.

MR FITZGERALD: Thank you. Mr Redfern, you have also been provided this morning with a chronology, have you not, about what happened in relation to Enid Spurgin?
A Yes.

D
Q Have you had some time to look through that?
A I have.

Q For your benefit the Panel also have that, and what we will do in a moment is just to go through it to look at the relevant entries from your point of view.
A Okay.

E
Q You were asked in 2006 to consider a number of different issues, some of which are relevant for us and some of which less so, but so the Panel are clear on the exercise that you have performed were you asked to address, first of all, whether or not Enid Spurgin suffered after her admission to the Haslar Hospital in this case from something called compartment syndrome?
A I was.

F
Q As a result of the operation that took place to her fractured neck of femur?
A Yes.

Q That was an issue that really related to her treatment at the Haslar Hospital?
A Yes.

Q Could you just help the Panel immediately with what compartment syndrome is?
G
A Compartment syndrome is a condition which arises most commonly after trauma or surgery. The segments of a limb are bound within a tight containing structure called fascia, which binds the soft tissues and the bones together under the skin. If you develop swelling within that tight fascia, then the pressure within that area builds. If the pressure builds sufficiently, then the return of blood from that segment of the body is obstructed. As a consequence, the blood coming in is also secondarily obstructed at the point of the micro circulation, which is where the blood vessels become very small. If that happens, then the
H
tissues in that area lose their oxygen supply and the cells will swell. This worsens the

A problem because it increases the pressure in the compartment. If left untreated this condition can lead to muscle and nerve death within the compartment and loss of function in the limb, or compartment of the limb. I hope that is reasonably clear.

Q I suspect it is. You make your point in your report in terms of why this really is an issue that is more relevant to the treatment at the Haslar Hospital. This is something that would arise in reasonably short order after an operation?

B A Either after trauma or after an operation, yes.

Q And so for the Panel's benefit, it is not such an issue when we come to her treatment at the second hospital, the Gosport War Memorial Hospital?

A The issue would have been only the sequelae of a compartment syndrome rather than the diagnosis of the compartment syndrome itself.

C Q Very well. By that point the damage from compartment syndrome is done?

A Is done.

Q Also for the Panel's benefit, I think it is right to say that from your analysis of the notes, you are unable to say that this patient did have compartment syndrome but it was a possible diagnosis?

A Yes.

D

Q You were also asked, though, to consider other issues. Firstly whether in your view it would have been reasonable to expect a doctor – one of the doctors who were treating this lady – to refer her for further orthopaedic review after her operation in the light of the symptoms that she showed?

A Yes. I was.

E Q You were asked to comment on the possibility that the pain that Mrs Spurgin suffered was due to any reversible post-operative complication?

A Yes.

Q And you were also asked to comment on the antibiotics that were used to treat Mrs Spurgin and whether they were sufficient in your view?

A Yes.

F

Q Those are issues which are relevant to both hospitals but certainly relevant to the treatment at the Gosport War Memorial Hospital. When you were looking at the records of Mrs Spurgin to inform you in making your report, is it right that you were concerned particularly to see, first of all, the details of the operation she went through and then also signs of further pain, discomfort, swelling – matters of that nature – after the operation?

A Yes.

G

Q What I will ask you if we can do is to go through this chronology now, to just look at the relevant points. There may be one or two moments while I just ask for your comments and refer you to your report. To run through the most relevant points from the chronology, we can see from the first page and the first entry that it was on 19 March 1999 that Mrs Spurgin was admitted to the Royal Haslar Hospital following a fall. It caused a right subtrochanteric femur fracture.

H

A We know, moving on to page 3 – do you have page 3 of the chronology?
A Yes.

Q At the top of page 3 we see that surgery was carried out. This was the next day, the 20th, under spinal anaesthetic with the insertion of a right dynamic hip screw. There was a blood transfusion that was given. Then there was a post-operative review that day by a senior house officer that there was a lot of ooze from the wound, that the thigh was about two times
B the size of the left thigh, and there was an issue of whether there was a haematoma, and the patient was complaining of discomfort in the leg and pain on palpation. I think you made a point in your report, that it was quite a complicated fracture and quite a complicated operation that this lady underwent?
A Do you wish me to expand?

Q Please, yes.
C A In the scheme of fractures around the neck of the femur, which is the hip, the subtrochanteric fracture is probably the most difficult of the three sub-types to deal with. It is difficult to reduce. It is difficult to fix and the fixation has a higher propensity to fail than standard fractures.

Q This may be relevant to the point we will come onto, but when you say "a propensity to fail," what does "fail" mean in this context?
D A Failure would usually involve some breakdown in the interface between the implant and the bone, so that the plate may pull away from the side of the bone to which it is fixed. May I stand up?

Q Yes, if you are more comfortable, I am sure. (The witness did so)
A It is fixed down the side of the femur here (indicating) and then there is a screw that passes up into the hip bone itself, so the plate can either pull off in *this* direction (indicating),
E or alternatively the screw can cut out through the femur superiorally, going towards the head. So those are the two commonest modes of failure. (The witness sat down)

Q So literally the fixation between the bones is ---
A It either pulls away from the bone, or it cuts through the bone.

Q That will have inevitable consequences in terms of pain and mobility?
F A Yes.

Q Moving on, we can see that on this day – the day of the surgery, at the bottom of the page – paracetamol was administered and also morphine for pain relief?
A Yes.

Q Unsurprising on the day of operation?
G A Perfectly standard.

Q Moving over to page 4, it is now 21 March. The first entry deals with the morning: "Seen by doctor today" – the X-ray was checked and was okay.

> "Mrs Spurgin able now to get into chair. Please give morphine before moving Mrs Spurgin – a lot of pain on movement."

H

A

We can see at the bottom of the page that again morphine was being administered that day. Again, this is the day after surgery. Would that level of pain be unusual?
A That would not be unusual.

Q You make a point in your report about the reference to an X-ray being checked and being okay. First of all, in terms of the fixation, in terms of the surgery, what does that reference tell us about at that stage?

B

A It states that the doctor reviewing the X-ray was satisfied both with the position of the implant construct on the bone and also with the position that the bone had been put into, which is termed its reduction. So the bone had been satisfactorily straightened and fixed.

Q You make a point in your report about this being on your analysis of the notes, the only reference to an X-ray actually being checked in relation to this patient?
A Yes. There were no X-ray reports and I did not have the opportunity of reviewing any X-rays personally.

C

Q The Panel will know that there is later at Gosport War Memorial Hospital a request by a Dr Reid for another X-ray to take place, but on your analysis of the notes that does not seem to have been followed up. Is that right
A I could not find a record of that X-ray having been taken or reviewed.

D

Q Moving on with the notes, in the middle of that page, page 4, I would just point out that the last three lines of that entry say that the right hip is painful +++, no ooze, but thigh enlarged, possible bleed into thigh but no evidence of hypovolaemia. The hip was still painful but that was not very surprising given how recent the operation was?
A It is not surprising. If you read the contents of my report, I was concerned that the issue of compartment syndrome was raised but not acted upon.

E

Q This is relevant to the criticism that arose in your report of the treatment at the Haslar?
A Yes.

Q That this should have put people in mind of ---?
A Compartment syndrome.

Q Very well. Particularly in light of the pain and the swelling that was occurring?

F

A Yes, and in the light that one doctor had actually made that diagnosis.

Q Yes. That is a note that has not been included in the chronology because it is not so relevant from our point of view but it features in the notes from the Haslar. Moving on to page 5, the next day, 22 March 1999, in the middle of the page, the second entry:

> "Sat out by physios. Drinking and eating much better today. Oral fluids pushed."

G

And it is paracetamol that is being administered that day.

The next page, 23 March, a couple of lines down, a.m. –

> "Moved patient to chair with 2 assistances. Patient has difficulty and pain ++ with mobility."

H

A Then the last couple of lines at 19.53:

> "Transferral and mobilising not well. No ooze on wound on hip."

Still it is just paracetamol being administered.

B We move on over the page to the next day, the 24th. There is a review by Dr Reid, consultant, who also saw the patient at the Gosport War Memorial Hospital. Dr Reid pointed out:

> "Main problem was pain in right hip and swelling of right thigh. Even a limited range of passive movement in right hip still very painful."

C He wanted to be reassured that all was well from an orthopaedic viewpoint. He was saying if it was, he was happy for transfer to take place to the second hospital.

If we move on over the page, again just paracetamol that day that was being administered. The next day, the 25th, there is a note on the ward round that the right leg had increased swelling, the skin was fragile. A haematoma had developed and broken down.

D Go over the page, please, to the top of the page. This is the last day the patient was at the Haslar Hospital. From the nursing notes, the patient was mobilised to the commode with two staff. The last line there is that she was very reluctant to mobilise. "Needs encouragement." Still just paracetamol being given though.

E Then it was the next day, the 26th, that we can see that the transferral took place to Dryad Ward at the Gosport War Memorial Hospital. There is a note in the transfer letter there saying that the patient was now –

> "… mobile from bed to chair with 2 nurses and can walk short distances with a zimmer frame."

It also pointed out that the right lower leg was very swollen and there was a small break in the skin. The only medication is analgesia PRN. On the 26th she was transferred.

F Going over the page to page 10, that day three was a review by Dr Barton. Dr Barton noted effectively she was not weight bearing, and that there was a plan to sort out analgesia. In the second entry on that page from the nursing notes, it is pointed out that transfer had been difficult since admission.

> "Complained of a lot of pain for which she is receiving Oramorph regularly now, with effect."

G The legs are swollen. The last few entries relate to the night time:

> "Requires much assistance with mobility at moment due to pain/discomfort. Oramorph … given…".

H Over the page:

A

"Oramorph given for pain in hip
Experiencing a lot of pain on movement"

We can see from the entries relating to the drugs that were given that there were four doses of Oramorph given that day.

Over the page to page 12, the 27th, Oramorph continued and also co-dydramol prescribed and the nursing notes states:

B

"Is having regular Oramorph but still in pain.
... In some pain, needs 2 nurses to transfer at present."

The next day, the 28th, Oramorph and co-dydramol both given. Moving through the next few pages quite quickly, page 13 on the 29th March, co-dydramol only given.

C

On the 30th, over the page to page 14, again co-dydramol given. In the nursing care plan it is observed that both wounds are redressed.

"Steri-strips from surgery removed. One small area near top oozing slightly...".

The next day, the 31st, Oramorph given again, a small dose and co-dydramol and MST – so slow release morphine – then prescribed for the first time and two doses administered.

D

We go over the page to page 15. At the top there is a nursing entry that the patient was now commenced on the MST.

"Walked with the physiotherapist this a.m. but in a lot of pain."

E

The next day, 1st April, the second entry is from the nursing care plan. There was a wound in the right hip oozing large amounts of serous fluid and some blood, and a hole was noted in the wound. Still having pain on movement.

You made a comment in your report about what this sort of oozing of serous fluid might indicate. Can you help us with that, please?
A I will just refer to my report.

F

Q It is page 11 of your report, just a few lines down from the top.
A Sorry – just to check. Leaking from a wound at this time following surgery would suggest that there was either a clot that had formed within the leg – and I differentiate this from a venous thrombosis. It is a different kind of thing. This is a post-surgical collection of blood. What happens is that over the course of a number of days after surgery it will liquefy, and then it will drain through if there is a patency in the wound. The alternative is that there was an infection on the implant and that this was discharge from that infection.

G

Q You have described that as a potential deep infection?
A Deep infection.

Q Because not just on the surface of the wound but actually inside?
A Inside, presumably right down to the level of the implant.

H

A

Q Just moving on, it was the most that was given that day, on 1 April. Then going over the page to page 16 on the 2nd, the next day, again MST given, and on the 3rd. There is a nursing entry for the 3rd, that the patient was still continuing to complain of pain on movement. Then on the 4th, there is a nursing entry that the wound on the right hip was oozing serous fluid and blood, as before, it would seem. MST was again administered.

B

Going over the page to the 5th, again MST administered. Then the next day, the 6th, there was a review by Dr Barton. That entry in itself is not particularly relevant to us, other than that the MST dose was increased to 20 mg. The next entry relates to swabs being taken from the suture line on the right hip and the right calf. Then there is a microbiology report coming back. The fact that swabs were taken would indicate that that was action being taken in respect of the potential infection. Is that right?

A Yes. It would suggest that there was suspicion of an infection.

C

Q The microbiology report is our page 57. It might be helpful to look at it briefly. Next to you there are a number of files on your left. Can you take out the file marked "I" – which is different from the filed marked "1".

A Yes.

Q Would you turn to page 57. The pagination that we are using is the one at the very bottom of the page with a dash either side. That is the microbiology report. That seems to have been the result of these swabs being taken. Does that seem to make sense to you?

D

A That would fit. Date received, 6th of the 4th.

Q So that would fit?

A Yes.

E

Q Date reported, 9th of the 4th. Does that mean the date that this report was actually made?

A The date that the microbiologist made the report was the 9th of the 4th.

Q Can you help us with the infection that was found? You made a point in your report about whether this would be considered a particularly serious or dangerous infection.

A There are two organisms. May I just check my report on that?

F

Q Of course.

A One is staphylococcus aureus and one is staphylococcus epidermidis. Staphylococcus aureus is a typical pathogen for causing wound infection. Staphylococcus epidermidis is usually a skin commensal, as the name suggests, on the epidermis. A commensal is an organism that lives ordinarily on the surface of the skin without causing problems. It is of theoretical importance in orthopaedic implants, but here, no sensitivities have been given for it. The sensitivities for staphylococcus are typical: flucloxacillin, erythromycin and, quite surprisingly, penicillin, because staphylococcus aureus is not usually sensitive.

G

Q In fact, when you reviewed the issue of whether the treatment for infection that was given at the Gosport War Memorial Hospital and whether the drugs that were used were satisfactory from your point of view, your conclusion was that it may not have been the perfect solution, but that it was satisfactory from your point of view; it was not something you would criticise. So we may not need to go into that.

H

A I am sorry, this is why I was looking through my report. I think they commenced on ciprofloxacin, metronidazole, which is a reasonable best guess, because the patient was incontinent of urine, although not of faeces as far as I am aware. So it was a reasonable best guess.

Q If we go over the page in our chronology to page 18, we can see these drugs being commenced. On page 18, the first entry there is the drugs that were given on the 6th, but on the 7th we can see there is an entry that the fracture site was red and inflamed, she was seen by Dr Barton and that those two antibiotic drugs were commenced: metronidazole and ciprofloxacin.
A Yes.

Q Ultimately, when you were giving your opinion on the prescription of those antibiotics, it was your view that that was a satisfactory approach?
A I think I also said, however, that the antibiotics should have been changed on receipt of the report.

Q Can you help us with why that is?
A The organism staphylococcus aureus is not sensitive at all to metronidazole. The antibiotic ciprofloxacin is a broad spectrum antibiotic which is less effective against staphylococcus aureus than antibiotics such as flucloxacillin and erythromycin, both of which are very good anti-staphylococcal agents.

Q We have seen that the report was only made on the 9th.
A Yes.

Q Just moving on to finish the relevant entries from the chronology, on the 7th, the last entry is a review by Dr Reid. That is the consultant who had seen the patient prior to her transfer to the Gosport War Memorial Hospital, and his entry was that the patient was still in a lot of pain and very apprehensive. He has said:

> "For x-ray Right hip as movement still quite painful – also, about 2" shortening Right leg."

You referred to this earlier in your evidence in relation to there being a further request for an x-ray. You dealt with this at page 10 of your report. From the note about the movement still being painful and the shortening of the right leg, what concerns would that raise?
A My concern would be, given that picture, that the implant had failed.

Q Is the level of pain that the patient had been in which was registered in the notes and which seemed to be continuing after the operation and in the second hospital, and the difficulties in mobilisation, would that be normal if the fixation was working properly?
A In a sound fixation and in the absence of other complications, you would expect the analgesic requirement to diminish and the ability to mobilise to improve steadily until an end point is reached.

Q So what concerns would have been raised by continuing pain and lack of mobilisation?
A In the first few days after surgery, there was the concern of a compartment syndrome causing pain in the thigh. Compartment syndrome is a very painful condition. After 48 to 72

A hours, the pain of compartment syndrome recedes and the likelihood of that being a reasonable cause for her pain recedes at that point. From then on, really at no time does she demonstrate improvement in terms of her general levels of pain as far as I can establish. There is a brief period while she is at Gosport when her analgesic requirements come down to a paracetamol requirement, but it is always documented in the case records that it is painful for her to mobilise.

B Q What concerns does that raise?
A That would worry me that the implant fixation was not adequate.

Q Is this entry by Dr Reid about the shortening of the right leg further evidence of that?
A It is quite strong evidence of that. The hip should not be short by that degree. That is about 5 centimetres. That is a long way short.

C Q By this stage, some two or so weeks or a little bit more after the operation that this patient underwent, would it be common or uncommon for the patient still to be requiring morphine?
A That would be very uncommon in my experience in the context of an adequate fixation.

Q Moving over the page in the chronology, on page 19 we can see that on that day,
D when the review by Dr Reid took place, again MST was given and on the 8th MST was given again. He records:

> "Wound oozing slightly overnight. Redness at edges of wound subsiding."

On the 9th, MST was given again and it was recorded by the nurses:

E
> "To remain on bed rest until Dr Reid sees the x-ray of hip."

As you said before, I think there is no sign in the notes that that x-ray was done or reviewed by anyone.
A I could not find a record of the x-ray having been taken. It would be logged initially in the x-ray department, but there was certainly no report.

F Q Over the page to page 20, on the 10th MST was given again and in the nursing notes it is recorded:

> "Very poor night. Appears to be leaning to left ... Stitch line inflamed and hard area. [Complaining of] pain on movement and around stitch line. Oramorph 5 mg given at 07.15 hrs."

G For the Panel's benefit, I should point out now that that 0715 entry would in fact be on the next morning. If it is helpful to write that in, it would in fact be on the morning of the 11th, because this is an overnight entry. Then moving on to 11 April, in the first entry there is another reference to pain on movement and Oramorph being given at 0715. She was complaining of tenderness around the wound, there is a review by Dr Barton, it seems, a reference to the condition of the patient deteriorating and:

H
> "The patient denies pain when left alone, but complaining when moved at all."

A

Then there is a note there that the patient may be commenced on a syringe driver and that is what took place the following day. I think for our purposes at the moment, those are the relevant notes we need to look at. As we have gone through, we have already commented on a number of the significant points, but if I could just move on to the opinion that you express having looked at the records. I think it is right to say that when you set out your view in your report, you have made some points about ways in which you were hampered initially and it is

B right to say that you felt you were hampered by not having had sight of any relevant radiographs of radiologist's reports. So x-ray reports.

A Or preferably x-rays.

Q Or x-rays themselves. But you did of course take account of the fact that there was the initial reference to the x-rays being okay and then the fact that later at the Gosport War Memorial Hospital, although there was reference to the fact that an x-ray should be carried

C out, there was then no further reference to it.

A Yes.

Q You also felt limited in what you could say because of the fact that there was no post mortem examination.

A Yes.

D Q Therefore is it right that in looking at what the diagnostic possibilities were, you could only give possibilities, rather than firm conclusions.

A A range of possibilities.

Q But you were able at page 14 to set out what in your view that range of diagnostic possibilities was. There are three I think. Can you just help us with what those were?

A They were an untreated compartment syndrome, a failure of the operative fracture

E fixation and a deep tissue infection or abscess formation.

Q You went into some depth in your report about compartment syndrome and about the failings at the Haslar Hospital.

A There is a much better definition of compartment syndrome there than I gave half an hour ago.

F Q That may be the case, although for my part it was sufficient for us and in fact, as it is not a criticism that you would level at the Gosport War Memorial Hospital in any way, I am not proposing to ask you more about that. From the bottom of page 17 of your report, in the final paragraph, you did have some conclusions that may be relevant for us. What is your opinion in terms of whether it would have been reasonable for any of the doctors who were looking after this patient to have considered the issue of the failure of the fixation of the fracture?

G A The fact that she remained in pain throughout the entire episode. I could understand her not being able to mobilise because of general debility – it is not uncommon in patients with femoral fractures of this kind – but for mobilisation to be painful and to continue to be painful and to fail to improve would have concerned me, certainly by the end of the first week.

Q So after that and whilst she was in the Gosport War Memorial Hospital, what is your

H view on whether consideration should have been given to that?

A It is consistently mentioned in the nursing records and in the medical records that she finds it painful to mobilise. Now, that really should not be happening at that point and the correct thing to do at that point would be to put her on to bed rest, take an x-ray and check that the implant fixation is sound.

Q Is that something that you suggest would be an appropriate course of action for just an orthopaedic doctor or for any doctor having the care of this lady?
A I train non-orthopaedic, non-surgical doctors at a very junior level: first and second year post qualification, and I would expect any of them to execute that course of action.

Q Would that course of action have been confirmed as necessary by the review by Dr Reid in terms of the shortening of the leg?
A It appears that – one can only surmise, but he makes the comment that the leg is shortened and requests the x-ray. So it would seem that it was fairly much in the fore of his thinking.

Q In terms of the treatment for a possible deep infection at the Gosport War Memorial Hospital, what was your opinion on ultimately whether the treatment given was appropriate or not?
A My conclusion was that the choice of antibiotics given at the beginning was reasonable, given the context of the patient as far as I could understand it from the case records. I would have reviewed the antibiotic medication on receipt of the microbiology report and at that time stopped the metronidozole and started flucloxacillin, but continued with the ciprafloxacillin.

Q You make a point in your report about appropriate secondary investigation.
A Yes. If the possibility of a deep infection or abscess were entertained, then the best investigation would be an ultrasound scan of the thigh.

Q Who would that be referring to?
A The actual ultrasound would be done by a radiologist, but it would be requested by a doctor. May I expand on that a little?

Q Yes, of course.
A I think that that is something that might not fall within the scope of a non-orthopaedic doctor.

Q In terms of evaluating it?
A Evaluating and recognising that it might come back to an orthopaedic opinion before an ultrasound would be requested. So it might have to come back to orthopaedics and at that point I imagine that investigation would have been requested.

Q That rather leads on to the next question, which is whether it would have been reasonable to expect a doctor at the Gosport War Memorial Hospital to have referred this patient back for an orthopaedic review in light of the symptoms that she was displaying?
A Yes, I think that would have been the reasonable course of action.

Q You commented in your report, and it is the bottom of page 18 and then on to page 19, about whether these possible diagnoses were reversible. Can you help us with that?
A Do you want me to comment on the compartment syndrome?

A

Q No, not for my purposes.
A The failure of the implant fixation is reversible. It is reversible by revision surgery. It is not common, but there are standard procedures in place for that. The deep infection is reversible as long as the infection does not get completely set on the implant. The difficulty with implants is that they do not allow blood into them, unfortunately, so you can very rarely completely eradicate an infection from an implant. You can keep it under control. So it is reversible to that extent.

B

Q In terms of controlling somebody's pain, or improving their mobility, is that something that can therefore be helped in that regard?
A Yes. There is a spectrum of infection from the more superficial and less serious infections which can be dealt with by antibiotic treatment, either by tablet form or intravenously, or if infection has become serious, or if abscesses develop, then surgical treatment of an infection may be necessary.

C

Q On page 20, your second paragraph on page 20, you make some conclusions about treatment at the Gosport War Memorial Hospital. Could you help the Panel with your view on what diagnoses there should have been, whether they are differential diagnoses or not, and what action should have been taken?
A The two possibilities that I reached for a differential diagnoses were that the implant had failed or that she had an uncontrolled infection, or indeed possibly both, which I do not state explicitly. I said that as a consequence it would have been prudent for further orthopaedic opinion to be sought.

D

Q Further investigation to have been carried out?
A Further investigation by way of a plain X-ray or an ultrasound of the thigh.

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MR FITZGERALD: Yes. Very well. Those are all my questions, thank you, but there will be some more.

THE CHAIRMAN: I think we have reached the point, Mr Jenkins, at which we will give the witness a break. You have been on the stand for an hour.
A Have I?

F

THE CHAIRMAN: It sometimes passes very fast, does it not? I will try and break at about this sort of interval, but I should tell you that if at any time you feel in need of a break you only have to say so and we will adapt to your comfort and convenience, but for now you remain on oath, the Panel assistant will take you somewhere where you can get some refreshment, and we will return at 5 minutes to 11, please. Thank you. I should say please do not discuss the case with anybody. Thank you.

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(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Jenkins, I stopped you before you could start.

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A

Cross-examined by MR JENKINS

Q You are refreshed now, Mr Redfern, so you are ready to deal with me. I have not got many questions, but can we just go back over the history for this lady.
A Yes.

B

Q She broke her hip on 19 March. We see that on the front page of the chronology. We know that by the 24th, this is page 7, and we see the date on the previous page (page 6) the date is given as the 24th, there is a ward round at the Haslar Hospital and a Dr Lord is being suggested as someone who can undertake an assessment. We have Dr Lord's assessment over the page at page 7, and then Dr Reid's assessment. So this is five days after her fall.
A Yes.

C

Q Dr Reid, we have already noted, and it is recorded in the entry on page 7, that he is asking for reassurance that all is well from an orthopaedic viewpoint; if all is well, then he would be happy for her to be transferred to the Gosport War Memorial Hospital. Your point, I think, is that this lady was not properly investigated whilst she was at the Haslar.
A In the context of what, the implant---

D

Q Well, I think the way you have put it in your report, which the Panel do not have, you say that it is of grave concern that no further action seems to have been taken in relation to the diagnosis of compartment syndrome, looking at page 19.
A Yes. In relation to the diagnosis of compartment syndrome?

Q Yes.
A That is why I asked in what context. Yes.

E

Q You say:

"In my opinion this lady had a significant bleed into her thigh in the early stages post-operatively" -

we are talking about the few days after the operation.
A Yes.

F

Q "and the possibility of compartment syndrome was raised. Once the diagnosis of a compartment syndrome had been considered" - in other words raised – "then it is of grave concern" – your words – "that no further action seems to have been taken in relation to this potentially serious diagnosis."

The suggestion I have made is that this lady was not investigated as thoroughly as she could or should have been at the Haslar Hospital.

G

A She probably did not even need to be investigated further. To explain the management of compartment syndrome---

Q Right.
A ---it is a clinical diagnosis. Really, almost once the possibility has been raised that a patient has compartment syndrome, then there is an obligation to act upon it.

H

A

Q What you have said in your report is that you would expect a basic level surgical doctor, junior doctor, to be able to make the diagnosis.
A Yes.

Q But that a GP perhaps would not be in that position?
A A general practitioner might not be in that position.

B

Q The time that that should have been considered properly was when Mrs Spurgin was at the Haslar Hospital?
A Yes.

Q It is not apparent that it was.
A That would appear to have been the case, I agree.

C

Q Again, Dr Reid indicates that he was seeking reassurance that everything was well orthopaedically. It was not in your view?
A That was at five days after the surgery. The issue of the compartment syndrome was a few days before that, if I could just refer back to the chronology.

Q Please do.
A Yes, it was the 21st, which is sort of 48 hours post-admission and 24 hours post-

D

operatively approximately. That is when the issue of compartment syndrome was raised.

Q Right.
A The issues related to compartment syndrome would probably have blown over by four or five days after the surgery.

Q Okay.

E

A That episode would have been completed and the damage done.

Q Okay. You also say, and I am just going on in your report:

> "Mrs Spurgin's early failure to mobilise and the pain that she described consistently on moving her injured leg should have given the doctors caring for her at Haslar sufficient reason to consider appropriate investigation by way of a further plain x-ray of the hip and thigh."

F

A Yes, I think that is fair.

Q "This would have eliminated the possibility of fixation failure."
A Yes, at that point.

G

Q You say:

> "It seems from the medical record that these issues occurred prior to transfer to the Gosport War Memorial Hospital."

That, it would appear, was not really done.
A Yes, that would appear to be.

H

A

Q Does it follow that if you had been treating this lady you would not have been in a position to give Dr Reid the reassurance he was seeking?
A I do not think I would.

Q Now, would it be your view that this lady was transferred out of the Haslar Hospital before properly she was ready for it?
A I would say that she was.

B

Q Yes. Once she arrived at the Gosport War Memorial Hospital, it is clear that this lady was still reluctant to mobilise and in a great deal of pain.
A Yes.

Q We know that she was given medication for the pain and swabs were taken. We have indications of that on the notes. If you turn, please, to page 17 of the summary, we see in the nursing care plan that swabs were taken. We have got indications in the medical records that those were sent off for analysis. If I can invite you to turn to the medical records for this patient, Patient I, if you still have them, and if I can invite you to turn to page 59 we will see that this is one report, and from the bottom left hand corner we see that this is a wound swab from the calf.

C

A Yes.

D

Q It is collected on 6 April 99, so that ties in with the date that we have just looked at on the chart. We will see, as we look along the bottom line, it is reported on 8 April, and we see a stamp when it is received on the ward. That would be typical, I think, a stamp or a date to be written on?
A Either when it is received or when it has been reviewed. It depends on the practice.

E

Q You would expect a doctor, when they review a result such as this, to initial it or sign it to say that they have seen it?
A Yes.

Q The Panel will hear in due course that that is Dr Barton's initials, which she entered. We see that it comes back, or is seen on the 9th. This is headed "Provisional Report!" We see that the culture result shows that staphylococcus aureus is isolated but that sensitivity tests were to follow; staphylococcus epidermidis again isolated. I think we have to look at the preceding page, page 57, to see when those sensitivity tests were reported. It took an extra day for that to be reported. The stamp at the bottom of the sheet, the date reported is 9 April.

F

A Yes.

Q The Panel will hear, I think, that the weekend (Saturday and Sunday) was 10 and 11 April. Signed by Dr Barton, and it is stamped as seen or received on the ward on 12 April, so a Monday?

G

A Yes.

Q What you have told us was that the antibiotics introduced by Dr Barton, we have them on the summary at page 18, you have told us that those antibiotics – metronidazole and suprox we have called it on the summary – those were a good best guess at that stage.
A Yes.

H

A

Q We know, because we have just seen the results, that the swabs have not been reported on by 7 April.
A Yes.

Q We will see from the next entry down that:

"Commenced antibiotics as hip wound may be infected."

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That was the view, I think, at that stage?
A Yes.

Q These antibiotics were brought in to deal with the infection that was probably there, but had not been identified.
A Yes.

C

Q What you have told us is that it might have been appropriate to review the antibiotics once the results had come in.
A Yes.

Q We know that was by 12 April. I think if one follows through the chronology, we will see that on page 20, on the night of Saturday, 10 April, it looks as if this lady had a stroke.

D

A I cannot comment on that.

Q All right. Her condition was very poorly on the 11th. The entry that we have in the summary, relating to page 134, suggests that she was seen by Dr Barton. I am going to invite you and the Panel to turn up page 134, because it may be that the entry needs a bit of explaining.
A This is still in file I?

E

Q It is still in file I. There are two page numbers at the bottom of page 134. The other number is in a rather fatter pen, 107.
A Got it.

Q What we see for 11 April 99 in this nursing summary document is an entry which would appear to be written after 7.10 p.m., because it starts by relating something that

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happened in the evening on that Sunday night. The inference I suggest to be drawn is that this is an entry made by night staff, and we will see the very end of what the night staff entry is, the very last thing they write is "Seen by Dr Barton". I do not know that you can comment on it, Mr Redfern, but I am going to suggest that that was Dr Barton seeing the patient first thing on the Monday morning. It is the last thing that the night staff saw at the end of their shift. Again, we have to go back to page 57 because we know that the pathology report was seen or arrived on the ward on 12 April, and that is when Dr Barton signed it.

G

A Yes.

Q You have told us that it would have been appropriate to alter the antibiotics once that report had come in, and I think what we see is that the consultant Dr Reid is reviewing the patient again on that day, page 136, just after the 134 that you were looking at, yes, but I think what we have is a full clinical picture of this lady, that she is in a very poor condition, and I think it may be you would agree that the orthopaedic considerations were not at the

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front of the consultant's mind?

A

A That might be reasonable, but again it is difficult for me to comment without---

Q I understand. So far as an X-ray is concerned, you have said that an X-ray was clearly sought. If we look back at the summary, page 18, swabs had been taken on 6 April. The summary, page 18, deals with the day after that. We see the entry in the clinical notes. Dr Reid, the consultant, has ordered an X-ray. If we are able to go back to page 134 of the notes, we see in a little more detail as to when the X-ray was actually booked for.

B

A Yes, I have that.

Q It is just about a third of the way down the page. It is the entry for 7 April. It reads:

"[Seen by] Dr Reid. For X-ray tomorrow at 15.00 hours".

A Yes.

C

Q Obviously the 8th. But you have not seen an X-ray that relates to the X-ray that was booked. If we go back to the summary, page 19, if you would, the bottom of the page, we see entries indicating Dr Reid wanted the patient to stay on bed rest until he saw an X-ray of the hip. You told us that was the way in which you would want to see the patient managed?
A Yes.

D

Q Off her legs?
A Yes.

Q Until the X-ray was undertaken and reviewed?
A Yes.

E

Q That clearly was the plan. That was a Friday. Dr Reid was due to come in on the Monday for a ward round and we know that he did by Monday the 12th. Again, it may be that the X-ray was not in the forefront of the mind, given this lady's condition. She was to die that night.
A We do not actually know whether the X-ray was taken.

Q We have not seen an X-ray in the records.
A So we do not know whether the X-ray was actually taken.

F

Q No. I think that notes that we have do not indicate that it was or was not taken, or if it was not, why it was not. Can I ask, if this lady was to be reviewed by an orthopaedic surgeon, you would anticipate in a community hospital she would have to be transferred back to a hospital such as the Haslar?
A I do not know what the local arrangements are at the Haslar. There are two ways of doing this.

G

Q One way is to ask a surgeon to come in?
A Yes.

Q What I am going to suggest is that in practice she would have had to be transferred?
A What – as an inpatient?

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A

Q That surgeons from the Haslar would not have wished to come over to the Gosport War Memorial Hospital to review a patient.
A Then she could have been seen as an outpatient or in an outpatient clinic.

Q I understand. At the time that would have been on 12 April?
A There is ample opportunity before that for her to be seen. This process began long before the end of April.

B

Q I understand. What would have happened if this lady had been sent back to the Haslar Hospital? Would it have required a re-exploration of her hip?
A On the assumption that there was a failure of fixation, then there would have been an evaluation of her general fitness to go revision surgery.

Q Yes?

C

A And had she passed that assessment, which is usually done by the anaesthetist who is schedule to do the surgery, then she would have undergone revision surgery.

Q That evaluation is very important?
A Yes.

Q Because decisions have to be made about what is in the patient's best interest?

D

A That is correct.

Q If a patient is elderly, in poor physical shape, it may well be thought this is not in the patient's best interests to undertake surgery under general anaesthetic?
A Yes. There would have to be considerable co-morbidity though. We have a very low threshold for operating on people with fractured neck of femur, because they commonly carry considerable co-morbidity. The bar is set fairly low.

E

Q I understand. It is well recognised that general anaesthetic itself carries risks?
A It is.

Q And one would want to evaluate whether it is generally in the patient's interests and that they will survive the insult that general anaesthetic involves?
A Death under anaesthesia is extraordinarily uncommon, even in very frail patients.

F

Q Under anaesthesia?
A Yes.

Q The patient has to be fit enough to undergo it?
A Yes.

G

Q And be able to come round afterward?
A Yes.

MR JENKINS: Thank you very much.

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Re-examined by MR FITZGERALD

Q Mr Redfern, there are just two matters. Forgive me if they seem obvious, but I just want to clarify them. The first is that you agreed with the suggestion that in your view the transfer from Haslar Hospital to the Gosport War Memorial Hospital took place too soon?
A In my opinion.

B

Q Because there were other things, other investigations, that you thought should have taken place there first?
A Looking at the case file in its entirety, it looks as though that is the case.

Q The question is therefore – and forgive me, as I say, if it is obvious – with that fact in any way remove the need for later doctors to consider an orthopaedic referral?
A No.

C

Q The second point is simply this; you were explaining to Mr Jenkins a moment ago that there was ample opportunity before 12 April for the orthopaedic referral to happen, and that the process started long before then. Could you just explain what you meant by that?
A Again, on my review of the case records, problems with mobilisation were present from the day that she was transferred which was the 26th, I think she was eventually transferred over. The 26th March.

D

Q Yes.
A There is assessment on the 24th and she was transferred on the 26th. Right the way up to the weekend immediately before she died. At any time there the consideration ought to have been given that there was something amiss.

MR FITZGERALD: Thank you. Those are the matters I wanted to clarify.

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THE CHAIRMAN: Thank you very much indeed. Mr Redfern, we have reached the stage I mentioned at an earlier point this morning. The barristers have completed their questions and it is now open for members of the Panel to ask questions of you, if they have any. I am going to turn now to see if we do have questions. Yes. Dr Roger Smith is a medical member of the Panel.

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Questioned by THE PANEL

DR SMITH: I am a physician. Just thinking about your evaluation of this lady at the beginning of her third week, the 15th day – this is 9 April. This is about the staph aureus swabs coming back and she is described as ill and not drinking. "Irritable. Leave me alone." From what you know of this lady, can you thinking for the lay members of this Panel, of any possible medical causes for that condition?

G

A As far as I understand from the documentation prior to her fracture she was independent, living alone and mobilising without assistance. She was not on any medications as far as I am aware. So her pre-morbid state was reasonable. It is very difficult to say but it would fairly exclude, say, any dementing process for example. She presents as somebody who might have a derangement of her electrolytes. Most commonly in my experience the derangement of her electrolytes or an infection would cause similar features as you describe.

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A

Q Indeed, one of your concerns is that she may have had a deep infection in the machinery that is in there?
A That is right, yes.

Q Forgive the physician's view of your world. Such an infection can be severe, can it not?
A It can.

B

Q And cause very important systematic effects on the patient, on the whole patient?
A Yes. It is well recognised as a cause of alteration in demeanour. I am struggling for the right word. Confusion. That is the word. It can cause confusion.

Q What I am coming round to and asking is, as an orthopaedic surgeon with such an ill, old lady is the situation irremediable?

C

A What?

Q If it is an infection.
A What? The condition of upset that she had?

Q Yes.
A No. It is absolutely remediable. You run a standard set of tests, a standard set of

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sources of infection are looked at, including the wound, the urine, if necessary the chest. The chest is listened to – not necessarily X-rayed – but there is a standard set of things that you do in those circumstances.

Q At this late stage when she is really ill?
A Well, yes. I would. I have done that, yes.

E

Q Going back to what Mr Jenkins was asking you about, operating on frail old ladies, is it not a kind of dictum in your world that if you do not operate on some people they die, so it is worth operating on them on the chance that they may survive.
A This is part of the reason we set the bar so low for the threshold for proceeding to surgical fixation. It is recognised that fracture of the femur represents a biological state as well as a pure fracture. Some of what we do is actually to a degree palliative but it is well recognised that if we do not operate on people with hip fractures and get them fixed and

F

mobilised, then it shortens their life expectancy.

Q Would you expect a physician to have that similar view as a general physician?
A It has been a dictum for 25-odd, 30 years now, so…

Q Would you expect a general practitioner to understand that?
A I have to say, I probably would these days because… I probably would. I think it is

G

that well known.

Q Would you expect nursing staff, whose job it is to receive patients from an orthopaedic unit, to know that?
A I would expect them to know. In the rehabilitation unit I would expect them to know that.

H

Q If there was proper liaison between the two units?

A A Yes.

Q And the scene was set for safety?
A If they are regularly receiving patients, then they ought to be aware of that.

Q In your opinion should this lady have died in Gosport War Memorial Hospital?
A It is very difficult for me to answer that.

B

Q In your opinion might she have had a better chance if she had been reviewed by an orthopaedic surgeon?
A I think she would have had a better chance had she been reviewed.

Q And that such a review is not a difficult thing to arrange, one way or another?
A No. It is fairly standard for patients to be sent to rehabilitation units and then sent

C back if there is something amiss.

DR SMITH: Thank you very much.

THE CHAIRMAN: Ms Joy Julien is a lay member of the Panel.

MS JULIEN: What I am trying to clarify is, if you can, what weighting you would give to

D the fact that in your opinion she was transferred too early and the seeming lack of review. What had a great impact, if that is a fair question?
A The answer to that depends on me surmising that her fixation had failed. Had her fixation not failed, then it is difficult to say whether it would have had an effect or not. If the fixation had failed, then I think it would have been picked up earlier at the Haslar Hospital. Does that help?

E Q Yes. It would have been picked up earlier, and so the outcome would have possibly been ---
A Earlier intervention.

Q Resulting in ---
A Resulting in the fracture healing and her being able to mobilise.

F MR JULIEN: Thank you.

THE CHAIRMAN: Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: Dr Redfern, I am not certain whether this is going to be really significant or not. There is something I did not quite understand. When you were talking about the microbiology report you said, or I understood you to say, the drugs were reasonable best

G guess, and I understood you to say "particularly as the lady was incontinent"?
A Yes. My best guess as an orthopaedic consultant would have been an anti-staphylococcal agent. I would have used a flucloxacillin and erythromycin or something similar.

Q As a lay person, could you break that down so that I can understand?

H

A

A The bugs that were growing the staphylococcus and different bugs are sensitive to different types of antibiotics, so one antibiotic is particularly good at treating one bug, fairly good at treating another and no good at all at treating another.

Q Right?
A So the commonest infection that occurs in orthopaedics by a street is staphylococcus infection. It is your number one suspect. If I was doing something on an empirical basis – best guess basis – I would have an anti-staphylococcal agent in there like flucloxacillin, which is probably the best. The antibiotics that were chosen: one is ciprofloxacin, which is a very broad spectrum. It will pick off a lot of bugs, but its direct action against staphylococcus is not as good as flucloxacillin. The other antibiotic that was chosen was metronidazole, and metronidazole is good against what are called gram negative bacteria, which are things that are found in the earth or in faeces, for example. So if a patient were faecally incontinent, then they might contaminate a hip wound, it being close enough proximately. So it was reasonable for those two antibiotics to be chosen.

B

C

Q But how would it have been different if the person had not been incontinent?
A I do not think there was ever... I did not find anything in the record that she was faecally incontinent.

Q No. That is right. I think there is a slight anxiety for me that this elderly lady had not been incontinent and then had gradually become, or there were indications of incontinence. I was trying to work out in my own mind, is that because this lady was actually incontinent, or is it because of the poor mobility and the worries, et cetera, of actually getting out of bed, because there was not previously ---
A Incontinent of urine.

D

Q --- incontinence of urine. Yes – incontinence of urine.
A It is quite common following hip surgery. Quite common.

E

Q So when you talk about incontinence, I have to link that to the faecal incontinence, not the urine incontinence?
A Excuse me. As far as the metronidazole is concerned, that is anti-faecal so in my book it is anti-faecal prophylaxis.

F

Q So the incontinence that we are saying may not necessarily be a sign of deterioration of the patient per se, but rather the incontinence of the urine, or can be a symptom of the fact that they are less mobile because of the pain?
A It is a transient feature commonly of people who have hip fracture.

MRS MANSELL: Thank you. That has helped me to understand that.

G

THE CHAIRMAN: It is just me now, Mr Redfern. I am also a lay member of the Panel. Can I ask you to address your minds to the time when this patient was first admitted to Gosport and, in particular, was assessed by Dr Barton. There is reference to it in the schedule on page 10 referring to the clinical notes on page 27 in the bundle, although they are quite helpfully produced for us in the first column in the schedule if you have difficulty in reading the handwriting in the bundle.
A Yes, I have those records.

H

A

Q Given what you have already told us about your misgivings as to the status of the patient at the time that she was transferred and the fact that in your view this should have been spotted at Haslar, I need to ask you specifically about the assessment that took place when she arrived in Gosport. From what you can see of the notes and what you know that the patient would have been exhibiting by way of symptoms at the time that she would have arrived, are you able to make any comment on the adequacy of the assessment that was made on her at that time?

B

A It seems a fairly sparse assessment at first glance. There is not an examination of the wound, for example, there is not an examination of – it is stated that she is not weight-bearing and that is the only assessment of the hip fracture that I can see in that record. Other than that, it does not appear that the patient's hips or legs have been examined.

Q Do I take it that is something you would regard as essential for the discharge of one's duty of proper assessment or not?

C

A Well, she has been transferred to a rehabilitation hospital. That is the difficulty I have with answering that, because I do not operate in that sphere. I operate in the sphere of orthopaedic acute admissions. That is probably a question that should be asked of a consultant who has a special interest in the care of the medical elderly.

Q The adequacy of the assessment is a specific question that this Panel is going to have to decide at some point in the future. If you do not feel that you are the appropriate person to comment on that, then I will not press you further on that point.

D

A This assessment was made in the rehabilitation unit, so I think it is probably not appropriate for me to comment on that.

Q Can I ask you a more general point from your experience of hospitals and records? You appeared to be expressing some surprise or perhaps concern that so far as the x-ray which had been ordered was concerned, there was no apparent note one way or the other to indicate whether the x-ray had actually been taken.

E

A I am surprised that there is no record of the image anywhere. In fact, there are no x-rays available for any of her orthopaedic episodes as far as I am aware. They are unretrievable.

Q One point then is the retrievability. No doubt that is something that counsel on both sides have explored already. The other is the note that we have ourselves is the nursing note. Would you expect there to be a reference to, "Patient sent off for x-ray"?

F

A Yes. I would expect it to be in the nursing record, "Patient went for x-ray today at X, Y, Z. Returned at A, B, C."

Q Where there is no such indication, are you able to make any inference?
A My inference is that the x-ray was not taken.

G

THE CHAIRMAN: Thank you. That is all from me. Now we are at the point where I have to ask the barristers whether they have any questions arising out of the questions that were asked by members of the Panel. I am going to turn first to Mr Jenkins.

MR JENKINS: I do not, thank you.

THE CHAIRMAN: Mr Fitzgerald?

H

A

MR FITZGERALD: No, thank you.

THE CHAIRMAN: So I am pleased to be able to tell you that does complete your testimony. We are most grateful to you for coming to assist us today. It is only through the presence of witnesses such as yourself that this Panel is able to get a clearer picture of what happened often months, even years, in the past and for your assistance in that regard we are extremely grateful. You are now free to go.

B

(The witness withdrew)

MR KARK: The next witness is Dr Richard Reid, please.

RICHARD REID, Affirmed
Examined by MR KARK

C

(Following introductions by the chairman)

Q I think it is Dr Richard Reid. Is that right?
A That is right.

Q Dr Reid, so far as your involvement in the various inquiries into what happened at the Gosport War Memorial Hospital is concerned, I think you have made a number of statements – is that right? – the first starting in 2000 in relation to Gladys Richards and then you were making statements in 2004.

D

A That is right.

Q Then in 2006, you were interviewed by the police in July and August I think over a period in excess of 20 hours.

E

A That is right.

Q So you have said a great deal about the events particularly concerning three patients. I am going to ask you some questions about that period in your life. If you find it difficult to remember, please just say so and if you need to have reference to material, then we may well be able to assist you. You will be able to have the patient notes in front of you when you are referring to them. Can I ask you first about your own medical background, please? I think so far as your own qualification is concerned, you qualified in Glasgow in 1974.

F

A Yes, that is correct.

Q You became a member of the Royal College of Physicians in 1978, a Fellow at Glasgow in 1988 and a Fellow of the Royal College of Physicians in London in 1990.
A That is correct.

G

Q As far back as the late 1970s and early 1980s, I think you were then beginning to consider a career in geriatric medicine.
A That is correct.

Q You became a consultant in geriatric medicine at Southampton General Hospital in August 1982.
A That is correct.

H

A

Q Did you remain there until about March 1998?
A That is correct.

Q Then I think you took up a role in April 1998 as a consultant in geriatric medicine and also medical director of the East Hampshire Primary Care Trust.
A First of all, it was Portsmouth Healthcare Trust.

B

Q That was its former name, as it were.
A Yes.

Q Then it evolved into the East Hampshire Primary Care Trust.
A Yes. I had a similar role with Gosport Primary Care Trust.

Q I want to deal, please, with your occupation since April 1998 as a consultant at Portsmouth. Where were you based?
A When I first started, I was based at Queen Alexandra Hospital.

C

Q Is that in the Portsmouth area?
A Yes. That is in Portsmouth. At that time, there were two district general hospitals in Portsmouth: the Queen Alexandra and St Mary's, and we had beds in both hospitals.

D

Q I think in early 1999, you took on the responsibility of one of the consultants at the Gosport War Memorial hospital.
A That is correct.

Q How many other consultants were there who were looking after patients at that hospital?
A One: Dr Lord. That is inpatients I am talking about.

E

Q How did you take on that role? How did it evolve that that hospital required a consultant?
A There had always been, as I remember , one consultant who oversaw Daedalus Ward and one consultant who oversaw Dryad Ward and our responsibilities were rotated every now and again.

F

Q I think you remained in position from early 1999 to about March 2000.
A That is correct.

Q That was as consultant specifically for the inpatients on Dryad Ward.
A That is correct.

G

Q In that role, did you come across Dr Barton?
A Yes.

Q Had you had dealings with Dr Jane Barton prior to that?
A Not to the best of my recollection.

Q You were aware no doubt that she was a local general practitioner.
A Yes.

H

A

Q And she had taken on the job of clinical assistant at Gosport War Memorial Hospital.
A Yes.

Q Were you aware that prior to the move to the Gosport War Memorial Hospital, she had worked in the same position at the Redclyffe Annex?
A No, I was not aware of that.

B

Q Were you aware that prior to you arriving there, she had been in post for quite some time?
A Yes.

Q Did you understand the position to be that when Dr Barton was not available, her work would be undertaken by locums, effectively partners at her practice?
A That was my understanding.

C

Q So there was an agreement of cover by the partners at her practice in relation to both Daedalus Ward and Dryad Ward.
A That is my understanding.

Q What role did you have in a supervisory context in relation to Dr Barton?
A Well, as the consultant in charge of the ward, I am ultimately responsible for the medical practice within that ward. At that time, I conducted a weekly ward round. My colleague, Dr Lord, also conducted a weekly ward round. Both ward rounds I think were on Monday afternoons, which meant that – in an ideal world, one would wish the clinical assistant to accompany one on the ward round. To try and overcome that problem, Dr Barton would attend my ward round on a fortnightly basis and on the alternate Monday would attend Dr Lord's ward round.

D

E

Q So you would be going along to Dryad Ward once a week.
A Yes.

Q That was Monday afternoons, was it not?
A Monday afternoons.

F

Q Dr Barton would join you on your ward round once a fortnight?
A At best.

Q At best. Does that mean there were occasions when she was not able to make the ward round?
A That is correct.

G

Q How long would your ward round normally take and what would you do?
A It was about three hours long and I would, with the senior nurse on duty and Dr Barton if she were there and with the senior registrar if one were attached to me at the time, take the notes trolley and do a ward round. In other words, look at every patient.

Q If there were patients causing Dr Barton particular concern, would you discuss those with her, or would you expect those to be raised with you so that you could discuss those with her?

H

A

A Dr Barton, if she was there, would raise issues with me. If Dr Barton were not there, then the nursing staff would point me in the direction of the patients who were causing concern.

Q Tell us something, please, about your understanding of Dr Barton's experience and seniority?
A She was a very experienced general practitioner who had been functioning in that role at the War Memorial Hospital for I think ten or 11 years before I arrived there.

B

Q Did you come across Sister Hamblin when you were there?
A Yes, I did.

Q Would she on occasion accompany you on ward rounds?
A Yes.

C

Q Were there occasions when both Dr Barton and Sister Hamblin accompanied you, or would it be one or the other?
A There would always be a senior member of the nursing team there, and Dr Barton if she was available.

Q In general terms how would you say that the ward was run?
A Very well.

D

Q Your appraisal of Sister Hamblin?
A I beg your pardon?

Q Your appraisal of Sister Hamblin? What would you say about her?
A I thought she was a very kind, caring ward sister.

E

Q By the time you arrived in 1999, as you have already indicated, I think, both of those individuals would have been at that hospital for a fairly considerable period of time?
A Correct.

Q How easy did you find it coming into your post and having to take charge, as it were?
A Well, I do not recall encountering any sort of great difficulty. I felt that the nursing staff were very mature, sensible nursing staff, and I found in general it was a pleasure to work in that ward.

F

Q We have heard a certain amount about how full the ward was at various times.
A Yes, that is correct.

Q You were able to get through all of the patients in an afternoon, were you, or not?
A Yes.

G

Q Did the occupancy of the beds vary from time to time?
A Not greatly. I would say most of the time the beds were one hundred per cent occupied.

Q In that respect, can you remember whether you had any conversations with Dr Barton about how busy she was?

H

A I recollect having a conversation, I think it would be in early 2000, about the pressures of the job.

Q Can I ask you a little bit about the sort of patients that were occupying those beds on Dryad Ward? What sort of patients did you deal with?
A Well, largely they were continuing care patients, in other words patients who were going to be there for the rest of their lives. That was a little bit different from my previous post in Southampton, where most of the type of patient who were in Dryad Ward at that time would actually have been in a nursing home. So that was slightly unusual. I said in statements that over the course of that year, I think that because of the move of patients who would formerly have been NHS long term continuing care patients out into nursing homes, we started to have beds become free on the ward, and at that time, even as there is now, there is always huge pressure at the front door of the hospital to move patients on who can be moved, and we were sort of put under pressure to take patients who might not be continuing care, in other words the sort of patient who I would describe as they have not made a full recovery from their illness, not quite clear in what direction this patient is going to go; are they going to get better or might they become a continuing care patient.

Q Does that indicate that those patients required more care?
A They could be more physically dependent. What they might also warrant though is occupational therapy and physiotherapy assessment, but it is also possible that they could have been less stable medically than patients who had been previously transferred over.

Q Now, some of those patients of all groups presumably at one stage or another might require analgesia.
A Yes.

Q I want to just examine with you for a moment what your understanding at the time was. Did you know of the principles of the analgesic ladder?
A I was aware of the principles but not the term.

Q Your understanding of the principles would be what?
A That one would generally make an assessment of a patient's pain, and broadly speaking there are three levels of analgesia: paracetamol; secondly, non-steroidal or mild opiates; and, thirdly, strong opiates.

Q The principle of the analgesic ladder would be what in dealing with a patient's pain?
A To ensure that the pain was appropriately managed with the correct level of analgesia.

Q We know also that a number of patients who were looked after on Dryad Ward eventually went on to a syringe driver.
A Yes.

Q Can I ask you, please, what your experience prior to starting this job at the Gosport War Memorial Hospital had been of syringe drivers?
A Very limited.

Q What does that mean?
A Well, where I had worked before we did not have continuing care patients, and we had a palliative care ward on site to which one could refer for advice or indeed transfer

A patients over, so we were not dealing with many patients who were at the end of their lives and needing palliation.

Q So previously if you found a patient did need palliation, then you would refer them over?
A Possibly. I mean, I might on occasion deal with it myself, and if I felt that I was managing the patient appropriately I would be content with that. If I felt that the patient's
B pain control was causing me problems, then I would refer on.

Q Okay. Prior to beginning your work at Dryad Ward, had you yourself prescribed syringe drivers to people, with opiates?
A I think yes, but I could not be absolutely sure.

Q Is that an indication that if you had done it was not a common thing for you?
C A It is not a common occurrence.

Q Dealing with opiates, the various styles of morphine that there are, what experience had you had prior to coming to this job at Dryad Ward prescribing morphine?
A Probably prescribing morphine on occasion, and on occasion diamorphine.

Q For what purposes?
D A Well, usually for pain control, but also for people who might be distressed in the terminal stages of an illness, where it was unclear whether the distress was mental distress or physical distress or a combination of both.

Q It may be obvious, but when you are talking about the terminal stage of an illness, these are patients who are very ill?
A Yes.

E

Q As you know, because you were asked about it by the police, because on some occasions at least you saw it, variable doses were prescribed by Dr Barton.
A Yes.

Q Those were variable doses of, among other drugs, diamorphine.
A Yes.

F

Q Had you, prior to coming to the Dryad Ward, come across variable doses of diamorphine?
A Possibly. I mean, it is so long ago and I did not see many patients in my previous career who required syringe drivers, I mean, possibly on one or two occasions, but I really could not say.

G Q Can you recall an occasion or occasions when you discussed variable doses with Dr Barton?
A Yes, I remember one occasion.

Q What did your discussion revolve around?
A It revolved around the sort of, if you like, principle of variable dose prescribing. I asked Dr Barton why she was prescribing a variable dose and she indicated to me that that
H was because at times she herself was not immediately available, or her partners might not be

A immediately available, and particularly at a weekend when she or her partners might be engaged in visiting patients at home, so as to allow a patient's distress to be relievable quickly rather than to wait for a doctor to attend she prescribed it for that reason, and I accepted these reasons.

Q What sort of variable doses did you think you were discussing with her, or were you discussing with her?

B A Well, I do not have a clear recollection of actually discussing a dosage range, but my recollection was that it was in relation to a patient who had received 20-80mg.

Q You raised that with Dr Barton?
A Yes.

Q Did you ever have any discussion with her about ranges such as 20-200mg?
C A I do not recollect having such a discussion.

Q Had you come across that sort of range prior to Dryad Ward, first of all?
A No.

Q Have you ever come across it since?
A No.

D

Q At the time did you realise, and we will have to look at some prescription sheets in due course, that those sort of prescriptions were being written by Dr Barton?
A No. I was certainly aware of variable dose prescribing, but I cannot recollect seeing prescriptions for 20-200.

Q If you had seen such a variable dose, is that something you would have potentially
E raised, or not?
A I should have raised that with Dr Barton.

Q Now, we are also I think in due course going to hear something about anticipatory prescribing.
A Yes.

F Q Have you heard that expression before?
A Yes.

Q Is that something that you have come across elsewhere or only on Dryad Ward?
A I have come across it elsewhere, and in fact we practise anticipatory prescribing on our palliative care ward in Queen Alexandra Hospital today.

G Q Just give us examples, please, of the appropriate ways that anticipatory prescribing can be performed, in what circumstances.
A Well, as I say, it is on the palliative care ward and it is usually the type of patient who again has been very ill, it is not really clear which course their life is going to take, in other words are they going to recover from this illness or might they soon become terminally ill; in other words, the timescale I am thinking of is becoming unwell within the next few days.

H Q What sort of anticipatory prescribing would you then expect, or might you find?

A	In terms of, what, the range of drugs, or dosages, or---

Q	First of all, drugs, and dosages.
A	Well, I am not involved with the palliative care ward at the moment, but diamorphine is obviously one. I think midazolam and haloperidol, and there is a fourth, and I am not sure off the top of my head what the fourth drug is.

Q	The sort of dosages that you come across in appropriate patients would be what?
A	I honestly cannot tell you---

Q	You cannot assist.
A	---what the current practice is in the palliative care ward.

Q	All right. What would you say about the concept of anticipatory prescribing of opiates for patients who were not then in pain?
A	Well, I think in the circumstances I have just described, if somebody is very frail, been seriously ill, in whom one did not know which direction their course were to take, I think it is not unreasonable, in fact good practice, to think about anticipatory prescribing, because I think it is better that doctors who are experienced in doing that do it during nine to five, in other words the patient has been seen by someone who is practising every day in palliative care rather than leaving the prescribing to out-of-hours junior doctors who may know very little about informed palliative care prescribing.

Q	If the doctor is going to write out an anticipatory prescription of that nature, what sort of instruction, if any, would it be necessary to go with that sort of prescription?
A	I think on the prescription chart there is a sort of small square for indication for pain, for distress, usually an indication about how frequently the drug may be administered, and obviously the dose.

Q	That would be an instruction to whom?
A	For the nursing staff.

Q	In terms of the ability to increase a dose, and I am sticking to opiates for the moment, again what was your understanding of the incremental nature of the increase in doses of morphine?
A	Well, at that time, and I would have to confess it reflects my sort of inexperience of palliative care prescribing, but I would have thought that doubling the dose every day would have been appropriate, but I had very limited experience of palliative care prescribing. That would have been my understanding at the time.

Q	You are referring to palliative care prescribing, palliative in those circumstances meaning in your mind---
A	Well, I think I am talking about any, sort of – where a patient is in significant pain and distress for whatever reason, they may be palliatively unwell or in pain or distress for some other reason.

Q	If you had at that stage been required to prescribe opiates, would you yourself have wanted to check in the *BNF*, or not?
A	Almost certainly.

A

Q Now, the *BNF* of course is a guide.
A Yes.

Q It is not a protocol. It does not require you to stick, as it were, to it, but to what extent would you have followed the guidance in the *BNF*?
A I think if it was any departure from normal, or if I encountered a patient on a preparation with which I was not familiar, then I would certainly look at the *British National Formulary*.

B

Q Did you also have an understanding of conversion rates from oral morphine to subcutaneous morphine?
A I think perhaps you mean subcutaneous diamorphine.

Q You are quite right, I do mean diamorphine. I am using morphine as the generic term.

C

A I mean, my understanding at that time was a conversion factor of 2 to 1, although that has since been amended to sort of 3 to 1, in other words you would half or third the dose of morphine to convert to diamorphine.

Q At the time in 99, when you were at Dryad Ward, your understanding would have been one half, would it?
A That is correct.

D

Q Does that reflect – and I do not mean this rudely – your training? Is that how you were trained or does that simply reflect inexperience?
A That was my understanding of what the conversion ratio was.

Q In terms of the prescribing and use of these sort of drugs, how would you compare your experience with that of Dr Barton and Sister Hamblin?

E

A They had much more experience of dealing with this than I had.

Q And did that reflect itself in your discussions and your relationship with them?
A I am sure it did.

Q In what way?
A I felt they had much more experience of using these drugs than I had and I was happy to rely on their advice.

F

Q I want to have it clear. There is one occasion that we are going to look at when you overruled something---?
A Yes.

Q --- that Dr Barton had done, but other than on that occasion are you saying that you deferred to their opinion?

G

A I was aware that Dr Barton and Sister Hamblin had a lot of experience of managing palliative care more than I had, and I would just say, I was happy to rely on them.

Q You spoke about a conversation that you had had about a variable dose with Dr Barton?
A Yes.

H

A

Q And you described her explanation for why it was necessary?
A Yes.

Q You may have said this already, but did you at that time accept the explanation that was given to you?
A Yes, I did.

B

Q In terms of the use of syringe drivers you told us already that your own experience was limited?
A Very limited.

Q Very limited. In terms of the use of syringe drivers at Dryad Ward the experience of Dr Barton and Sister Hamblin – would that have been greater than yours?
A Oh, yes.

C

Q And again in terms of the use of syringe drivers and whether it was appropriate to utilise them or not, is that something you would have deferred to their opinion or not?
A One generally looks to using a syringe driver when someone will not be able to take oral medication or it may be distressing for them to have repeated injections. That is the sort of situation in which one would be looking to employ a syringe driver.

D

Q I understand that. But if you felt that a syringe driver had been set up with a patient by a doctor as experienced, as you have told us, as Dr Barton or potentially, I suppose, by Sister Hamblin, is that something in normal circumstances that you would query or challenge?
A I would certainly ask why a syringe driver had been commenced.

Q Did you actually do that in this case? When you were on Dryad, did you ever ask about that, can you remember, or not?
A I am sure I would have done.

E

Q I want to move on, please, to some patients that you dealt with. You have explained, of course, that you did not start there until 1999. So far as we are concerned, the patients that I think you dealt with directly would be Enid Spurgin, Geoffrey Packman and Elsie Devine?
A Yes, and there is also Sheila Gregory.

F

Q We are not dealing with Sheila Gregory in this case. I think also you wrote a letter in relation to Gladys Richards. Do you recall that now or not?
A This was after assessing her in Haslar Hospital, was it?

Q Yes.
A Yes.

G

Q I think we shall start with her because I think your dealings with Gladys Richards were very limited.
A That is correct.

Q You will see on your left there are a number of bundles. Could you take up bundle E, please. Could you have a look at page 24, please. I think we have now added a second page

H

A

to this, 24 and 26. I am not going to ask you a great deal about this at all, but is this effectively your letter to Surgeon Commander Scott?

A Yes.

Q At the Royal Haslar. Why were you reviewing this patient?

A Because one of our roles as consultants in geriatric medicine was to review elderly patients on non-elderly medicine wards where it was felt that our involvement would be appropriate, either in terms of giving advice or taking over the patient's care.

B

Q If we go to the second page, I think you summarise, helpfully, your findings. You say:

C

> "When I saw Mrs Richards she was clearly confused and unable to give any coherent history. However she was pleasant and cooperative. She was able to move her left leg quite freely although not able to actively lift her extended right leg from the bed, she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport War Memorial Hospital. I understand that her daughters intend to give up the place in Glenheathers Nursing Home as they have been unhappy with the care but would be happy to arrange care in another nursing home."

D

When you talk there about giving her the opportunity to try to remobilise, first of all can you recall this patient now?

A Very vague recollection.

Q Is there any reading that we should do between the lines here when you use that expression? What are you saying about Gladys Richards?

E

A I think I felt her prospects for remobilising were not good.

Q Why is that?

A We know that patients who are confused and have dementia, it is often difficult for them to assimilate instructions, so often when they are seen by physiotherapists they are unable to remember what they have been instructed to do the day before. So it is quite difficult to make progress.

F

Q Nevertheless, you were arranging for the transfer of this patient to Gosport War Memorial Hospital?

A Yes.

Q For what purpose?

A Because I felt she should be given the opportunity to.

G

Q This patient, in fact, was admitted to Daedalus Ward on 11 August 1998. Was there any distinction between Dryad and Daedalus Ward in terms of rehabilitation?

A Yes.

Q Tell us about that, please.

H

A

A Daedalus Ward was a rehabilitation ward, and Dryad Ward had been designated as a continuing care ward. There was, as I recollect, no routine physiotherapy or occupational therapy available on Dryad Ward whereas there was on Daedalus Ward.

Q Did that change? Did you begin to get more rehabilitation patients on Dryad Ward as time went on?
A Certainly patients who were not clear continuing care patients.

B

Q And how did that change come about?
A It came about, I think, because of the move of what formerly have been NHS long-stay patients into private nursing homes, and so that created capacity within the continuing care ward. Because of pressures at the front door, one looked to see who would be the most suitable patients to transfer to Dryad Ward, in other words, ones who were not likely to need significant amounts of input from physiotherapy or occupational therapy.

C

Q I think that was your only dealing with this particular patient?
A Yes.

Q She was transferred to Daedalus Ward as we know and, of course, that was not your sphere at that hospital.
A Yes.

D

Q We can put that away. I want to turn, please, to your dealing with Enid Spurgin, who is our Patient I. Could you take out Patient I's file, please. We are going to start just by reviewing her history, I hope, because I think you saw this patient first of all at the Haslar Hospital?
A Correct.

E

Q Could we start, please, at page 356. You will have to get used to this, but the page numbers to concentrate on are those with a little line either side. This is not your note, but I think it may just help you to bring the patient back to mind. We can see that she had had an accident. She had been pulled over by a dog, apparently, and landed on her right hip. It is described as a direct blow. She had a fractured right subtrochanteric fracture. Is that right?
A That is correct.

F

Q If you go to page 374 – in fact would you look at the page before that, 373. Your note appears on page 374, I think. Is that right?
A Yes.

Q Let us just look at the note before that. This is a note made, I think, after the lady had been operated upon. We can see that there is a note to Dr Lord.

G

> "Many thanks for reviewing this pleasant 92 year old lady who was admitted on the 18th March having sustained a sub-trochanteric fracture to the [right] femur … She was previously well, with no significant past medical history, living alone and independently with no social service input. She was transfused with 3 units of blood, but otherwise made an unremarkable post-op recovery. 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

H

A

of breaking down. Surgeon Commander Scott would appreciate your advice regarding her rehabilitation and consideration of a place at GWMH."

That is written by a house officer to Surgeon Commander Scott. Could we look at your note, please, of 23 March and could you just take us through that?

A You mean just read it?

B

Q Yes

A

"Thank you.

A delightful 92 year old lady, previous well, with sub-trochanteric fracture of the [right] femur. She is still in a lot of pain which is the main barrier to mobilisation at present – could her analgesia be reviewed?

C

I'd be happy to take her to GWMH provided you're satisfied that orthopaedically all is well with the [right] hip.

Please let me know."

And there is a telephone number.

D

Q I think at that time, and you can have a look at some drug charts from the Haslar if you wish, the patient was on paracetamol. The drug charts are at 328. Yes?

A Yes.

Q Together with that note that we just looked at, could we now go to page 301. This is a note from you, again to Commander Scott, dated 26 March 1999. You referred to seeing her on ward E6 on 24 March. The last note we looked at was 23 March. Is it likely to reflect the same visit?

E

A Yes.

Q You say in the third paragraph down:

F

"When I saw her she was fully orientated and able to give a good account of herself. The main problem was the pain in her right hip and swelling of her right thigh. Even a limited range of passive movement of the right hip was still very painful. I was concerned about this and I would like to be reassured that all is well from an orthopaedic view point. If you are happy that all is well, I should be happy for [her] to be transferred to the War Memorial Hospital ...".

G

So the purpose of this, perhaps, is obvious. You wanted to make sure that she was all right for transfer?

A Yes.

Q The pain and the swelling in her right thigh would be an indication of what, if anything – or is that just post-operative?

A You may get some bleeding post-operatively and I would suspect that is the most likely reason at that time for her thigh to be swollen. Another possibility is she could have had a deep venous thrombosis, but I think if it was centred around ---

H

A

Q Could you say that again? A deep venous ---?
A A deep venous thrombosis. It would really depend on clinical examination at the time, but if it is centred around the wound then the most likely thing would be that it would be a wound haematoma bleeding into the wound.

Q I do not think that we have any response from Surgeon Commander Scott. This patient was transferred on the day that this letter was written on 26 March to Dryad Ward. If we go to page 23, is this a transfer note effectively?
A Yes.

B

Q Written by whom?
A It looks like the signature is – is it – Rankin?

C

Q And it is addressed, "Dear Sister". Would that effectively be addressing it to Sister Hamblin?
A Yes.

Q We can see the note that is made. It describes what has happened to her.

> "Post operatively, she is now mobile from bed to chair with two nurses and can walk short distances with a zimmer frame. She has no urinary catheter and although she is continent during the day she has been sometimes incontinent at night.
>
> The skin on her lower legs is paper thin so she is not to TED stockings."

D

Those are those tight stockings to prevent a DVT. Is that right?
A Yes.

E

Q

> "Her right lower leg is very swollen and has a small break on the posterior aspect. This has been steristripped. Her consultant recommends they be elevated.
>
> She needs encouragement eating and drinking but can manage independently.
>
> Drugs have not been included as her only medication is analgesia (paracetamol) PRN."

F

Does that reflect the position on her transfer?
A It certainly reflects what Sister Rankin… Presumably it reflects what she observed.

Q Is this a patient who in your view was appropriately transferred to Dryad, or more appropriately would have been transferred to Daedalus Ward?
A I think if at the time there was no physiotherapy or occupational therapy available on Dryad Ward, it would have been more appropriate that she should be transferred to Daedalus Ward.

G

Q Can we go to page 27, please? Do you see a note there by Dr Barton at the top?
A Yes.

H

A

Q We see on 26 March:

"Transfer to Dryad ward
Fracture of neck of femur
Previous medical history – nil of significance
Barthel"

B

But there is no Barthel score. Then:

"No weight bearing
Tissue paper skin
Not continent

Plan – sort out analgesia"

C

Can I just ask you to help us with this? That does not seem quite reflective of the note that has gone before by the previous assessor. Help us with this. If there is a difference between the state of the patient when they arrive on Dryad Ward and the state as it is described in the previous notes or in the transfer letter, what, if anything, would you expect to be done?
A A number of things could be done. One could contact – the nursing staff could contact the ward to speak to Sister or Captain Rankin. It would also be important to examine the patient and see if there is any obvious reason for the apparent change. Might I say something?

D

Q Yes.
A Captain Rankin's note was really quite at variance with what I found two days before.

E

Q Just keeping a finger where you are, let us go back to the letter that you wrote at page 301. You say that she is fully orientated and able to give a good account of herself.
A Yes.

Q And:

"The main problem was the pain in her right hip and swelling of her right thigh. Even a limited range of passive movement ... was still very painful."

F

Yes?
A Yes.

Q Does that indicate that she is not weight-bearing?
A I would be very surprised if this lady were able to weight bear without very significant help and support.

G

Q When you talk about somebody weight-bearing, does it mean walking on their own or walking with assistance?
A I would say standing in the first instance.

Q The purpose of this transfer, if it were possible, was to mobilise the patient.
A Yes.

H

A

Q Let us go back to page 27 and let us see what happened. First of all, the plan is described as "Sort out analgesia".
A Yes.

Q Help us. Would you expect to see any other sort of plan written out by the assessing doctor, or not?
A I think it is difficult, because one cannot remember the patient, but clearly if

B

Dr Barton has written "Nil of significance" in terms of past medical history, I said this lady was alert and orientated or words to that effect, so I think the most important thing would be reviewing her analgesia and then – after a hip operation, it is very common for people to be in pain and discomfort. The issue then is, one would expect that pain and discomfort, if all has gone well orthopaedically, to gradually lessen with time.

Q If it does not, what is that an indication of?

C

A There would appear to be a problem somewhere.

Q Would you expect that problem to be assessed?
A Yes.

Q And hopefully diagnosed?
A Yes.

D

Q And a plan written up to deal with it?
A Yes.

Q The next note is I think some 12 days later. Whose note is this?
A That is mine.

E

Q Could you read it through for us, please?
A Yes.

"Still in a lot of pain and very apprehensive.
MST [increased] to 20 mg bd yesterday
Try adding flupenthixol
For x-ray right hip as movement

F

still quite painful – also about
2" shortening of right leg."

Q Again, it may be obvious, but what does that indicate to you?
A There is clearly a continuing problem with the right hip.

Q What did you think the nature of that problem might be?

G

A There would be a number of possibilities. The hip could have been dislocated, there could be a deep-seated wound infection, a superficial wound infection. Given that this lady is 92 and she has had a fracture, it is likely that she has osteoporosis. I think she had a dynamic hip screw inserted and if the bone into which that insert is very soft, then the head of the femur can collapse and that can cause shortening of the leg. That was the purpose behind requesting an x-ray, to see if we could get to the bottom of what was going on.

H

A

Q If Dr Barton had formed the same view when she reviewed this patient, would she have been able to ask for an x-ray? It does not take a consultant to ask for an x-ray, does it?
A No.

Q You also note that there is a two-inch shortening of the right leg.
A Yes.

B

Q How would you have ascertained that?
A From examination of the patient's leg.

Q Standing?
A Oh, no. It would be lying on a bed. I cannot say for sure, but almost certainly. We generally measure leg shortening with people lying in bed.

C

Q The last note was on 26 March and this note is now 7 April 1999.
A Yes.

Q Does that surprise you in any way, or not?
A If the patient had been in a lot of continuing pain, then I think it would have been appropriate that an assessment be made of the patient.

D

Q What we do know from the drug charts – and I am just going to use the chronology that we have for the moment – is that this patient had been administered 20 mg of MST since 31 March.
A Yes.

Q Prior to that in fact she had been prescribed and administered Oramorph.
A Which page is this?

E

Q If you go to page 178, do you see the prescription for MST, "Morphine MST", dated 31 March halfway down the page?
A Yes.

Q You have told us obviously that Dr Barton had considerably more experience than you prescribing certainly diamorphine. What about opiates?

F

A Diamorphine is an opiate.

Q I am sorry. What about MST?
A Again, it is an opiate. It is morphine.

Q Who had the greater experience, would you say?
A Of prescribing MST?

G

Q Yes.
A Probably Dr Barton. Probably.

Q Where a prescription like that is written, would you necessarily expect to see anything in the clinical notes?
A I think that in general terms when one is introducing opiates, there should be a note in the clinical record.

H

A

Q Why?
A Because opiates are controlled drugs and they are controlled for a reason.

Q Did you expect this patient to go off for x-ray?
A Yes.

B

Q Who, following your note on the 7th, would actually have had to arrange that?
A I am not clear whether – I might have written the x-ray card on the ward round or, if Dr Barton was there, she might have written it. I could not say.

Q We have a nursing note at page 134. Do you see in the middle of that page:

"7.4.99 Seen by Dr Reid. For x-ray tomorrow at 100 hrs."

C

A Yes.

Q When you write a note like that in the clinical records, who would you expect to read it?
A The medical staff and possibly nursing staff too.

D

Q The medical staff in this case would be - ?
A Dr Barton or if there was a senior registrar or one of Dr Barton's partners who were covering.

Q The next clinical note that we see is written by who?
A By me.

E

Q Does that surprise you in any way?
A One would have expected by that time that the x-ray had been undertaken and a note made of the result.

Q Let us have a look at what had happened on 12 April. Could you read through your note, please, first of all?
A Yes.

F

"Now very drowsy (since diamorphine infusion established)
reduced to 40mg for 24 hours
if pain recurs, increase to 60mg.

Able to move hip without pain
but patient not rousable."

G

Q Can we just deal with the necessity of making notes? You have made notes in relation to both of your assessments of this patient at this stage.
A Yes.

Q How important do you regard it to make a note?
A I regard it as very important.

H

A

Q Again, I am sorry to ask such obvious questions, but why?
A So that there is a clear record available, both to me when I might see the patient next or to any other medical practitioner who is called or for the nursing staff.

Q Can we have a look, please, keeping a finger where you are, at page 174? Again, it is the drug chart. Do you see at the top there a prescription has been written out by Dr Barton?
A Yes.

B

Q For between 20 and 200 mg of diamorphine.
A Yes.

Q If we look below that, we can see a prescription for hyoscine.
A Yes.

C

Q And if we look below that, a prescription for midazolam, between 20 and 80 mg.
A Yes.

Q The effects of midazolam are what?
A Sedative.

Q Does midazolam have an effect on either the heart rate or the respiration rate?

D

A I am not a pharmacological expert, but I would imagine it would have an effect on your breathing, but not on heart rate.

Q The diamorphine has an effect on what?
A Breathing, consciousness.

Q There we have an example of what I asked you about as a generality before: a variable

E

dose of between 20 and 200 mg.
A Yes.

Q You have told us I think that you had never seen that before.
A Well, I did not recollect that prescription.

Q Do you have any view about it?

F

A I think, as I said before, the dosage range is very wide. When I talked before about variable dose prescribing, if I remember correctly, it was in the context of over a long weekend, where Dr Barton or her partners might not be available and we can certainly see that over a course of a long weekend it might be necessary for someone's diamorphine to be increased from 20 to 80 mg, but I could not see that with 20 to 200 mg.

Q Do you think it is an acceptable prescription or not?

G

A No, I do not.

Q The starting dose appears to be 80 mg.
A Yes.

Q You reduced it by I think half.
A Yes.

H

A

Q Tell us why you did that.
A Because I thought that was too large a step up in dosage.

Q What effect do you think it was having on the patient?
A Over-sedation of the patient.

Q If this patient had been up to this stage on MST – and MST, we know, I think is an oral dose.

B

A That is correct.

Q Is it a tablet?
A Yes.

Q We know I think from the drug chart that MST – I am going in fact from our chronology, but if we look at page 178, we can see that there is a dose of morphine MST at 10 mg.

C

A Yes.

Q Prescribed on 31 March. Then on 6 April, a new dose of 20 mg bd. Is that twice daily?
A Yes.

D

Q Those are regular prescriptions to be given at eight o'clock in the morning and eight o'clock at night.
A Yes.

Q We can see, if we go along the row, that those were indeed administered.
A Yes.

E

Q If you keep your finger at 178 but also go to 160, please, we can see, I think, that on the day before – you came along on the 12th – on 11 April the patient had been given, in addition to her MST, some Oramorph.
A Yes.

Q That would appear to have been, I think it is, 5mg.

F

A Yes.

Q Because it is two and a half millilitres and there is 10mg in 5ml.
A Yes.

Q So on the day before that syringe driver was started, the patient appears to have been on 45mg total of morphine, whether it is MST or Oramorph?

G

A Yes.

Q You told us earlier about your own understanding of the conversion rate, which I think has been reviewed since these events?
A Yes.

Q But at the time your understanding of the conversion rate would have been to halve it?

H

A Yes.

A

Q Which would mean a subcutaneous dose of between 20 and 25mg?
A Yes, but I think it is perhaps important to say that at this stage this lady's pain was still not controlled.

Q Now, is that an explanation for the 80mg dose, or is than an explanation for why you only reduced it to 40?

B

A It is an explanation of why this lady needed a higher dose of opiates than the 20-25 she suggested.

Q We have to add to that, I suppose, your understanding at the time that you could double up the dose---
A Yes.

C

Q ---as your incremental increase.
A Yes.

Q So first of all we start off with your understanding that you should halve from oral if going to subcutaneous---
A Yes.

D

Q ---but then your understanding that you should double up if an increase was required?
A At that time that was my understanding.

Q Is that how you got to 40?
A Yes.

Q Well, you tell us, how did you arrive at the figure of 40?

E

A I think that would be the way I would have done it.

Q Using your own figures would that have been a substantial increase, or as much of an increase as you would want to allow, or would you have gone higher than that?
A Than 40?

Q Yes.

F

A No. I think 40 was the right dose in these circumstances.

Q What was the danger, if any, for this patient of the dose that she was then on, of 80mg?
A Over-sedation and respiratory depression.

Q What is the danger of that?

G

A Well, if patients are sufficiently over-sedated, respiratory depression can result in death.

Q If we just follow this through, back to your clinical note, please, page 27, you have recorded:

> "Now [very] drowsy (since diamorphine infusion established) – reduce to 40mg/24 hrs – if pain recurs" –

H

A

and then that is an arrow up, I think, to 60mg, is that right?
A Yes, that is right.

Q What is the note below: "Able to move hips"?
A "without pain but [patient] not rousable".

B

Q "patient not rousable" perhaps we all understand. What efforts would you make to rouse the patient?
A Well, first of all speak to the patient. If they do not respond to speech, then touch them, perhaps shake an arm. In extreme circumstances what one can do is give the patient a painful stimulus, for example squeezing a toe, squeezing a finger, earlobe, or, in someone who has been in pain from the hip, then moving the hip would be---

C

Q You were unable to get any response from the patient?
A Yes.

Q What was your understanding of how long it would take for your reduction to have effect?
A I would have thought that would have been having an effect within an hour of reducing it, but I am not an expert in pharmacology.

D

Q We can see from the clinical record that on 13 April at 1.15 in the morning the patient was confirmed to have died.
A Yes.

Q Now, I just want to look at timing, please, so I am going to ask you to be given the original – we have now created a file with all of the originals that we have got in it, and I am going to ask for the original prescription sheets for Patient I to be handed to you. (Same handed) It is difficult for us to read, on page 174, but can you just help us with the timing: I think the original 80mg was started at eight o'clock in the morning, is that right? Sorry, you will have to find the right page first.
A Yes. Well, it looks like eight o'clock or nine o'clock in the morning; I think probably eight o'clock.

E

F

Q I see what you mean, yes. The midazolam, I think perhaps that is a bit easier to read.
A Well, that looks like nine o'clock.

Q So that appears to be when the syringe driver was initiated.
A Yes.

G

Q What have you written underneath?
A I beg your pardon?

Q Have you written anything underneath when you have reduced the dose?
A On the drug chart you mean?

Q Yes, on the drug chart, which I thought you were looking at.
A I do not think I have written anything on the drug chart.

H

A

Q Can you tell us, please, at 16.40 what happens?
A Oh, "Dose discarded 40mg 16.40".

Q Would that be as a result of your intervention?
A I presume so.

Q So at 16.40 effectively a new syringe driver is started?

B

A Yes.

Q With your reduced dose. Did you give any consideration to the midazolam?
A I do not recollect doing so.

Q You do not recollect it?
A No.

C

Q Just looking at that sheet in front of you, Dr Barton had prescribed, concentrating on midazolam, 20-80mg, and when the syringe driver was restarted it looks from our copy as if the midazolam was increased to 40 from 20.
A It does.

Q Can you help us as to how that happened?

D

A I have no idea.

Q Would you have directed the increase?
A I would find that astonishing if I directed that increase.

Q Why do you find it astonishing?
A Because when I saw the patient I thought the patient was over-sedated, and it would

E

seem totally counter-intuitive to increase the dose of midazolam.

Q You have directly brought about the reduction in diamorphine?
A Yes.

Q Now, just stepping back from the drugs, and then we will take a break, this patient had continuing pain from her hip.

F

A Yes.

Q You had directed that an X-ray take place in your clinical note of 7 April.
A Yes.

Q What did you want to happen with this patient?
A At what stage are you talking about?

G

Q On 7 April when you intervened.
A Well, to have an X-ray to find if we could get to the bottom of why this lady was having so much pain.

Q An explanation of the two inch shortening of the leg?
A Yes.

H

A

Q That does not appear to have happened.
A No.

Q By 12 April, when you come across this patient, you have found an unrousable patient.
A Yes.

B

Q Can you recall if you made any enquiries about what had happened about your note?
A I cannot recall.

MR KARK: Sir, I think that is all that I need to ask about this patient, but I will review my notes, if I may, over the short adjournment.

C

THE CHAIRMAN: We are going to break now for lunch. We will return at 5 minutes past 2. In the interim period, please remember that you remain on oath in the middle of your testimony and you should not discuss the case with any person nor allow any person to talk to you about the case. Thank you very much. 5 past 2, ladies and gentlemen.

(Luncheon adjournment)

D

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Kark.

MR KARK: There was just one more question I wanted to ask you about the previous patient. Do you still have the bundle in front of you, bundle I? We have seen what happened with this patient: the problems with the hip; the diamorphine that was prescribed, and then your reduction, yes?
A Yes.

E

Q We know the patient died the following day.
A Yes.

Q If we go right to the back, please, to the death certificate, and you will find a little tab, and if you just turn over the final interlever, the cause of death is given as?
A Cerebrovascular accident.

F

Q Where does that come from, as it were? What is that based upon, do you know?
A No.

Q Is there any indication of that that you have seen in this patient's terminal stage?
A No.

G

Q Let us move on to the next patient. If you can put that file away, please. I want to ask you about Mr Geoffrey Packman. If you could take up file J. This gentleman we know, just to remind everybody, if we go back to 6 August, this is prior to you having any dealings with him, I think, the first note we have got for this gentleman, the easiest place to find it is page 47, we know that this gentleman was admitted to accident and emergency at Queen Alexandra Hospital on this date, 6 August.
A Yes.

H

A

Q We can see that the problems are set out, and he has got cellulitis. Is that actually an infection?
A Yes, it is an infection of the skin and subcutaneous tissues.

Q Cellulitis in the left leg. He has got chronic leg oedema, poor mobility, morbid obesity, TBP?
A No, I think it is increased BP, which is increased blood pressure.

B

Q Oh, sorry, arrow up?
A I think so.

Q Then "AF", is that atrial fibrillation?
A That is correct.

C

Q Then if we go on to page 49, are either of those notes made by you?
A Yes, the first one.

Q The top one, 9 August.
A That is correct.

Q Can you just take us through that, please?

D

A Yes. "Cellulitis of [left] leg settling -- switch to oral fluclox" – that is flucloxacillin.

Q Which is what?
A It is an antibiotic. "Oedema [left greater than right] foot – continue frusemide", which is a water tablet. "Arthritis of knees [left greater than right] +++ Arthritis of hips – mild [left greater than right] CNS intact Apyrexial BP [satisfactory] – continue felodipine but [reduce] to 2.5mg ([because of] oedema)".

E

Q I am sorry, what is that last entry all about?
A Felodipine is an agent which is used to control blood pressure, but one of its side effects is it causes swelling of the legs, and I have recorded in the third line of my note that Mr Packman had oedema with both feet, more so on the left side, so it was trying to get rid of that, because you are more at risk of having cellulitis if you have got edematous, swollen legs.

F

Q Below that we can see an entry which, I think, is not yours but we can see that the patient is described as being well.

"Cellulitis improving on antibiotics"

He is awaiting physiotherapy?

G

A Yes.

Q Over the page, page 50:

"Patient well.
Cellulitis improved on [antibiotics]
Continue physio
Apyrexial"

H

A

Apyrexial?
A Yes.

Q Meaning no temperature?
A No temperature.

B

Q Then again, just glancing through this quickly, the next entry is the same day:

"Clinically brighter.
Leg looking better marginally
Pressure sores being dressed

...

C

Continue nursing care as now and try to mobilise."

A Yes.

Q Over to 13 August, please. I do not think this is your note, is it?
A No. It is Dr Chatterjee.

D

Q I do not think we need to go through this in any detail. We can see much better than on admission; carry on with antibiotics, take them 10 days. That is on the middle of the page. Then, right at the bottom, do we see:

"Transfer to Dryad Ward on 16/8/99"

E

A Yes.

Q Page 52, the following page. I do not think he did get transferred on the 16th?
A No, I do not think he did.

Q I do not think your notes appear. Would you just look through the next couple of pages. I think it is most Dr Chatterjee?

F

A Yes.

Q Is that right?
A Yes, and my colleague, Dr Tandy.

Q Can we then go, please, to page 55. This is 23 August. This is a note which we think is made by Dr Ravindrane?

G

A That is correct.

Q Dr Ravindrane worked where?
A He was a senior or specialist registrar who would be based at Queen Alexandra Hospital but at that time he was working with me and he would on occasion come out to Gosport with me.

H

A

Q Are you able to help us. This is a note by him. Do you know where this assessment took place?
A I think it was at Gosport.

Q I think that accords with Dr Ravindrane's statement as well. It is just that the letter-headed paper, I do not think we have seen as coming from GWMH before.
A Sorry?

B

Q This is page 55.
A Yes.

Q Do you --- Sorry, go on.
A I was just going to say on the previous page it says "for Gosport" on the 23/08.

C

Q That would seem to indicate that although Dr Ravindrane was working at the QAH, this was an assessment which actually took place on the ward. That is Dryad?
A Yes.

Q Just looking through this, what is happening here? What is Dr Ravindrane doing?
A He has outlined the patient's problems and conducted an examination. Then he has written a plan at the bottom: repeat haemoglobin; I think it is urea and electrolytes, and liver function tests on Friday.

D

Q In terms of a note, just by way of example, you presumably have made many such notes in your time?
A Yes.

Q Is this an acceptable note of an assessment and examination?

E

A Yes.

Q And is that the sort of note that you have seen many times before?
A Yes.

Q And it describes what the patient's problems are. It describes what his present position is, and we see in the middle of the page is it "MTS"?

F

A "MTS = very good", I think it is. "No pain." I cannot read what ---

Q I think it is "Better in himself"?
A "Better in himself". I think the next bit is "0 JVP", which is jugular venous pulse, which is a clinical sign that we look at to tell whether someone might have heart failure.

Q And that would indicate that he is or is not in heart failure?

G

A Not in heart failure. Then the next line, I think, is "CDs [tick]", which means he thinks the cardio vascular system is unremarkable on examination. The next thing is "Rs", which is ticked.

Q "Rs"?
A Respiratory system.

H

Q So he is checking all the functions?

A Yes.

Q Vital functions.
A Then I think "PA" is the next thing.

Q Then we see "Obese"?
A It says "obese", and then, "Legs slightly…"

Q Oedematous?
A Oedematous, yes. "Chronic skin change. Ulcers dressed yesterday."

Q Do you have a recollection now of this patient?
A No.

Q No.
A Not really.

Q We have heard that he was a very large gentleman?
A Yes.

Q With very bad ulcers, but that does not ring any bells with you?
A I have a vague recollection of a patient who when he was admitted to Ann Ward at Queen Alexandra Hospital, who was extremely obese and, if I remember correctly, and if it is Mr Packman, the nursing staff had to put two beds together to accommodate. That is the only real memory I have – if my memory serves me correctly.

Q I think we go to some drug charts towards the back. Start at page 179, and then go backwards, as it were. We can see that the patient had been on paracetamol, which he declined at the Queen Alexandra Hospital on a number of occasions?
A Yes.

Q Then could you go to 173. There is an entry in the middle for something called Clexane?
A That is correct.

Q We can see, I think, that all of these drugs were prescribed on 23 August?
A Yes.

Q Do you see?
A Yes.

Q It seems to be that these were prescriptions by Dr Ravindrane?
A Yes.

Q Do not say "yes" if you are not sure about it. Do you recognise this signature or not?
A The first three certainly look like Dr Ravindrane's signature. I am not sure about the fourth.

Q In the middle of that page, we can see that a drug called Clexane was prescribed?
A Yes.

A

Q Do you know what Clexane is for?
A Yes. It is what is called an anti-coagulant. It is used to prevent and treat deep venous thrombosis and pulmonary embolism.

Q That seems to have been prescribed for this patient and at some stage certainly administered?
B
A Yes.

Q The other drugs that we can see are doxazosin?
A Doxazosin, which is for high blood pressure.

Q Frusemide?
A Which is a diuretic, or water tablet.

C

Q And paracetamol?
A Pain killer.

Q And then, is that a cream?
A I think it is 50-50 cream. I am not sure what that is.

D
Q And the very last entry there?
A Is magnesium hydroxide, which is a laxative.

Q Again, I am afraid we are going to have to do this thing of keeping a finger where you are from the prescription charts and then going back to the clinical notes. Could you go back to page 56?
A Yes.

E

Q There is an entry right at the top there which I think is Dr Barton. Is that right?
A Yes.

Q

"Called to see"

F
is it –

"pale, clammy, unwell.
Suggest ? MI…"

Can you read the next words?
A Yes. It is –

G

"Treat stat diamorph and Oramorph overnight.
Alternative possibility GI bleed but not haematemosis
Not well enough to transfer to acute unit
Keep comfortable
I am happy for nursing staff to confirm death."

H

A

Q In what circumstances would you expect those words to be used, the last sentence: "I am happy for nursing staff to confirm that"?
A I think if you felt that someone was terminally ill.

Q The suggestion of "MI" – myocardial infarction. What is a myocardial infarction?
A It is a heart attack.

B

Q Are there circumstances where diamorphine can be an appropriate drug?
A Oh yes, indeed.

Q The reference to a GI bleed?
A Yes.

Q Is that what you would call a differential diagnosis?

C

A Yes.

Q If this patient were having a GI bleed, as we may see in due course that is possible or even likely, is that a treatable event?
A Potentially.

Q Potentially how? What would you do?

D

A By transfusion, and then investigation of the cause which would usually be by what is called endoscopy. At endoscopy it is possible to carry out specialised treatments to try and stop bleeding, if that is felt to be the appropriate thing to do.

Q Try and find out the cause of the bleed, presumably?
A Yes.

E

Q And if you could treat it?
A Yes.

Q Of itself, is it inevitably a terminal event?
A Not of itself.

Q Underneath this entry we have another entry, I think, from Dr Barton.

F

"Remains poorly but comfortable. Please continue opiates over week-end."

A Yes.

Q That entry on 26 August – can you keep a finger there, please, and then go to the drug charts at 174. Do we see that on 26 August Oramorph was prescribed?

G

A Yes.

Q I am going to ask for you to be given the original prescription sheet for this please, because I hope you will find the writing a bit easier to read. (Document handed to the witness) Do you see against the entry for diamorphine "40-200 mg"? There is an entry to when it was first administered?
A First administered on the 26th.

H

A

Q Do you see just above the word "Dose"?
A Yes, 30?

Q It says "30"?
A Yes, yes. And then 31st, the following one, so I presume that refers to the day it was ---

B

Q Actually administered?
A Yes.

Q The date above that appears to be the 26th?
A The date of ---

Q The date above that?

C

A Yes. A lot of prescriptions.

Q And you would take that to be the date of prescription?
A Yes.

Q And the prescription there was for diamorphine between 40 and 200 mg?
A Yes.

D

Q And that is the sort of wide range – I will not ask you again – that you spoke about earlier?
A Yes.

Q You said you had not seen before?
A Yes.

E

Q Or here, or since?
A Yes.

Q That starting dose of 40 mg, do you have any comment to make about that? Did you see that at the time or not?
A I think... I am sorry. The Oramorph starting dose – I beg your pardon. That is the

F

prescription above – the Oramorph.

Q No. The Oramorph had already started, I think.
A But it had never been given.

Q I think you are right. I think it had been prescribed on 26 August. Just give me a moment.

G

A I think it is over the page.

THE CHAIRMAN: It is page 175, Mr Kark.

MR KARK: I think the Oramorph had first been given, in fact, on the 27th, and it was ---

THE CHAIRMAN: Mr Kark, if you look on page 175, below the first row, there is a second

H

Oramorph which in time is the first.

A

MR KARK: You are quite right. I am grateful. So there are two entries for Oramorph on page 175 and we can see that there is an initial, I think, under the 26th at 22.00 hours?
A Yes, yes.

Q Can you help us with the dosage that was actually given?
A It looks like 20 mg.

B

Q Thank you. In the clinical notes that we have been looking at, back at page 55, there is reference to the possibility of an MI - yes?
A Yes.

Q There is no reference to pain?
A No.

C

Q This patient, we know, was put onto a syringe driver?
A On the ---

Q It was ---
A On the 30th.

D

Q Actually administered, it was prescribed, as we have seen previously, but he was put onto it on the 30th at a rate of 40 mg?
A Yes.

Q Can you just help us with this. Treating a myocardial infarction, if that is what was being done, is there a dose, a normal dose, that one would give for myocardial infarction, as opposed to for pain?

E

A Depending on the size of the patient – 2.5 to 5 mg. But this was a very large gentleman.

Q Yes. So do you use what?
A It might have been up to 10 mg, an initial dose of diamorphine.

Q To treat a myocardial infarction, if that is what the concern was, would you have used

F

40 mg?
A Usually with myocardial infarction you would give a single dose.

Q Not a syringe driver?
A Not a syringe driver straight off.

Q Staying on page 56, underneath the entry that we have been looking at do we see an

G

entry for 1 September?
A Yes.

Q Whose note is that?
A It is mine.

Q Could you help us with it, please?

H

A

A

"Rather drowsy, but comfortable.
Passing melaena stools
[Abdomen] huge, but quite soft.

Pressures sores over buttock and across the posterior aspect of both thighs

B

Remains confused
For T.L.C. – stop frusemide and doxazosin
Wife aware of poor prognosis."

Q Can you help us, please, why you formed the view at that stage that you apparently did that this patient was effectively for palliative care?
A He was a very large man who had become immobile prior to admission. I think the final precipitant probably of his loss of mobility was his left leg cellulitis, but it was clear that

C

this man had been struggling to remain mobile without any intercurrent illness prior to his admission to hospital. I have recorded in my earlier note that he had arthritis +++ of his knees, he had grade 4 pressure sores. My view is that this man was extremely unlikely ever to leave hospital and, probably worse than that, that this man's life expectancy was likely to be extremely limited. When I saw him, he was obviously having a very significant gastrointestinal bleed – that is the reference to passing melaena stools – and I felt that he was terminally ill.

D

Q Had this problem been recognised earlier, could something have been done for him?
A Possibly, but I think it would be important to state that his pre-existing problems would remain. In other words, his arthritis, his grade 4 pressure sores and I think there was something else which I cannot bring it to mind.

E

Q On 26 August, when she first made a note about seeing this patient, Dr Barton made her notes at the top of page 56 and appears to have prescribed on the same day Oramorph, diamorphine with a variable range and midazolam.
A Yes.

Q What do you say about that sort of prescription?
A I think without having seen the patient, it is difficult. If one is considering – this man was clearly unwell on 26 August, very unwell, and I think to give diamorphine was an

F

appropriate measure. Given his multiple problems, I would have felt that this man's prognosis for life was extremely poor and I feel at that stage that he might well have needed regular Oramorph and diamorphine in the next few days.

Q Is that the sort of prescription you are saying you would have written?
A No, no. I am talking about diamorphine.

G

Q What I am asking you about this prescription, this range of prescriptions on 26 August: midazolam, Oramorph, diamorphine with a range of 40 to 200. Is that a prescription you would have written?
A I would not have written a prescription for diamorphine 40 to 200 or midazolam 20 to 80.

Q You would not?

H

A No.

A

Q Why not?
A Because I think the range is too great.

Q When you saw the patient on 1 September, you described him as drowsy.
A Yes.

B

Q Does that indicate to you the appropriateness or otherwise of the degree of sedation?
A It may be entirely appropriate, because it is sometimes not possible to relieve a patient's distress without them becoming drowsy.

Q That depends I suppose on the degree of pain.
A Or distress.

C

Q Is there any reference to distress or pain?
A In Dr Barton's first note, she refers to him being "pale, clammy and unwell." Often when people are clammy, they can feel pretty unwell and distressed. Often if people are unwell, they become clammy and be feeling distressed.

Q They may be distressed presumably or they may not be distressed. Do you see any note of pain or distress?

D

A No, I do not see any note of pain or distress.

Q Can we move on, please, to the next patient, Patient K, Elsie Devine, and could you take up file K? First of all, can you help the Panel by telling us whether you have any independent recollection of this patient?
A Not really. I remember meeting her daughter, but I do not have a very clear recollection of Mrs Devine.

E

Q Could you go to page 155, please? This patient, as we see at the top of the page, had been transferred to Dryad Ward for continuing care.
A Yes.

Q She had been through Mulberry Ward, as we can see at the top, then went to the Queen Alexandra and then to Dryad.

F

A Yes.

Q Then there is a record by Dr Barton. Did you see the patient on 25 October?
A Yes.

Q Can you help us, please, with what you found?
A Yes.

G

"Mobile unaided
Washes with supervision
Dresses self
Continent
Mildly confused
Blood pressure 110/70

H

A

Normochromic anaemia – chronic renal
failure.

Was living with daughter and son-in-law
? son-in-law awaiting bone marrow transplant
Need to find out more re son-in-law etc."

B

Q We have heard quite a bit about this patient, but "mobile unaided" and "dresses self" seem to be an indication that certainly physically she was fairly comfortable.
A At that time, yes.

Q I just want you to help us, please, with the drugs that this lady was being administered. Could you go to the prescription charts, starting at page 279C? We can see I think that the patient was on thyroxine, which is obviously to treat hyperthyroidism.

C

A Yes.

Q Frusemide.
A Yes.

Q For what?
A It is usually used for cardiac failure and sometimes used for ankle swelling.

D

Q And amiloride, is it?
A Yes. That is used for cardiac failure too.

Q Trimethoprim, is it?
A Trimethoprim is an antibiotic.

E

Q Underneath that, although that is rather later, we can see fentanyl.
A That is right.

Q I think also in fact that at this time there was also a prescription for Oramorph. If we go to page 279B, do we see that on 21 October there was a prescription for Oramorph?
A Yes.

F

Q Can we go back to the clinical notes? Your note was made on 25 October. The next note in the clinical notes is what?
A I think it is 1 November, which is my note.

Q That appears to be the next note sequentially.
A Yes.

G

Q Can you read it through for us, please?
A Yes.

"Physically independent but
needs supervision with washing and dressing
help with bathing
Continent
Quite confused and disorientated

H

A

Eg, undressing during the day.
Is unlikely to get much social
support at home.
Therefore try home visit to
see if functions better in own home."

Q There is no note between 25 October and 1 November. If the patient's condition had not changed, would you necessarily expect there to be any note?

B

A No.

Q Again, going back to the drug charts, please, a drug called chlorpromazine was issued. If we go to page 279B, we can see right at the top chlorpromazine was given.

A Yes.

C

Q Can you tell us, please, what chlorpromazine was used for?

A It is a tranquilliser.

Q That sort of dosage of chlorpromazine of 50 mg?

A A substantial dose.

Q If we go to 15 November, back to the clinical notes at page 156, we can see that apparently there had been something of a change in the patient's condition.

D

A Yes.

Q This is not your note, I do not think.

A It is.

Q I am sorry. Before we go through the note, where are you getting this information from?

E

A From the nursing staff or Dr Barton, if she was present on the ward round.

Q So this is not obviously based on what you have seen of her?

A No.

Q Can you just take us through your note, please?

F

A Yes.

"Very aggressive at times
Very restless – has needed thioridazine"

Which is another sedative drug, tranquilliser rather.

G

"On treatment for [urinary tract infection] – MSU sent"

That is a mid-stream specimen of urine because of blood and protein in the urine.

"[On examination] Pulse – 100/regular
Temperature 36.4
[Jugular venous pressure not elevated]
HJR …"

H

A

This is hepato jugular reflux. It is a test of whether someone might be in heart failure. It was negative.

> "Oedema +++ to thighs
> [heart sounds] – nil added"

B Meaning the patient had normal sounds –

> "Chest clear
> Bowels regular – PR"

That means "per rectum"; a rectal examination had been done on 13 November 1999.

C

> " ... empty
> but good bowel actions since."

Then in brackets an asterisk with "MSU – no growth". What that probably reflects is that a member of the nursing staff had gone off and found the result of the specimen of urine and it said there was no growth.

D

> "Asked Dr Luznat to see."

Dr Luznat is a consultant in old age psychiatry.

Q The fact that this lady appears to have a UTI or consideration for a UTI, is that something that would normally be noted in these clinical notes, or not? It has been noted by you obviously.

E

A Yes, ideally, but urinary tract infections are quite common and it certainly often would be my experience in the past that people have not recorded things like a urinary tract infection in the notes because it is thought to be relatively minor, but it should be in ideal circumstances.

Q If we look at the note underneath yours, is that a sort of referral?
A Yes.

F

Q It is a referral written in the clinical notes.
A Yes.

Q That is to Rosie Luznat, who I think is the doctor that you have just been referring to.
A Yes.

G

Q That says:

> "Thank you so much for seeing Elsie. I gather she is well known to you."

Can you read it any better than we can?
A I think it is:

H

A

"Her confusional state has increased in the last few days to the point where we are using thioridazine."

Q That is the sedative that you have referred to, is it?
A Yes.

Q Then there is a reference to her renal function.
B
A Yes.

"Her renal function is deteriorating. Her MSU showed no growth. Can you help? Many thanks."

Q The patient I think in fact continues on thioridazine. It is administered, according to the drug charts – and I will lead you on this, if I may – on 17 November in the afternoon.
C
A Yes.

Q Then if we go to the top of page 157, can I ask you this? We have seen your two notes on the 1st and the 15th. If a patient deteriorated, first of all, would you be available to be spoken to by Dr Barton if she required any assistance?
A Yes. I might not be immediately available, but I should be available.

D
Q Was that your role?
A To be available, yes.

Q And to give advice if it was needed.
A If Dr Barton felt she wanted advice, yes.

Q Then at the top of page 157, we can see:

E

"Elderly Mental Health

Thank you. This lady has deteriorated and has become more restless and aggressive again. She is refusing medication. She does not seem to be depressed and her physical condition is stable."

F
Yes?
A Yes, I think that is what it says.

Q Then I think it is:

"I will arrange for her to go on the waiting list for Mulberry Ward."

G
Mulberry Ward we have heard quite a bit about. It was the elderly psychiatric ward.
A Yes.

Q The next note is made by Dr Barton. You at the time did not have any dealings at this period of time.
A No further contact after that last note.

H

A

Q I just want to ask you one matter about this. If we look at the next note made by Dr Barton on 19 November:

> "Marked deterioration overnight
> Confused, aggressive. Creatinine 360
> Fentanyl patch commenced yesterday
> Today further deterioration in general condition."

B

In what circumstances to your knowledge is a fentanyl patch be appropriately used?
A For a patient who is in pain and/or distress.

Q Pain or distress.
A Yes. I think its licence indication is for pain, but, like diamorphine and opiates, they are often used where it is unclear as to whether the patient's distress is physical or mental or a combination of both.

C

Q Where a doctor has taken the decision to place a patient on opiates - and fentanyl is an opiate, is it not?
A Yes.

Q Is that something that you would or would not expect a note to be made in a clinical record, the reasoning behind it?
A Yes, I would expect a note to be made of the reason for it being started.

D

Q We can see that the note on 19 November finishes – I think it is "Please make comfortable. Am happy for nursing staff to confirm death".
A Dr Barton has written "Confused and aggressive", which is clearly someone who is distressed.

E

Q If we go to page 281 – have you got the original prescription sheet still? Have you got it?
A I am not sure.

Q If you pass the file to us we can find it for you and hand it back. (Same handed) (After a pause) You are going to have the file handed back to you. (Same handed) If you would like to take the prescription sheet out. I just want to concentrate on the drugs that were prescribed and administered on 19 November. Now, I am afraid I cannot tell you where it will be on the original, but you will find at the very bottom of one of the pages, I think, an entry for fentanyl.
A Yes.

F

Q We have that on our 279c. We have already looked at 279b, which is 19 November, chlorpromazine.
A Yes.

G

Q Then we can look, our page 281, at diamorphine 40mg and midazolam 40mg.
A Yes. Midazolam 20-80mg.

Q Yes, but actually it was 40, was it not?
A Started on 40.

H

A

Q Started on 40. So on 19 November, it appears, in the morning at least, that this patient had in her system fentanyl, chlorpromazine, midazolam, diamorphine. Is that the sort of prescribing that you would ever have written out?
A I think I would have been more cautious in my use of diamorphine and midazolam.

Q More cautious?
B
A Yes.

Q How much more cautious?
A Well, I am not an expert in opiate prescribing and fentanyl in particular, and what I would have wanted to do is make reference to the *British National Formulary* to see---

Q I was just going to ask you that: you have said on a number of occasions that you are
C
not an expert in prescribing, opiate prescribing particularly.
A Yes.

Q Would you have had reference to the *BNF*?
A Would I?

Q Yes. Would you have followed the guidance?
D
A Yes.

Q Do you say you did not see these prescriptions? Sorry, you are shaking your head.
A Sorry. No, I did not see them.

Q If you just give me a moment, please. (After a pause) You told us about your view so far as the clinical notes are concerned of recording the use of fentanyl. What do you say
E
about the necessity or otherwise of recording the prescription and the use of the other opiate drugs?
A I think the change should have been recorded.

Q Can I finally just ask you this: you have got the original prescription sheets in front of you.
A Yes.
F

Q Can you just take one up, and it may be if you use this as an example. Throughout these prescription sheets in relation to the patients that we have been dealing with on Dryad Ward, the three patients that you have been talking about, Dr Barton has prescribed a wide variable dose, yes?
A Yes.

G
Q Can you explain why you did not see those?
A I mean, I must have seen them, but I do not recollect seeing them.

Q If you saw them, why did you not take action about them?
A Well, I should have done.

MR KARK: I see. Would you wait there, please.

H

A THE CHAIRMAN: I think we have reached the point where we should give the doctor a break. He has had an hour of examination in-chief. So we are going to break now. You will be taken somewhere where you can get some refreshment, and we will return, please, at quarter-past three, everybody. Thank you.

(The Panel adjourned for a short time)

B THE CHAIRMAN: Welcome back, everyone. Mr Langdale.

Cross-examined by MR LANGDALE

Q Dr Reid, obviously I am asking you questions on behalf of Dr Barton, you will appreciate that.
A Yes.

C

Q I have quite a number of matters to ask you about. What I will try to do is to ask you about general matters first of all, to seek your assistance about various points, touching upon points you may have already mentioned yourself, but I am inviting you to flesh them out and so on, and then towards the end of my cross-examination I will turn to the individual patients you have been asked about. It may be that at times we will come back to a particular topic, but I will try and keep it in that sort of order. First of all, this: you have described in your D own statement, and I quoting your words, that you thought Jane Barton was a good doctor.
A Yes.

Q I would like you to flesh that out a little bit more. Why do you say that?
A Well, I felt that she was assiduous in attention to her duties when working at War Memorial Hospital. I obviously was only there for one afternoon per week, and, in situations like that, one often relies on the nursing staff for feedback about how a doctor is performing, E and the nursing staff were, I would say, fulsome in their praise for the support that Dr Barton offered them. I never ever heard it suggested that Dr Barton had not attended or been unhelpful in giving advice. She was a great source of support to the nursing staff, and I felt the patients were being well looked after.

Q So I think it follows, from what you have been asked and the remark you made, that you were not somebody who had concerns about the standard of nursing care, and you were F not somebody who had concerns about the standard of medical care?
A That is correct.

Q Did you also, so far as you could get the picture, whether from others or your own observations, form any conclusion about Dr Barton's attention to the needs of relatives?
A I mean, I think that is difficult to answer, because I was, as I say, there once a week, but certainly what I am aware of is that Dr Barton did come in in her own time to speak to G relatives.

Q I think at one point in the voluminous records we have of things that have said, either by way of interview with the police or your evidence at the inquest, that the impression you got was that she did a lot of counselling and advising of relatives.
A I certainly know she would see relatives at the request of the nursing staff.

H Q Did she on any occasion seek your advice about things?

A I would say on three or four occasions during the year perhaps Dr Barton sought my advice.

Q You have indicated to the Panel that Dr Barton was more experienced than you were in certain areas, is that right?
A Yes.

Q *It nonetheless remains the case, does it not, that she was, as it were, responsible to* you?
A Indeed.

Q You were the person whom she was entitled to expect would correct her if she was doing something wrong.
A Yes.

Q She was entitled to expect that you would advise her and guide her if you felt that she needed advice and guidance.
A Yes.

Q In general approaches to care and a whole range of other matters.
A Yes.

Q I think also it follows from what you have already told us that if you thought something was wrong about her practice, or something which ought to be corrected or amended, you would say so?
A Yes.

Q It was not as if you hesitated to exercise your proper supervisory duties?
A No.

Q Obviously there were a number of pressures on Dr Barton.
A Yes.

Q She was working as a clinical assistant to deal with the needs of a number of patients in two wards, Daedalus and Dryad.
A Yes.

Q Obviously her duties with regard to, whenever she could, seeing relatives, another aspect.
A Yes.

Q Somebody who had far from unlimited time in order to carry out those duties.
A Indeed.

Q It is not her fault; that was the fault of the way the thing was set up.
A Yes.

Q It is not obviously your fault, but would it be right to think of both of you, different roles, because no doubt you were under pressure as well, and I will come to that in a moment,

A both of you endeavouring to perform your respective roles as best you could in the circumstances you found yourselves?
A Yes.

Q The Panel have already heard about the comparatively limited amount of time that she had in order to perform her functions - I do not think there is any dispute about it, so I need not trouble you with that – but you knew that she came in and did a morning round, or check,
B every morning Monday to Friday?
A Yes.

Q You knew that also she would come back, usually in the middle of the day, and hopefully also be available for you when you did your ward rounds?
A Yes.

C Q Also, that she was somebody who would attend on occasion, not necessarily every day but on occasion, later on in the day perhaps to see relatives, or whatever it might be?
A Yes.

Q A significant number of patients to attend to on the two wards.
A Yes.

D Q Patients in general terms who presented with a number of different problems.
A Yes.

Q May I just ask you, while we are dealing with that, about the state on the wards? I appreciate you can assist us with Dryad, a well run ward and all the rest of it, there is no dispute about that, but just the general nature of the patients? Do we have a picture of everybody just sort of sitting around, or lying in their beds peacefully and not doing
E anything? What is the general picture in terms of patients with dementia and so on?
A Well, it would be a very sort of mixed picture. There would clearly be some patients who would be extremely dependent and probably presented a heavy nursing burden, but in terms of medical attention did not require very much, and that was the predominate population, as I understand it, when the ward was established, but that gradually changed so that, as I have said before, patients of increasing dependency, and by that I mean in terms of getting someone out of bed involves more effort than nursing someone who is usually
F confined to bed. Also, because the patients were probably being transferred at an earlier stage than had been previously done, they would have been more likely to be medically unstable than they had been in the past, or develop medical problems while they were there. So in that sense I think the workload medically certainly increased, and I would suspect that the nursing workload did too, because what we tried to do when we were presented with patients who we felt did need some physiotherapy and occupational therapy we managed to negotiate they would at least be assessed by a physiotherapist or occupational therapist, but
G the nursing staff would have to try and carry out what the physios had recommended.

Q You have already spoken about the problems that might exist with patients who just were not able to cope with that, for example patients suffering from dementia and so on, but there really were not any facilities for physiotherapy on Dryad?
A No.

H

A

Q I also want to ask you about the difficulties that might arise with regard to nursing with patients suffering from dementia and so on. Might they present problems in terms of---
A Well, indeed; restlessness, confusion, et cetera.

Q Different people seem to use different expressions but I think you probably covered the spectrum in a very general sense. Can I just ask you about the pressures on you yourself?
A Yes.

B

Q You were under quite a lot of pressure?
A Yes.

Q You had not only your role as a consultant, which you described, but you were also, I think you told us, the medical director of the Plymouth Healthcare Trust?
A Portsmouth Healthcare Trust.

C

Q I am sorry – not Plymouth. Portsmouth. That no doubt took up a certain amount of your time?
A A very substantial proportion.

Q And there was a further pressure, again which you said something about but I would like you to expand on this a little, in terms of the desire of the two main hospitals we are concerned with, obviously – Queen Alexandra and the Haslar – the desire to move, and I do not mean in some frightful, inhumane sense, but the desire to move on patients as quickly as possible to free up beds on acute wards?

D

A That is correct.

Q No doubt a pressure felt in many other places in the country, but what is the effect of that in terms of the impact on Dryad?

E

A I think that it meant that patients who were not wholly suitable for transfer to Dryad Ward were transferred.

Q Can I ask you about that by way of enlargement on what you have told us. Did you find in your experience that the hospital sending the patient on to Dryad, seeking and obtaining the transfer to Dryad, was sometimes presenting a slightly rosier picture of the patient's general medical stability?

F

A Yes.

Q And how would that manifest itself. We have come across one example already, I think, in what you said, but in general terms how did that show itself?
A Because of the interest in moving patients on from specialty wards they would make light of, perhaps, new medical problems that had developed. So, for example, if someone was being transferred from a cardiology ward who had had a stroke, they did not necessarily say, "This patient has had a stroke." What often happened was there was a considerable delay between my colleagues and I assessing a patient on an acute ward and them being transferred – up to three weeks.

G

Q I am sorry. So first of all the gap between your assessment and the actual transfer - yes?
A Yes. And as a result the patient's condition had often changed in that time, but because we had accepted the patient and they are on the waiting list, the wards were only too

H

A happy to let the patient come and perhaps not be as forthcoming as they perhaps ought to have been about the problems the patient had, at the time of transfer.

Q It would not necessarily be a surprise – I appreciate it depends individual patient to individual patient – if the assessment and view of a patient arriving on Dryad would be different from the transfer letter assessment?
A Oh, quite different on occasion.

B

Q I am leaving aside the question that in some patients, as we have already heard, there might in fact be a deterioration as a result of the very transfer itself?
A Yes.

Q Which is something, again, you would be familiar with?
A Yes.

C

Q As a possibility. I think it follows from what you have said already, that would have a knock-on effect with regard, for example, to the prospects of mobilising a patient for rehabilitation generally?
A If patients had had an intercurrent illness develop in the interim, then that could clearly prejudice any chances of rehabilitation. Also, there was a tendency for staff on other wards to say things to relatives like, "We'll transfer to the War Memorial and they will soon have her walking in no time", in the interests of encouraging the transfer and persuading the relatives to accept the transfer.

D

Q So an effect, is on the expectation, as it were ---
A Absolutely.

Q --- of the relatives. Are we talking about a minor problem or a real problem, or what?
A Sometimes a very significant problem.

E

Q How would those manifest themselves?
A Patients or relatives being told that they were coming to the War Memorial Hospital for rehabilitation when the reality would be that on assessment the chances of rehabilitation were remote.

F

Q How might that manifest itself in terms of the relatives feeling towards the staff?
A Dissatisfaction, concern and, not unnaturally, relatives want to listen to the more optimistic prognosis.

Q I think around 1999, and that is really the period we are concentrating on so far as you are concerned ---
A Yes.

G

Q Around 1999. It was not the practice to have any staff reviews or regular supervision?
A No.

Q Again, lack of resources. Is that what we put that down to?
A No. Appraisal was not compulsory at that time – the sort of appraisal I am talking about, medical staff appraisal.

H

A

Q	But in terms of supervision by consultants, were there constraints upon that or not?
A	In terms of time, yes.

Q	May I just ask you this in a general sense, about what you would expect as a consultant with regard to a decision made by the clinical assistant, in this case Dr Barton – obviously the only real person at the time we are concerned about. Would you expect or would you not expect to be informed by the clinical assistant if the position had changed with regard to a patient?

B

A	No. I would only expect her to contact me if she had significant concerns about that change.

Q	Would you expect or not expect contact with you if Dr Barton decided the time had come for a patient to receive analgesia subcutaneously, in other words via a syringe driver?
A	No, I would not have expected that.

C

Q	Or, as another illustration, Dr Barton deciding that it was appropriate for to record the fact that she was happy for nursing staff to verify or confirm death?
A	Sorry. Could you just repeat that.

Q	Would it be something you would expect or not expect, for Dr Barton to contact you about in terms of her concluding that she wanted to record the fact that she was happy for nursing staff to verify or confirm – whichever word was used – death?

D

A	No. I would not have expected her to do that.

Q	I want to ask you more than one thing about prescribing practice by Dr Barton, but I am going to try and deal with it in sections. I appreciate they may slightly blur, the one into the other. What has been described as anticipatory prescribing?
A	Yes.

E

Q	What do you understand by that expression?
A	It is prescribing of a medication and for someone who does not require the medication at that particular moment, but in whom one might reasonably anticipate they would need in a shortish timeframe.

Q	That is something that you knew Dr Barton did?

F

A	Yes.

Q	And I may have misunderstood you. Were you also saying that Queen Alexandra, for example, anticipatory prescribing takes place?
A	It does at Queen Alexandra Hospital but just, perhaps, in relation to the last question, I cannot remember a specific incident of Dr Barton engaging in participatory prescribing, but I think there are occasions when it is appropriate.

G

Q	Was there any occasion when you spoke to Dr Barton – again, I want to make sure we are talking about the same thing – was there any occasion when you spoke to Dr Barton about anticipatory prescribing?
A	I do not recollect ever doing that.

Q	Because you have told us that you did have a conversation with her about the principle, I think, of variable doses?

H

A That is correct.

Q So we are talking about something different when we are talking about anticipatory prescribing?
A Indeed.

Q But had you been aware of Dr Barton prescribing in anticipation ---?
A Yes.

Q Assuming it is not absolutely barmy, but reasonable anticipation, as it were, you would have been perfectly happy with that practice?
A Yes.

Q Then can I turn to variable doses, as to what we are talking about, because you indicated that before you came on to Dryad, in the sense of becoming the consultant and therefore taking on Dryad, you had possibly had experience of variable doses of diamorphine, maybe on one or two occasions, but you had a discussion with Dr Barton about this topic. What was it you were raising with her?
A It was why she was engaged in variable dose prescribing – larger range variable dose prescribing.

Q What do we mean by "larger range variable dose prescribing"?
A The recollection I have was this was in the context of a patient who had been prescribed 20 to 80 mg of diamorphine.

Q So are we talking about two different things, or the same thing? I just want to make sure. Variable dose, in the sense that there is a range, or are we talking about variable doses also meaning a range which is quite wide?
A Sorry. Could you repeat that?

Q If there is a range of a dose ---
A Yes?

Q --- whether it is 10 to 20, or 20 to 200, is that what we are talking about in terms of a variable dose?
A Yes.

Q Right. The fact that there is not a set amount to be administered to the patient?
A Yes.

Q But there is a range?
A Yes.

Q All right? So by variable prescription we are talking about something where the doctor has prescribed a range for a particular drug to be administered?
A Yes.

Q And the example you had had in mind, or your recollection is ---
A My recollection.

A

Q When you spoke to Dr Barton – I appreciate all the difficulties remembering exactly – was that it involved a variable dose prescription?
A Yes.

Q The diamorphine?
A Yes.

B

Q With a range ---?
A Yes.

Q --- which you recall as being, I think you said ---
A 20 to 80.

Q 20 to 80?

C

A That is my recollection.

Q And she gave you an explanation?
A Yes.

Q And it was an explanation which satisfied you?
A Yes.

D

Q Again, in general terms – I am not expecting you to remember every word she used, and I doubt very much if she could ever remember, but what in general was her explanation which she gave you?
A As I recall, she stated that at times it was difficult for her, or her partners, to be in immediate attendance and particularly so at a week-end when she or her partners could be visiting patients as part of the on-call GP arrangements. And she had done this so that

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patients would not have to wait and suffer as a result of nursing staff being unable to contact her or her partners.

Q Would you help, please, with the importance of that fact – the desire to prevent patients unnecessarily suffering?
A Indeed.

F

Q Where does that rate in importance in the scale of things?
A It is the overriding priority.

Q Because we are dealing with patients who were not patients on an acute ward recovering immediately from an operation, we are dealing with a different class of patient?
A Yes.

G

Q For continuing care patients, palliative care patients, would it be right to say that the relief of pain and suffering has a particular importance?
A Yes.

Q Would it be right to say in general terms that the level of pain tolerated on an acute ward would be rather higher than the level of pain tolerated on a continuing care ward?
A Sorry. I do not follow.

H

A

Q We have seen cases, for example, if we take the example of one particular patient, the lady with the hip.
A Yes.

Q On paracetamol, I think it was?
A Yes.

B

Q After her operation?
A Yes.

Q Although obviously still in pain?
A Yes.

C

Q Is concern about controlling the level of pain rather less on an acute ward than it is in terms of continuing care?
A I am not sure....

Q You do not see any difference or you do?
A I am not sure that I see any difference.

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THE CHAIRMAN: Mr Langdale, I am sorry to interrupt at this point, but I need to say something that perhaps I should have said at an earlier stage. It is this. We, as a Panel, are acutely aware of the stresses and strains that come with the giving of evidence. We understand how very rapidly a witness can feel exhausted. It is very important that we receive evidence from you at a time when you are feeling fit and fresh enough to apply your mind fully. If at any time you feel that it is getting a bit much, and you need to take a break, or even that you have had enough for the day, you only have to indicate, and you will not be required to go on answering questions.

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THE WITNESS: Thank you very much, but I feel fine.

THE CHAIRMAN: Good. Okay – thank you.

MR LANGDALE: You can feel fortunate, Dr Reid, that counsel are not allowed the same latitude, whatever they feel about the amount of questions they have to ask.

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Just on that topic, I was putting that general proposition to you that in general on an acute ward, somebody recovering from an operation, there may be less attention to the problem of controlling pain – I do not mean in the sense of ignoring it – than there would be in terms of patients on continuing care ward?
A I think if you mean because in an acute ward there are some junior medical staff 24 hours a day, absolutely, whereas in a ward like dry ward, we are dependent on GPs out of hours cover. It is a different situation.

G

Q That again brings me on to something I wanted to explore with you as well – that different situation, and the realities of endeavouring to care for patients on a continuing care ward like Dryad – patients coming in, maybe, for continuing care; coming in, in effect, for palliative care almost from the start and that sort of category of patient. Would it be right to consider that there is a balancing exercise that has to be carried out by ---?

H

A Absolutely.

A

Q We will start off with one obvious balancing exercise, and that is the question of note-taking?
A Yes.

Q You should know that there is no dispute on behalf of Dr Barton that her note-taking was not adequate; it was not as good as it should have been.

B

A Yes.

Q It may be that in the 1990s the standard of note-taking by GPs, by other doctors, was rather lower than it is now in general terms?
A Yes. Before I came to Portsmouth, I worked in Southampton, where we had a four-ward continuing care type rehabilitation hospital, for which we had a GP in a similar role as Dr Barton. His notes were equally brief. I know from colleagues who worked in other

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community hospitals in Portsmouth – I am talking in general terms – note-keeping was much briefer than it is now.

Q In any event, you would be aware of the brevity of her note-taking, but there was no occasion on which you thought it necessary to speak to her about it by way of pulling her up about it?
A No.

D

Q May I just ask you this as well. Was there ever any occasion when you had any difficulty understanding what the position was with regard to a patient as a result of the brevity of Dr Barton's notes?
A Never, I would see part of my role in the ward round as not just talking to medical staff that were present, but asking the nursing staff about what was happening, because medical staff cannot be there all the time. One is heavily reliant on nursing staff for

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information.

Q Again, give us an idea of how important that was to you, reliance on the information from the nursing staff?
A Critical. Critically important.

Q May I ask you this in general terms, about the nursing staff on Dryad. You told us

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about the standard of care, and I am not going into that again, but in terms of whether you felt you could trust the nursing staff to perform their duties properly?
A Without question. I said earlier that I was very impressed by the quality of the nursing staff we had on Dryad Ward.

Q When you asked Dr Barton about the rationale or the reason for the variable dose, and she explained to you what the reason was, as I understand it, you yourself did not have any

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concerns that there was any real risk that a member of the nursing staff would suddenly do something absurd, and just up the dose by some ridiculous extent?
A Yes, I trusted the nursing staff.

Q Again, dealing with the problems that existed by virtue of the set-up – not Dr Barton's fault and not your fault – and the balance that had to be carried out, the balance between, "Do I spend time taking fuller notes or do I spend time attending to patients?" that is the choice,

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because that is really what it comes down to, is it not?

A A At times the pressure can be very difficult.

Q Where do you think the balance lay between spending time writing up more ample notes or time spent looking after patients?
A Oh, it has clearly to be with seeing patients.

Q Because of that problem, with Dr Barton not being there save for the limited periods of time we have already discussed, there is a problem with what one does about making a decision as to what should be the starting dose for a particular drug. We are focusing on opiates here obviously. Would you agree?
A You have to make a judgment. There are guidelines about what the starting dose should be, but you have to make a judgment about the patient in front of you.

Q If you have a fully medically staffed ward, in the sense of somebody being available, as it were, all day, medical staff available all day, it is much easier to take an approach with regard to the administration of opiates which is bit by bit, a gradualist approach.
A Yes.

Q That luxury is not afforded if the doctor cannot be there save for limited periods of time in the day.
A That is correct.

Q So it would not be a surprise to find a doctor in those circumstances prescribing higher than might otherwise be the case if the doctor was there all day.
A Or certainly prescribing a wider range.

Q Or a wider range. But there is a difficulty, if the starting dose is too low, that the patient, when the time comes to start on the opiate, will have suffered unnecessary pain.
A Yes.

Q How would you assess the importance or the significance of the doctor's own judgment about this, the doctor who has seen the patient and knows what the situation is?
A It is critical.

Q Was Dr Barton somebody in your experience of her who made medical judgments with little or no reason behind them?
A I would have said not.

Q There therefore has to be a balance struck, perhaps with the patient in the middle, but a balance struck between nursing and medical care dealing with the problem with the patient in terms of pain control and the pharmacological approach.
A Indeed.

Q Requiring judgment. Yes?
A Yes.

Q How would you weigh the significance of experience in this field? Is that something which counts for much or little or how do you see it?
A Considerable.

A

Q In your experience, would it not be surprising to find two doctors, perfectly genuinely, perfectly sensibly, coming to a different conclusion as to what the appropriate dose was with regard to the administration of opiates?
A Yes, it could happen.

Q One doctor might say, "I think in the circumstances 20 is about the right starting point." Another might say 10.

B

A Yes.

Q Another might say 40.
A Yes.

Q As long as there is a sensible reason for prescribing a particular drug at a particular dose range or limit, then that course is justified.

C

A Yes.

Q Still on the same topic of pressures that people were under, you have told the Panel about the change with regard to patients, the type of patient and so on, and the increasing pressures both on medical staff and nursing staff. I think there came a time in the early part of 2000 when you had a conversation with Dr Barton about the pressures.
A Yes.

D

Q We know that there came a time when Dr Barton handed in her resignation.
A Yes.

Q Without going into unnecessary detail, that was because of the pressures which had been put upon her in terms of demands on her time and the expectations and the reality of the situation she faced.

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A Yes.

Q Indeed – and again it was probably not your decision, although you may have been involved in discussions about it – a decision was taken by the management side that what was needed was a full-time doctor.
A Yes.

F

Q Again, I am not worried about all the details, but would you assist the Panel with what came into place after Dr Barton had resigned and left because of the pressures she was under?
A Yes. They appointed a full-time clinical assistant who was working 9 to 5 and Dr Barton's role then was covering 44 beds. Today it is actually 30 beds. It is covered by two junior doctors, plus half an associate specialist's time. So we have two and a half doctors looking after fewer beds.

G

Q Immediately after she left, there was one full-time doctor.
A That is correct.

Q It may be stretching your recollection too far, I do not know, but what was done in terms of night-time and weekends, when that doctor would not actually have been there? Was there some kind of on-call arrangement?
A Yes. There was an arrangement made I think with one of the local practices to cover

H

all of – I cannot recall.

A

Q But we can think in terms of there being some sort of cover at the times when, am going to call it the 9 to 5 doctor, although that may be unfair, was not available.
A Yes. Perhaps if I might illustrate that. If I remember correctly, while Dr Barton was in post, there would be approximately about 40 out of hours calls per month to Dr Barton and her partners. After we appointed a full-time clinical assistant, I think it dropped to four.

B

Q Still on the same topic, with regard to the provision of services by consultants when Dr Barton resigned, did that remain the same or did that change?
A I think that remained the same.

Q While we are on the question of consultants, Dr Tandy was not in post when you started on Dryad. Is that right?
A She was in post before. I took over from Dr Tandy.

C

Q You were not there at the same time.
A No.

Q Dr Lord was of course a consultant.
A Yes.

D

Q How did you find Dr Lord in terms of her ability and experience?
A Extremely capable and likeable and just a lovely person.

Q I think it is right that you – obviously not only you yourself, but also Dr Lord – were very grateful to Dr Barton for the services and work that she had provided?
A Absolutely.

E

Q Was there an occasion, even if you cannot remember the exact details, when a complaint was made? I make the point now, it was nothing to do any of the 12 patients that the Panel are considering, but a complaint was made about a patient who had been on morphine tablets and those morphine tablets or the administration of them was discontinued by Dr Barton.
A That is correct.

F

Q And the patient was put on less strong medication.
A Yes.

Q What did that produce in terms of the family or the relatives' position?
A It produced a complaint.

Q Because?

G

A Because they felt the patient's pain was not being adequately controlled.

Q I am not going to go into any more detail of that. Do remember when about that was? Was that 1999?
A I would think it was in 1999.

Q There was another complaint relating to a patient – again, not one of our 12 – who had

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developed heart failure on a Friday – this is again from information which you have disclosed

A – when Dr Barton had prescribed morphine. That was quite appropriate in your opinion in that case.

A Indeed. It was someone who was in acute heart failure.

Q But you saw the patient yourself the following Monday and you took a decision to do what?

A To stop it, because the patient was better.

B

Q A further point in relation to transfers which I did not ask you about at the time we were talking about transfers. Would you assist with the question of notes being available with patients? We have seen examples of transfer letters and so on and you have told the Panel about how they might not present a very realistic picture. Not in every case, but they might not. In terms of the patients' notes, what did you find on transfer was a common occurrence?

C A Missing notes, incomplete notes, no x-rays was a recurring feature of transfer.

Q I want to ask you about particular opiates. We have been talking about them in general terms, but I want to ask you about particular ones in certain circumstances. First of all, Oramorph. Was Oramorph a convenient and sensible opiate to provide, assuming of course the circumstances justified it, or was it something which caused problems?

A It would be I think most people's first choice of strong opiate.

D

Q In terms of opiates which we have heard mention of in terms of patients in this case, opiates such as co-codamol and co-dydramol, sometimes the choice between those two might result in the choice being Oramorph. Are there preferences for administering Oramorph compared to ---

A Co-dydramol and co-codamol are weaker opiates and I think one would look to prescribing them before prescribing Oramorph normally.

E

Q As you have already indicated to us, there may be circumstances where that is not appropriate.

A Exactly.

Q Oramorph again has the advantage of being flexible and of inducing a sense of euphoria to a certain extent.

F A It can do.

Q It is helpful in general terms in cases involving heart failure.

A Yes.

Q Anxiety and distress.

A It is difficult at times, as I have said before, to determine whether someone's distress

G is physical or mental or a combination of both.

Q Then diamorphine. We need not trouble about the circumstances which justify that, because you have already given your evidence about it, but in terms of diamorphine being administered subcutaneously by means of a syringe driver, am I right in thinking that there was never any occasion in relation to any patients treated by Dr Barton where you felt the use of and the commencement of a syringe driver was inappropriate?

H A I never, ever felt that.

A

Q Can we take it that if you had felt that, you would not have hesitated to say so?
A That is correct.

Q Did you also find yourself in terms of dealing with relatives and the pressures of time so far as you were concerned that sometimes it was a struggle for you to find the time to speak to relatives when the need arose?

B

A It could be difficult at times. I do recollect coming down in the evenings to speak to relatives and coming I think on one or two occasions at a weekend when I was not on call.

Q In terms of matters which might arise in terms of dealing with relatives, you have already indicated to us the problems that might arise if expectations had been raised too high, for whatever reason, but I think also it was your experience – I do not think it is something that is in dispute – that in fact the decline of patients on a continuing care ward might occur quite suddenly into what really was a terminal phase.

C

A Oh, yes. A patient can gradually decline or they can suddenly decline.

Q No doubt if the decline was sudden, it would be something that would be, normally speaking, particularly shocking for relatives.
A Yes.

D

Q I think it is right – again this is taken from something you have said yourself either in interview or at the inquest; I think in interview – you yourself in 1999 were not aware of any guidelines or protocols for the use of opiates and sedatives.
A That is right.

Q You have already told us that you were not aware of the analgesic ladder, although you would know what that would mean.

E

A Yes.

Q It does not mean to say your approach was not in general that, and you were not aware of the Wessex protocol.
A No.

Q I think also you have indicated in the past that it was not unusual that there were no policies in place at Dryad with regard to the prescribing of strong opiate analgesic.

F

A At that time I do not remember them being in place anywhere, and that applied to Southampton too, from where I had just come.

Q Yes. Well, that flows on to the next thing I was going to ask you by way of clarification, which I think you have covered; there were not any at Queen Alexandra, for example, at that time. May I come, please, to the question of the range of dose. I appreciate the difficulties of trying to remember detail back to 1999, but it may be that you have actually clarified this in the last thing you said in answer to Mr Kark, but I am putting to you that you were aware in 1999 of Dr Barton prescribing diamorphine in the range 20-200.

G

A No, I did not say that. I said I was aware of it being prescribed 20-80mg.

Q Yes. Well, that is why I want to clarify this. I may have misunderstood you, but at the very end of the questions you were dealing with I thought you said, when you were asked

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A about prescriptions in the range of 20-200, "I must have seen them and I should have done something about it".
A Indeed, I did say that.

Q So I just want to get it straight. You did see at the time prescriptions for diamorphine in the range of 20-200 or you did not?
A I do not recollect seeing them. That is what I said. I did not recollect seeing these
B two prescriptions.

Q Because I have to put to you, Dr Reid, that you would have seen them on a number of occasions, and that you did not at any time query it with Dr Barton. That is what I am putting to you.
A I did not query it with Dr Barton. I think I would have seen both of these prescriptions once. I did see them once.

C

Q I appreciate you did not have dealings with all the twelve patients we are dealing with in this hearing, but you did have dealings with a number of them, and I think with the exception of one of them they all had prescriptions which had a range of 20-200.
A That is correct.

Q So are you saying, "I might well have seen them at the time. I just do not remember
D it", or, "I categorically would not have seen them", or what?
A Well, certainly the one we have not discussed, which was for 20-200 as an as required prescription, where it was written on the prescription sheet I would not normally have looked. The patient was not on a syringe driver at that time, and, while I accept that it is my responsibility to have looked, I would not have done that in practice.

Q I think we had better, in fairness to you apart from anything else, just take an example
E of one of these drug charts, or prescription sheets, and just see what the position is. Might I have that? (To the Panel) There is a file containing a number of these and I may need to show the witness some. (Handed to the witness) I think, because some of them are now in pieces, they are not all folded together, if I could have the file for a moment I will show one example to you so we can establish what the picture would normally be. (Same handed) So the particular one I am asking the witness to look at, and I have not been through the entire file but I think it is one that is still intact, relates to Ruby Lake, Patient F. (To the witness)
F This is not a patient you dealt with. If I can just hold it up so that we can all see, this is the normal way in which these documents would be available to you when you did your ward round.
A Yes.

Q The first sheet has a prescription sheet, safety of the patient and all that, at the front. The inside sheet has various matters relating to the patient and so on, and has a column on the
G left "As required prescription".
A Yes.

Q On the inside of the first sheet.

THE CHAIRMAN: Sorry, Mr Langdale, may we at some point pass one of those around so that the Panel can be familiar with the layout?

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A MR LANGDALE: What I am going to suggest is if I take the witness through it so he confirms this is what they normally look like, and then I can have that handed to the Panel and they can see. (To the witness) The second page, if you are reading it through in that way, having opened up the back fold, shows regular prescription drugs.

A Yes.

Q In this particular case none of them opiates. There is then a further sheet that covers B the same thing, in this case blank.

A Yes.

Q In this particular case, and it would normally be folded like *this*, back page in, cover sheet---

A No.

C Q Can we go on to that in a moment. If we just deal with the content of the sheet, the last sheet, if we open it all up, has "Daily review prescriptions", regular prescription details set out on the final page of this particular case, and in this particular case on that back sheet there is diamorphine 20-200, hyoscine 200-800, I think it is, midazolam 20-80.

A Yes.

Q All by Dr Barton, with the times and dates and so on. Before we hand this to the D Panel so they can see it, you were going to make a point, and you shook your head when I was showing the thing folded up. Explain.

A The drug chart was kept inside a blue plastic folder which opened out in three parts like *that*.

Q So can I just pause. It would be sitting in the folder like *this*, would it?

A No.

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Q All right. How would it be in the folder normally?

A The three parts of the blue plastic folder contained a piece of clear cellophane at the top and bottom, and the whole drug chart is slipped inside that.

Q If I can interrupt you, do you mean it was sitting inside the folder like *this*?

A When you opened up the blue plastic folder, that is---

F

Q That is what you would see? You would see the three inside pages. Carry on.

A So unless a patient were on a syringe driver or a variable dose prescription I would not have lifted the prescription sheet out of the blue folder to see what was on the reverse.

Q How would you know there was nothing there, because it is a regular prescription on the rear sheet? It is not saying anything – it says "Daily review prescriptions"---

G A On the particular patient we are talking about, she did not receive the prescription which Dr Barton had written up.

Q Yes. Again, not your fault, I am trying to take it bit by bit. So you are saying, and I will come back to that, I am just pointing out the last sheet, the one which you would have to turn over and look at---

A Yes.

H

A

Q It talks about daily review prescriptions.
A Yes.

Q What is the significance of that heading "Daily review prescriptions"?
A I think what it was designed with in mind was for using possibly with syringe drivers, with drugs like warfarin.

B

Q Yes.
A So in other words where you might think of changing the dose on a daily basis.

Q I am going to pause there, and then the Panel can see it for themselves and I will ask you some more about what you were going to say. (Handed to the Panel)

C

THE CHAIRMAN: Mr Langdale, while the Panel are looking at the document, if I have understood the evidence correctly, this blue folder in effect blocks out entirely a view of what is in effect the back of the form when it is opened out, so that the only thing that would be visible when it is in the blue folder would be those three inside pages, as it were.

MR LANGDALE: I am going to ask the witness about that in a moment, because he was about to say something and I cut him off, and I want to make that quite clear when we take on board the shape of the thing. A lot of the others, the pages have come apart and they are separate. (After a pause) (Handed to the witness) Dr Reid, you heard the Chairman's last point?

D

A Yes.

Q And I was going to ask you: we picture it unfolded?
A Yes.

E

Q In this, we will call it, the blue cover?
A Yes.

Q Supposing you wanted to look at what was written on the back sheet. What would you do when it is sitting in the blue cover?
A I would have to take it out of the blue cover.

F

Q So the back of the blue cover is not transparent, so you cannot see what is on the back of the sheet?
A No.

Q If, however, the prescription for diamorphine – and I am focusing on that for obvious reasons – was written on one of the inside pages. I am holding up an example which you will look at later on dealing with the case of Enid Spurgin, our patient I?

G

A Yes.

Q I think Mr Kark asked you about this. We shall come on to the photocopies in due course. You would see the range?
A Yes.

Q And there is a range plainly, in her case – diamorphine 20-200?

H

A Yes.

A

Q You could not have missed that, could you?
A I could not have done, but I do not recollect seeing it.

Q Really we have to conclude you must have seen it. We should conclude, should we not, that you did not take it up with Dr Barton, although you had seen it?
A I have already acknowledged that I have no recollection of it. It is my responsibility to see that, to review prescription charts and where there was an entry like that to have taken it up with Dr Barton.

B

Q Because it would be a considerable concern for you as the consultant to check what the patient is on?
A Yes.

C

Q And to see what the prescribing history was?
A Yes.

Q In regard particularly to opiates of this kind?
A Indeed.

Q It obviously would have a significant effect upon your judgment and analysis of the situation?
A Yes.

D

Q We may have to come back to that just to illustrate the point with regard to the patients you yourself saw, but I am going to leave that for the moment, thank you. Perhaps you could fold that up, and then somebody can put that back in the proper little plastic folder for Ruby Lake. (So done) Thank you very much. I want to ask you, please, and it is still in the same context ---

E

THE CHAIRMAN: Mr Langdale, I am sorry. The witness has been on the stand now for more than an hour, and I am getting indications from the Panel that they, at least, would appreciate a short break.

MR LANGDALE: Sir, of course.

F

THE CHAIRMAN: If that is a convenient moment, as you are about to move on – if there is ever a convenient moment.

MR LANGDALE: Of course. Just for the Panel's benefit, I am going to ask him about a couple of documents – they are not enormously long – but touching upon the same topic really, the same issue, and unless there are any other general questions I need to ask, I will be turning to the individual patients, which I will not be able to do within five or ten minutes. Those are going to take a bit of time. I imagine, depending on how long the Panel propose to sit this afternoon, that probably my questions may well run into tomorrow. I just say that to give you an indication.

G

THE CHAIRMAN: We normally sit until five o'clock as a general deadline. If we take a break now, then we are going to come back in in fifteen minutes or so and have not a great

H

A deal more time. It therefore may be, if everybody is happy, we continue with the questions on this section now and then, tomorrow morning, resume and deal with the patients.

MR LANGDALE: If that is convenient to the Panel, it may certainly be convenient to me and it may be convenient for the witness. I do not know.

THE CHAIRMAN: Would that ---

B

THE WITNESS: Yes, that is fine.

THE CHAIRMAN: Good, thank you. Panel? (The Chairman conferred with the Panel) Yes, very well. That is what we will do, Mr Langdale.

MR LANGDALE: Thank you very much. (To the witness) Dr Reid, some further

C documents – not a great number of them. I would like you to look, please, at this one. First of all, I will get the witness to identify it before the Panel have it. This is a document which, as you will see in a moment – I will make sure you have a copy – is a letter from Barbara Robinson, a lady whose name will be familiar to you, in October 1999 and it is headed "Learning Points from the Wilson complaint". I am not asking you to read every word of it at the moment, but perhaps you would like to look at the last line but one where you see a Christian name. I would just like you to consider whether that would be referring,

D apparently, to you?

A I suspect it was.

Q It looks like it, but I think we have to confirm that with you.

THE CHAIRMAN: Mr Langdale, do you wish us to receive this as an exhibit?

E MR LANGDALE: I think I have gone as far as I need to. It is October 1999, when you are still engaged, obviously, in the Dryad Ward. Does this ring any bells with you?

A I had not seen it until perhaps a couple of months ago.

Q At the time do you remember seeing it? I am going to ask for the Panel to have it, and then I can ask the questions if I need to about it.

F THE CHAIRMAN: We will receive it as exhibit D4, please, ladies and gentlemen.

MR KARK: I am sorry to interrupt, but before this is handed out, I am a little troubled by this. The witness said he has never seen it, and he was not aware of it.

THE WITNESS: I saw it two months ago, just before the inquest.

G MR KARK: He might have seen it two months ago, but how is that going to assist the Panel in relation to his state of mind at the time of these events, which is what he is being asked about. There may be a way of introducing this legitimately by calling evidence about it, but I do not quite understand how this witness can help you about his state of mind at the relevant events by looking at the document which he has not seen till two months ago.

MR LANGDALE: Sir, the writer of this letter will be called in due course. I think I must put

H it to the witness to see what he has to say about it. Apparently it refers to him even if he has

A not necessarily seen the letter itself, except shortly before the inquest. I am entitled to ask him about it. It is the only way the Panel are going to make sense of the questions.

THE CHAIRMAN: Mr Kark, if the letter is coming in advance of the witness ---

MR KARK: I absolutely accept that. If the writer is being called, then I certainly accept it can be put in.

B

THE CHAIRMAN: Thank you very much.

MR LANGDALE: I understand the nature of my friend's objection if we were not going to call the writer of the letter.

THE CHAIRMAN: Thank you for clarifying that. As I indicated, we will now receive that

C in evidence and marked it exhibit D4, please. (Document marked and circulated)

MR LANGDALE: Do you still have a copy in front of your?
A I have it here.

Q We appreciate, without my reading through every word of the letter, that it is not to you.

D A Yes.

Q Top right-hand corner: it is to somebody called Max Millett?
A Who was the Chief Executive.

Q The Chief Executive of the then Portsmouth Healthcare Trust?
A Portsmouth Healthcare Trust.

E

Q And is he still the Chief Executive of whatever the new ---
A No.

Q He is not. But he was then? All right. And Barbara Robinson was a manager at the Trust, I think?
A Yes, she is a manager in Gosport War Memorial Hospital.

F

Q Dated 27 October 1999, top right. "Learning Points from the Wilson Complaint". She is thanking Mr Millett for his memo and a copy of Dr Turner's letter. The first section is "Microfilming" and I am not going to trouble you with that. The next, 2b), is "Nursing Care Plans":

> "This has been picked up as part of the Clinical Governance Action Plan..."

G

And 3d) "Good Practice in writing up medication." That is the bit I want to focus on with you if I may.

> "It is an agreed protocol that Jane Barton, Clinical Assessment, writes up diamorphine for a syringe driver with doses ranging between 20 and 200 mgs a day. The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not

H

A

written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient.

Ian may wish to raise this at the Medicine and Prescribing Committee.

I hope this cover all the points

B

Barbara"

I think it may follow from what you have said, you never actually saw this letter at the time?
A I have never seen the letter.

Q Except for it was drawn to your attention before the inquest?
A Yes.

C

Q But the suggestion that you, Ian, may wish to raise this at the Medicine and Prescribe Committee. What happened there?
A I have no recollection of this now. I am not aware of any protocol which existed which allowed Dr Barton to write up diamorphine for a syringe driver with doses ranging between 20 and 200 mg a day. I am not aware of any such protocol.

D

Q This is something you did not know anything about at the time? Yes?
A Correct.

Q Nobody had said to you, "This apparently is a protocol and you may wish to raise it." Nobody asked you to do that?
A Not to the best of my recollection.

E

Q In the ordinary course of events, would Mr Millett, having received a message like this or a letter like this from Barbara Robinson, would you have expected him to pass it on to you or raise it with you?
A I would have expected him to.

Q All right, but you have no recollection ---
A Absolutely not .

F

Q Indeed, you are saying, "So far as I am concerned, that did not happen"?
A As far as I am concerned there was not an existing agreed protocol .

Q That I fully understand. I just want to make absolutely clear, in fairness to you, are you saying Max Millett never mentioned to you anything about ---
A I have no recollection of this at all.

G

Q All right. That is as far as I can take it with you. Do you want to add something - sorry?
A No.

Q Then there is another document which I would like you to look at, which is headed "Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion".

H

A

Take a look at it, see if it rings a bell and then I will see if you can assist us with that. (Same handed) Dr Reid, looking at that, does it ring any bells with you?

A Yes.

Q Down in the bottom left, it looks as though it is a document emanating from you.

A Yes, I was the author.

B

Q In that case, I think the Panel can have the document.

THE CHAIRMAN: Mr Kark, are you content for us to receive it?

MR KARK: I have just been given it. At this stage I have no objection to it going in, on the basis that it is a document about which the witness can give evidence. Can I ask if this is being produced by a witness in due course, somebody who is going to speak about it?

C

MR LANGDALE: This witness is going to speak about it, because it is his document.

MR KARK: I am sorry. I did not hear the witness say that.

THE WITNESS: Yes, I am the author of this document.

D

MR KARK: I beg your pardon. I did not hear. I accept that entirely.

MR LANGDALE: Then perhaps it can be handed to the Panel. (Same handed to the Panel)

THE CHAIRMAN: We will mark it D5, Mr Langdale.

MR LANGDALE: If you just take a moment to look through it, Dr Reid, it may be you are

E

familiar with it. (Pause for reading) Dr Reid, I need to take you through most of this quite rapidly, I hope, and the Panel will be able to follow it as we go through it. Looking in the bottom left-hand corner, it is your reference, as it were, and it looks like the date is 3 December 1999.

A That is correct.

Q Would you just help us, please? How did this come about? Was this something you

F

were asked to do or is it something you produced yourself by way of a protocol?

A I think where this originated from was the Wilson complaint, where we had had an independent consultant come in to review that complaint. As part of reviewing that complaint, she wrote to the chief executive, expressing concern about the range of diamorphine that had been administered or had been prescribed for a particular patient. It was as a result of that – I think principally that – that I felt we needed to have clear policies and procedures in place for the prescribing of diamorphine.

G

Q Thank you very much. That gives us the context. May I make it clear, the Wilson the witness is referring to is not the Wilson we are concerned with as Patient H? Can we just look at what it says:

H

A

"INTRODUCTION

In community hospitals, particularly at weekends and bank holidays, medical cover is provided on an emergency call out basis.

This can lead to a situation whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met. To overcome this and also to give guidance to nurses who may be unsure as to who much analgesia (diamorphine) to administer within a variable dose prescription.

B

So we can see what you are talking about. Then:

"DOSAGE

C

Guidance from the palliative care services indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day i.e. up to 2 x 'Xmg' should be given."

You have dealt with that already.

"PAIN CONTROL CHART

D

It is suggested that a pain control chart (see appendix) should be completed on a four hourly basis for all patients receiving a diamorphine infusion.

PRESCRIPTION

E

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

ADMINISTRATION

If pain has been adequately controlled within the previous 24 hours, the nurse should administer a similar dose of diamorphine over the next 24 hours.

F

If the previous 24 hour dose has made the patient unduly drowsy etc, the nurse should use his/her discretion as to whether the dose to be administered for the next 24 hours can/should be reduced, within the prescribed dosage regime. If the minimum dose appears to have made the patient too drowsy, the on-call doctor should be contacted.

G

If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose.

INFORMATION TO PATIENTS and RELATIVES

Where patients are mentally capable of receiving such information, they must be told that an infusion of a painkiller (diamorphine) is being started and that the dose will be

H

A adjusted if necessary to allow them to be as comfortable as possible without being unduly sedated.

When patients are unable to understand such information, by reason of either their physical or mental status, the decision that diamorphine is being, or about to be, administered should be communicated to their next-of-kin/relatives, again indicating that the aim is to make the patient as comfortable as possible and that the dose will be

B adjusted to keep the patient as comfortable as possible without being unduly sedated. If relatives express concern about the administration of diamorphine, despite the above discussion, the medical staff should be informed and the medical staff should make every effort to discuss the administration of diamorphine with the patient's next-of-kin/family. A resume of the discussion should be recorded in the patient's notes."

C We can just take a moment to look at the Infusion and Pain Control Chart, which is attached to your document. That was, as it were, compiled by you as an illustration.

A Yes.

Q The next page is the Diamorphine Infusion and Pain Control Chart. So this was something which you were seeking to institute.

A Yes.

D

Q May I just ask you this, because it is obvious you stand by the content of that, because you have explained it in your own evidence. Was that something which actually did come into place? Do you remember?

A No, not in that form.

MR LANGDALE: That may not matter. Sir, that is all I need to ask about those documents

E and if that would be a convenient moment for us to break, then may we do so?

THE CHAIRMAN: Yes. Thank you very much indeed, Mr Langdale. Doctor, we are going to break now and we will be returning at 9.30 tomorrow morning. Is that convenient to you?

A That is very convenient, thank you.

THE CHAIRMAN: Very well. I remind you that you remain on oath. Please do not discuss

F this case with anybody in the intervening period, nor allow anybody to address you on the subject. Thank you very much indeed. 9.30, ladies and gentlemen.

(The Panel adjourned until 9.30 a.m. on Wednesday, 1 July 2009)

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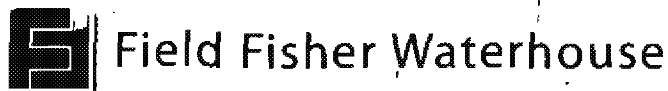

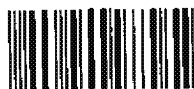

Strictly Private & Confidential

00475728

Code A
General Medical Council
Regent's Place
350 Euston Road
London
NW1 3JN

Our ref: RC2/GML/00492-15579/13628053 v1
Your ref:

Rachel Cooper
Senior Associate
Code A (Direct Dial)
Code A

16 July 2010

Dear Code A

General Medical Council - Dr Barton

Please find enclosed copies of Counsel's advices regarding Drs Lord, Tandy and Reid, together with transcripts referred to by Counsel when drafting the said advices.

Yours sincerely

Code A

PP **Rachel Cooper**
for **Field Fisher Waterhouse LLP**

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

General Medical Council	
Original was a Photocopy	
Original was Poor Quality	
Date rec for scan	20 JUL 2010
Original has been Photocopied to improve Scan Quality	
Document had physical objects ref	

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

GMC

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Code A

direct responsibility of the Consultants but can not be entirely divorced from it. Professor Ford was critical of the degree and quality of both management and consultant support available to Dr Barton but focused his attention on the Consultants' responsibility.

17. **Professor Ford** Day 22 page 48 –

Q In general terms, is the general picture this so far as you can judge it on the information you have? Dr Barton really had inadequate clinical consultant

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[1] General Medical Council Fitness to Practise Rules 2004
[2] The Queen on the application of Zygmunt v GMC 2008 EWHC 2643 (Admin)

Code A

[3] Dr Cohen v GMC 2008 EWHC 581(Admin)

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Out	Back

Memorandum

Ref: 2000/2047
To: Venessa Carrol
Michael Keegan

From: Michael Hudspith
Code A

Copy: Peter Swain

Date: 3 October 2002

Dr Jane Barton (1587920)

Peter/Venessa - we spoke and agreed that I would provide a summary of all the 'Barton-related' issues that screening is aware of but which did not feature in the recent PPC item papers.

The PPC considered charges against Dr Barton based on her management of 5 elderly patients (Eva Page, Alice Wilkie, Gladys Richards, Arthur Cunningham and Robert Wilson) on Daedalus/Dryad Wards at Gosport War Memorial Hospital between February and October 1998. These cases were referred to the GMC by Hampshire Constabulary with each case study being supported by an independent expert opinion(s) critical of Dr Barton .

In addition to the 5 'police' cases, the following information was or has also been brought to our attention:

1. **(2000/0247/03)** - In **(date)** Mr Mike Wilson wrote to the GMC about the death of his mother, Mrs Purnell, who died on Dryad Ward on **(date)** following her transfer to the Gosport War Memorial Hospital for rehabilitation.

   Mr Wilson's complaint concerns failures in communication by hospital staff and as well as his mother's clinical car, particularly relating to prescribing. Although specifically naming Dr Barton in his complaint, the available records appeared to show that Dr Barton was only one of a number of doctors who reviewed and prescribed for Mrs Purnell. Unfortunately only limited records are available as a section of the records were erroneously destroyed by the Trust during microfilming in April 1999.

   By the time Mr Wilson wrote to the GMC Mrs Purnell's care had already been reviewed both locally and by the Health Service Ombudsman. Both reviews sought independent medical advice and both considered Mrs Purnell's treatment to have been acceptable in the circumstances. On the information available, the screeners considered that the complaint raised no issue of spm on the part of Dr Barton.

2. **(2002/0553)** - In February Mrs Ann Reeves wrote to the GMC about the death of her mother, Elsie Devine, who died on Dryad Ward in November 1999 a few weeks after being admitted for respite care.

Whilst specifically naming Dr Barton in her complaint, Mrs Reeves complains of failures in communication by hospital staff as well as her mother's clinical care. By the time Mrs Reeves wrote to the GMC Mrs Devine's care had already been reviewed both locally and by the Health Service Ombudsman. Both reviews sought independent medical advice and both considered Mrs Devine's clinical treatment to have been acceptable in the circumstances. On the information available, the screeners considered that the complaint raised no issue of spm on the part of Dr Barton.

I should add that Mrs Reeves is currently seeking legal advice with a view to a possible civil claim. Her solicitors have requested that should we need to contact Mrs Reeves, we do it through them:

Alexander Harris Solicitors (contact Lisa Elkin), Ashleigh House, Ashleigh Road, Altrincham, Cheshire WA14 2DW

3. **(2002/1345)** - In June 2002 Mrs R E Carby wrote to the GMC concerning the death of her husband, Stanley Carby, who died on Daedalus Ward in April 1999 shortly after being admitted for 'rehabilitation'. After her husband's death Mrs Carby met with representatives of the Trust to discuss her concerns but was not satisfied with their responses.

Whilst specifically naming Dr Barton in her complaint Mrs Carby writes mainly of inconsistencies or inaccuracies in her husband's medical and nursing records and failure's in communication by hospital staff. Of perhaps more concern to the GMC would be the wide range of drugs written up for this patient by Dr Barton shortly after his admission and whether the manner of her prescribing was in any way inappropriate of irresponsible.

In order to properly assess whether this case raises any issues of spm against Dr Barton (or any other doctor) I would suggest we would need to obtain an expert opinion.

4. **(2002/~~1068~~ 1608)** - In July 2002 CHI published their report into the treatment of elderly patients at the Gosport War Memorial Hospital between 1998 and 2001. Whilst the report criticised a failure of Trust systems to ensure good quality patient care during this period, the Report does not apportion blame to specific individuals or mention them by name.

However, page 5 of the report makes reference to 10 complaints made to the Trust since 1998. We requested details of these complaints and

discovered that the majority were either made but individuals who subsequently wrote to the GMC or were about matters not related to our case. Only one complaint, made by a Mrs Batson in 2000 concerning the death of her mother, Mrs Gilbertson, on Dryad Ward in December 1999, appeared relevant and we recently requested and received further details. Whilst the complaint raises a number of different issues, Mrs Batson does raise the issue of pain relief (oral morphine) and mentions Dr Barton by name.

It would appear however that Mrs Batson was satisfied by the response of the Trust to her complaint and chose not to pursue the matter further.

Matters 1 and 2 are brought to your attention for background information only. With regard to matters 3 and 4 I understand that it may be open to us to consider adding these cases under Rule 11 to those matters already referred up by the PPC?

Should you have further any questions concerning any of the above, please don't hesitate to contact me.

Code A

FAX: GMC Legal

Please note that this message is intended only for the use of the Addressee and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended recipient (or employee or agent responsible for delivering this message to the addressee), we must draw your attention that dissemination; distribution or copying of this message is prohibited. If you have received this message in error, please notify us by telephone and should be grateful if you would return the original by post to "GMC Legal, Regent's Place, 350 Euston Road, London NW1 3JN"

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

To Mark Shaw QC

Fax Number 020 7822 7350

From

Direct Dial Code A

Direct Fax

No of pages (inclusive) 6

Time 12:45

Date 21/01/05

Re: Dr Barton

Please find attached some items of correspondence with the police from May 2004 onwards.

As you have probably found out from speaking to Toni, there has not been an official minute taken. Toni advised to contact her should you require further information on Code A or Code A.

Yours sincerely,

Code A

PA to Toni Smerdon

Toni: corresp. / communications faxed – marked w/ green tags

Code A.

21/01/c

TS/PCC/Barton

20 January 2005

The Clerk to Mark Shaw, QC
Blackstone Chambers
Blackstone House
Temple
London
EC4Y 9BW

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear Sir

Dr Barton

I now enclose papers for the urgent attention of Mr Shaw to draft a letter on behalf of the GMC. Mark has been closely involved in relation to this case during the course of 2004 and is familiar with the issues involved.

Once Counsel has had an opportunity of considering the papers, perhaps Counsel's clerk could telephone to confirm the likely time scale for a draft letter. The GMC would, if possible, like a draft letter on or before 20 January 2005.

Yours faithfully,

Code A

Toni Smerdon
Solicitor
Direct Dial
Direct Fax
email
Code A

Encs.

In the Matter of the Medical Act 1983

General Medical Council

-v-

Dr J A Barton

Instructions to Counsel to Advise

To: Mark Shaw, QC
Blackstone Chambers
Blackstone House
Temple
London
EC4Y 9BW

From: GMC Legal
Fitness to Practise
General Medical Council
2nd Floor
Regents Place
350 Euston Road
London
NW1 3JN

Direct Dial:
Direct Fax:
E-mail:
Code A

Ref: TS/PCC/Barton

Enclosures

1. Advice from Robert Englehart QC dated 10 December 2003
2. Notes for consultation for conference – 26 May 2004
3. Summary of Baker Report
4. Chronology
5. Notes for consultation - 14 June 2004
6. Draft letter to the police
7. Note from Hampshire Constabulary for meeting 13 January 2005
8. Template request for documentation pursuant to Section 35A Medical Act 1983 (as amended)
9. Transcript of the hearing before the Interim Orders' Committee on 7 October 2004.

Instructions

1. Instructing solicitors act on behalf of the General Medical Council ('GMC') in relation to advice sought in the case of Dr Jane Barton.

2. Counsel will be familiar with the case of Dr Barton, having advised on two previous occasions in conference on 26 May 2004 and 14 June 2004 and thereafter drafting a letter to be sent to the police. The letter was not sent to the police as information was subsequently disclosed.

3. That information was put to an Interim Orders' Committee on 7 October 2004. A copy of the transcript of the hearing is at Tab 9. The Interim Orders' Committee determined that it was not necessary for an interim order to be made.

4. The GMC remains seriously concerned at the time which is being taken on the investigation by Hampshire Constabulary.

5. To try to progress matters further, a meeting was held between Hampshire Constabulary and the GMC (Paul Philip, Paul Hylton and Toni Smerdon) on 13 January 2005. A copy of a note prepared by DS Williams (who attended the meeting is included). Whilst progress appears to have been made, it is unlikely that all matters will be resolved by Hampshire Constabulary before the end of 2005. They have identified 10 cases which they will be interviewing Dr Barton about. They have already conducted a generic interview and an in-depth interview in relation to Elsie Devine. A second interview in relation to another case is being arranged and it is anticipated that they will be conducted thereafter at intervals of approximately 6 weeks.

6. They anticipate getting Counsel on board by May/June 2005. Only when the interview process has been completed, would they anticipate the CPS being of the view that they could release any documentation as their concerns over potential views on the fairness of any trial.

7. As previously indicated, the General Medical Council remains concerned at the inability of the Council to take action whilst this process is ongoing.

8. Counsel is therefore instructed to draft a formal but friendly letter to the police, requesting disclosure of information in relation to the case of Elsie Devine. This is the case over which Dr Barton has already been interviewed about. The letter should then set out clearly the GMC's position and concerns and inviting the views of Hampshire Police.

9. Paul Philip has suggested that we also send a Section 35 notice in draft. The letter should conclude in terms that no action would be taken until such time as we have had an opportunity of considering their response to the request and also their position and that a further meeting would take place to try to resolve matters if necessary.

10. Paul Philip's view is that once we have sent our letter and received their detailed response and advice in writing from Counsel would be sought to confirm whether or not proceedings should be issued for a failure to comply with a request for information under Section 35 or not.

11. Once Counsel has had an opportunity of considering the papers, then he should not hesitate to contact Ms Toni Smerdon of Instructing Solicitors to discuss matters further. Ms Smerdon can be contacted on 020 7189 5126 or by e-mail: tsmerdon@gmc-uk.org

Signed .... Code A .... Dated ...20/01/05...............

14/06/04 2-30pm-3.45pm

Barton.

- PP to contact CMO's office to see whether progress made re: response.

- need response reminder to police - date / milestone.

  - what are police waiting for before disclosure?
  - why need to wait / progress.
  - what is likely timetable
  - when interviewed Barton no defence to non-disclosure.

to Mark (asap).
- need rotsg meetings - 20/11/02
  - 27/02/04

- ? 6/10/03 letter from police - what response given

- IOC bundle - last occasion →

Investigation.
- where, how, what - Health Authority

- material on 15/16 cases.

- can police identify patients - consents?
  - S35A - medical records
  - underlying material for report.

-> advice specifically on merits of OR in Barton.

-> how should we proceed.

Peter Steel (020 7915 3589)

From: Mark Shaw [Code A]
Sent: 26 May 2004 15:19
To: Peter Steel [Code A]
Subject: RE: BARTON

When/if you want me to draft general guidance for the interface between police and GMC cases, let me know.

-> in writing

-----Original Message-----
From: Peter Steel [Code A]
Sent: Wednesday, May 26, 2004 2:26 PM
To: Mark Shaw
Subject: RE: BARTON

thanks Mark

-----Original Message-----
From: Mark Shaw [Code A]
Sent: 26 May 2004 11:56
To: [Code A]
Subject: BARTON

Dear Peter,

As promised at this morning's meeting, I attach my notes in the above (to you only) - advice on remittal to IOC was a bit different in the light of discussions.

Best wishes,

Mark
<<BARTON - notes for con (26.5.4).doc>>

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Was going to say
GMC should not

- put case back to IOC

(IOC refused × 3, Med Screener refused in Oct 03) If we go back stressing lifting of vol/und. highly significant
but feel we should
- if go back to IOC need some fresh material - properly presented
Shld be a cond^n at least restricting Rx.
CSI wld need to explain why cause for concern - which he may not want.
Need to get ducks in a row (which means fund own investigations)

2 other points:

meetings b/w us:
notes of those meetings?

20/10/02
22/12/02

but chances are it would fail (+ other reasons)

delay wld appear to be inexplicable

1/4 optimal treatment

1/2 sub-optimal "

1/4 cause for concern.

probably about a year away from prosecution

CSI will give evidence to IOC

Advice

- riot Act shld be read to police in corres.
  only in extreme cases shld JR be an option
  this may be that case.

(NB Rx here is always overt & documented)

- whether or not a JR, GMC shld do 4 things:
  - get on with own investigation (no request or demand from police to halt investigation) no stat. bar on conducting parallel investigation
  - pressing police for action & investigatory timetables,
    (progress, where police going, vice that would be created by disclosure etc)
    curious comment "risk caused by disclosure would not arise after Dr B interview" - hold them to that? MC says no interview until after single expert report.
- explain why disclosure by police must lead to disclosure to doctor.
- ask for Baker report (PS explain circs in which disclosed - investigate

Police should be pressed to indicate what the vice is that not disclosing during investigation is designed to prevent.

- too late for a sensible, effective JR particularly in light of timetable in their latest offer, and political / practical ramifications of suing police.

(If at end June they say they can't help then may need to revisit question)

So not a good case & worse possible moment in that case

Other ways GMC

- GMC shld not remain inactive
  - first by placing material before HCt re. IOC extension
  - second to protect own interests by clarifying c̄ police exactly what can & can't do at the mo
  - preserve own PCC proceedings by pressing police to disclose as much as it can as soon as it can

(no reason in law why GMC can't proceed in parallel c̄ police)

Barton

(potential conflict)

all principles are the same.

application :-

much more difficult, dangerous & demanding for GMC & Police

analogy c̄ Shipman (premature, excessive resort to opiates) (poor records) (5 pts before IOC & 57 ors during 1990s under investigation)

Case has potential to explode.

applaud PS letter

Police delaying much worse than in VV. Barton is free to practise as IOC has refused to make an order × 3 (may Rx opiates as vol. U/takings have lapsed)

impossible to advise on JR prospects as depends on detail of investigations conducted etc - we don't know what defence is her.

GMC has a rather better chance of JR [illegible] in W

prospects of challenging police refusal are <u>slim</u>

so slim not prudent to launch a challenge (may wish to threaten...)

because

1. stat. scheme distinguishes b/w criminal/disc. proceedings it implies police go first GMC goes second

2. GMC's well established practice to go second.

3. Strong policy/public interest reasons for police not disclosing witness statements to GMC to prevent risk of contamination. (R v Green 2004 1 WLR 72[illegible] paras 71-72, 8[illegible] 8/24 Archbold)

(? of confidentiality) not here, as w.s signed consents

Legal factors

(Crim Procedures Act 1998
A-G's guidelines

→ public interest defence can't survive disclosure

1. disclosure.
2. danger of prejudicing jury trial by
3. danger of self-incrimination
4. Convenience of conviction route as opposed to conduct route.
5. ? Reduction of effort.

Applying this to VV.

- v. substantial delay by police
- since late 03/04 Police have become markedly more cooperative
- unlikely HC will grant any useful relief to GMC - current offer from police allows GMC to progress investigation & decision by end June)

(what [illegible]

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.

In the Matter of the Medical Act 1983

General Medical Council

vs

Dr J A Barton

Instructions to Counsel to Advise

To: Mark Shaw, QC
Blackstone Chambers
Blackstone House
Temple
London
EC4Y 9BW

From: GMC Legal
Fitness to Practise
General Medical Council
178 Great Portland Street
London
W1W 5JE

Direct Dial:
Direct Fax:
Email:
Code A

Ref: PS/PCC/Barton

Instructions

1. Counsel will find enclosed:

    a. Counsel's notes for consultation, dated 26 May 2004.

    b. Copy of documents entitled "A Review of Deaths of Patients at Gosport War Memorial Hospital" (NB. This document has been disclosed in confidence to Paul Philip, Director of Fitness to Practise at the GMC. The enclosed copy is being provided to Counsel for the purpose of legal advice on the Barton case. Counsel is not to make any copy of this document, nor to disclose it or its contents to any third parties. Should Counsel wish to discuss this further he should not hesitate to contact Instructing Solicitor.)

2. Counsel will be familiar with this matter, having previously advised in consultation on 26 May 2004.

3. Counsel will note that he is instructed on this matter on behalf to the GMC by its In-House Legal Team.

4. Whilst Counsel's views on the case as conveyed at the consultation on 26 May 2004 are entirely clear to Instructing Solicitor, Counsel is now asked to consider the enclosed report disclosed by Chief Medical Officer to the GMC and to advise on the following three points:

    a. The specific merits of Judicial Review of the police's failure to disclose information in the Barton case or to progress their investigation.

    b. The steps the GMC should take in order to progress its own inquiry concerning Dr Barton.

    c. General guidance for the interface between police and GMC cases.

5. Counsel should hopefully retain the papers provided to him by Field Fisher Waterhouse. Should there be any difficulty in this respect, Counsel is instructed to please contact Instructing Solicitor.

6. If Counsel wishes to discuss these instructions further, then he should not hesitate to contact Mr Peter Steel on Code A or by email on Code A

SIGNED Code A

DATED 8/6/04

Peter Steel Code A

From:	Mark Shaw Code A
Sent:	26 May 2004 11:56
To:	Code A
Subject:	BARTON

BARTON - notes for con (26.5.4...

Dear Peter,

As promised at this morning's meeting, I attach my notes in the above (to you only) - advice on remittal to IOC was a bit different in the light of discussions.

Best wishes,

Mark
<<BARTON - notes for con (26.5.4).doc>>

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FIELD FISHER WATERHOUSE

attendance note

Name:	Judith Chrystie	Type:	Meeting
Duration:		Date:	3rd October 2002

Attendees:

GMC: Peter Swain
Michael Keegan

FFW: MSL
JZC

Meeting

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. 1991 Allegations
2. Timescale
3. Further Cases
4. Dr. Lord
5. Police Involvement

1991 Allegations

MSL indicating that he doubted that the further information received by the GMC and passed to MSL 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 effected 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.

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 unofficial it appeared that the matter would not proceed.

The parties agreeing that an early meeting with DSI James would be useful in order to establish what was going on. JZC to arrange a meeting with the police.

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 if we were able to progress investigations.

MSL pointing out that the report prepared by CHI would provide useful background information; FFW would wish to see everything that the investigators for CHI had obtained. Noting that the CHI report may have helpful information and statements that could be utilised. In addition, CHI may have obtained the necessary consents from witnesses and relevant medical records.

MK to provide JZC with all the information regarding the CHI report.

Dr Lord and Further Cases

The parties discussing the difficulties that would be presented by the fact that both Dr. Lord (Dr. Barton's Consultant) and the nurses involved with 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.

MK advising that owing to media coverage, further cases had been received by the GMC. These were currently being considered by Mike Hudspith.

MSL suggesting that all the new complaints were sent through to FFW in order to investigate and decide whether it was possible to push them through to the hearing under Rule 11(2). Noting that there would be some concern as to when the complaints were received and whether these were after the Rule 6 letter but before the PPC.

JZC suggesting it would be helpful for her to pop through to the GMC to enable her to analyse the GMC's current file and identify any information that should be considered by FFW.

MSL suggesting that we would make enquiries with the UKCC in order to identify what the position was regarding the complaints against the nurses.

General

MSL advising MK and PS that the case provided by Dr. Barton to the IOC was "*very powerful*". Neither MK or PS had read the IOC transcript or response letter and MSL and JZC suggesting that they did so as owing to the particular resource issues identified in Dr. Barton's response, it may be difficult to attach sole blame for hastening death to the doctor. MSL noting, however, that following receipt of the 1991 allegations, it was clear that there had been long-standing concern regarding treatment by Dr Barton which resulted in the ending of life. The parties agreeing that there did appear to be problems with the doctor's practice but this may not be a 'Shipmanesque' case.

PS stating that this was a case in which there was indirect pressure from external sources for the GMC to push on with its enquiries - PS emphasising that there was no agenda being pursued to achieve a particular result. The GMC would, however, have to ensure that all matters were fully explored.

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

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London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

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

FIELD FISHER WATERHOUSE

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.

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London Berlin Dublin Düsseldorf Edinburgh Essen Frankfurt Glasgow Hamburg Munich Paris

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

Chrystie, Judith

From: Chrystie, Judith
Sent: 16 January 2003 13:46
To: 'Michael Keegan Code A
Subject: RE: Dr Barton

Dear Michael

Many thanks for your email. Sorry for the delay in responding: I have been over at CHI.

I will update you next week as to the documents and information CHI held and any information DI Niven passes to me on Tuesday. I will also ask him to make a formal request to us for the release of papers (I suggest that the request is comprehensive to include all the papers we hold - even those that you are content to release now - for the sake of consistency).

See you at 2pm on Wednesday!

Kind regards
Judith

-----Original Message-----
From: Michael Keegan Code A
Sent: Wednesday, January 15, 2003 4:39 PM
To: Judith Chrystie (E-mail)
Subject: Dr Barton

Dear Judith,

I have had a chance to speak about disclosure to the Police of the IOC transcript in this case and consequently advise that the Police should make a formal, reasoned request for the same. That request can then be considered at a senior level. This is, as you can imagine, in light of both the sensitivity of this case and the lack of precedent of which we are aware.

I should be grateful if you would communicate this to DI Niven.

Regards

Michael Keegan
Conduct Case Presentation Section
Direct Line: Code A
Direct Fax:
Email: Code A

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 178 Great Portland Street London W1W 5JE Tel: +44 (0) 20 7580 7642 Fax: +44 (0) 20 7915 3641

Meeting Note

Judith Chrystie	Call type: Meeting
Att: Michael Keegan	From: GMC
Duration:	Date: 5 February 2003

Dr Barton

JZC meeting with Michael Keegan (MK) of the GMC at FFW's offices.

The meeting was arranged in order to update MK as to the investigation that JZC and JHO had undertaken at CHI and the meeting with Hampshire Constabulary on 21 January 2003.

JZC advising that she had visited the office of CHI over two days and was assisted by JHO on one day. Advising that the documents JZC had requested in November in Appendix A of the CHI report had been copied for JZC. Explaining that JZC had only requested those documents which were in existence during the period 1998/1999. JZC advising that many of those documents were not relevant but that it was important that we had obtained copies of them.

JZC advising that CHI had interviewed a number of witnesses she and JHO had moved through each of the witnesses identified in Appendix C and D of the report. A brief summary of the nature of the statement and whether it would be valuable to interview both individuals had been made.

JZC advising that she had concerns that the CHI investigation had not specifically questioned the prescribing habit of Dr Barton, therefore, the statements were not of assistance to the GMC as they stood. Stating that the CHI investigation did, however, allow the GMC and FFW to identify those individuals who may be able to provide information of relevance and, indeed, those witnesses that had to be interviewed owing to their presence on the wards at the relevant time.

JZC indicating that Hampshire Constabulary were happy for the individuals interviewed by CHI to be notified that their statements were being passed to the GMC but that no action would be taken.

JZC advising that in addition to examining the statements she had had an opportunity to consider some of the correspondence held by CHI. Advising that one piece of correspondence was a letter from Dr Barton to the Personnel Director of Portsmouth Healthcare Trust. The letter to the Trust referred to the IOC decision not to place an interim order upon Dr Barton's registration and, Dr Barton had concluded that if "*in other words, in their [GMC] view there was no case to answer*". In addition, Dr Barton had suggested that she did not "*consider that I have done anything wrong, a view supported by the GMC*".

JZC advising that she was anxious to write to Dr Barton in order to prevent her from interpreting the IOC's decision in this way. Advising that she had spoken to Nigel Niven who had indicated that he would be happy for JZC to write to Dr Barton. JZC specifically requesting MK's instructions to do so. MK indicating that it would be appropriate for JZC to write to Dr Barton. JZC would provide a draft to MK for comments.

JZC stating that Nigel Niven had also suggested that he would be happy for the GMC to advise that the police were undertaking enquiries and, it was for this reason, that the GMC had placed their disciplinary hearing in abeyance.

JZC querying whether MK held any GP records. MK confirming that he did not have any medical records. JZC advising that the police were searching for these records and had asked JZC whether any were held by her or the GMC.

JZC advising that the police were undertaking investigations into 62 deaths based on concerns that had been raised by families of deceased relatives.

JZC commenting on the first issue for the police, in addition to obtaining the medical records, was to establish a panel of experts. JZC explaining that in addition to Professor Robert Forest the police intended to have an expert from Palliative Care, Care of the Elderly, General Practice and Epidemiology. JZC confirming with MK that we would be happy to pass on any comments to the policy about the expert they chose if we had any concerns.

JZC indicating that the task for the police was to determine causation, determine a mechanism for establishing the significance of the number of deaths and the cases causing concern and to determine whether there had been any inappropriate prescribing regime in place.

JZC querying whether the GMC had any information to indicate that Dr Barton had undertaken a course in Palliative Care. MK stating that he had checked the specialist register and she was not registered on it. JZC confirming with MK that attending a course would not be registerable matter.

JZC advising that Hampshire Constabulary had requested a letter regarding formal disclosure of documents. JZC receiving instructions from MK for her to draft a letter to Hampshire Constabulary formally asking them to formally request documents. JZC explained that she had not passed on any of the documents that MK was happy that it was in the public interest to do so as she felt it was appropriate for a formal request to be made for the documents. MK agreeing.

JZC advising MK of the suggested timescale for the police investigation and the fact that Nigel Niven hoped that his investigation would be concluded and legal advice obtained by the end of 2003.

JZC suggesting that as there was no interim work that could be done at present between meetings with FFW and Hampshire Constabulary, it may be appropriate for MK to attend the meetings with Nigel Niven. This would avoid the need to have a separate updating meeting with MK. MK agreeing that this would be an appropriate step.

DR JANE BARTON

ADVICE

Introduction

1. Further to consultations on 26 May 2004 and 14 June 2004[1], I am asked to identify, and to advise on the strengths and weaknesses of, the options available to the GMC in the light of the letter dated 28 April 2005 from DS David Williams of the Hampshire Constabulary ("the police letter") responding to the GMC's letter dated 25 January 2005 ("the GMC letter").

2. The GMC letter:
   - expressed concern that the slow pace of the police investigation was hampering pursuit of the disciplinary investigation;
   - sought limited disclosure of information in the possession of the police in relation to the case of Elsie Devine, in particular five items (witness statements, medical records, written representations and transcripts of tapes, recorded interviews and expert reports);
   - explained the two bases of that request (first, that Dr Barton had been interviewed twice in relation to the case of Elsie Devine so the advantage of surprise had been already been secured by the police and, second, that any IOC/IOP hearing would almost certainly take place in private so there would be very little risk of prejudicial publicity); and
   - expressed the hope that the requested disclosure could be given without the need to invoke section 35A of the Medical Act 1983 ("section 35A").

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[1] My notes for those consultations have already been provided and should be read with this Advice.

3. The police letter[2]:

- declined to disclose any record in relation to the case of Elsie Devine other than her medical records because these had already been served on Dr Barton[3];
- stated that the other records are to form the basis of "challenge interviews" with Dr Barton later in 2005 and that it cannot not be in the public interest or the interests of an effective criminal investigation to allow those records ultimately to be served on Dr Barton in a professional conduct hearing;
- stated a concern that the other records might also reach the public, thereby affecting the fairness of a potential criminal prosecution through adverse prior publicity;
- set out a summary of the police interpretation of events and concerns arising from the meeting on 13 January 2005[4] and informed by counsel's advice;
- stated that Dr Barton was to be interviewed about another nine patients and that the priority cases should be complete by the middle of the year but that the investigation would span the whole of 2005;
- dismissed the possibility of incremental disclosure;
- stated that the voluntary arrangement seemed to be "holding" but noted the GMC's anxiety that this was not secure and that Dr Barton could practise in a short-term locum without supervision;
- confirmed that consideration had been given to one of the ACPO Protocols for the Notification and Disclosure of Information entitled "Managing Risks to the Public Safety from Health Case & Teaching Professionals" (2000) ("the ACPO Protocol")[5];

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[2] Overall, the police letter is long on facts but short on legal reasoning: see, further, paragraph 6(4) below.
[3] Whichever option is selected by the GMC from those suggested below, the police should be asked to provide copies of those medical records immediately.
[4] Curiously, this (the major) portion of the police letter appears in italics. The reasons is unclear. Is it, perhaps, taken as a quotation from another document?
[5] Available on the ACPO website.

- stated that confidentiality, security of the criminal investigation, article 6 ECHR and the need to protect the public had all been balanced; and
- noted that there had been "significant previous disclosure to the GMC between August 2002 and October 2004" and that the IOC made no order against Dr Barton "seemingly content with her voluntary acceptance of conditions in terms of the prescription of controlled drugs".

Summary of the options

4. In my view, only two realistic options are now open to the GMC.
   (1) The first is to make a formal request to the police under section 35A and to contest the predictable refusal in court.
   (2) The second is to defer making a formal request under section 35A but to keep the progress of the police investigation under very close review.

   I have considered whether any hybrid option is available but have identified none. The GMC letter tried a conciliatory approach but has secured disclosure of only one of five heads. Before a choice between the two options is made, the matters set out in paragraph 11 below should be clarified as much as reasonably possible.

5. The strengths and weaknesses of each option are described in paragraphs 9-10 below, prefaced by an overall assessment of the GMC's position in paragraphs 6-8.

Overall assessment

6. Having been rebuffed by the police in respect of four out of five heads of disclosure, the GMC must now decide whether to invoke its power under section 35A to require disclosure.

7. The GMC can deploy, and the police can respond with, 12 main arguments and counter-arguments.

(1) Section 35A gives the GMC statutory power to *require*, not merely request, a doctor or any other person who in its opinion is able to supply information or produce any document which appears relevant to the discharge of any disciplinary function, to supply such information or produce such a document for the purpose of assisting it or any of its committees in carrying out such function.

(2) Section 35A does not, however, give the GMC an *absolute* right of access. It is phrased in broad, general terms. It does not contemplate the countervailing public interests which can compete in particular contexts. In the present context, the two countervailing public interests were identified by the Court of Appeal in Woolgar v Chief Constable of Sussex [2000] 1 WLR 25.

   (a) The public interest in ensuring the free flow of information to the police for the purposes of criminal investigations and proceedings, which requires that information given to the police in confidence would not be used for some collateral purpose.

   (b) The public interest in protecting public health and safety, which could justify police disclosure to a health regulatory body confidential information relevant to that body's inquiry provided confidentiality would be otherwise maintained.

(3) In balancing those interests, the Court of Appeal in the Woolgar case upheld the disclosure by police to the UKCC of the transcript of an interview under caution of a nurse accused of the over-administration of diamorphine and allied misconduct. There are, however, three important features of the Woolgar case which make it more helpful to the police than to the GMC.

   (a) The police were eager to disclose the transcript of the interview to the UKCC, which was keen to receive it. It was Ms Woolgar who opposed disclosure and who sought an injunction to restrain it[6]. In the present case, the police are reluctant to disclose and it is the GMC

[6] The injunction was refused.

which would need the court's assistance to compel disclosure.

(b) The police investigation was complete. Ms Woolgar had been interviewed and a final decision had been made that that there was insufficient evidence to charge her with any criminal offence. The reasoning of the Court of Appeal focused, therefore, on the competing requirements of confidentiality and Article 8 ECHR[7] rather than those of any on-going criminal (or other) investigation[8]. In the present case, the police investigation is incomplete. Indeed, that is the main reason for the refusal to disclose.

(c) The Court of Appeal recognised that the reasonableness of the police decision (to disclose or not) "may be open to challenge" in court by the regulatory body as well as by the practitioners[9]. It added, however, that the primary decision as to disclosure should be made by the police[10]. In other words, the court will be slow to interfere with the judgment made by the police about the balance to be struck between the competing interests.

(4) The police have failed to identify, precisely or convincingly, the real vice presented by compliance with the GMC's request.

(a) The police letter states, contrary to the understanding set out in the GMC's letter, that the documents covered by the four disputed heads of disclosure are to form the basis of "challenge interviews" with Dr Barton later in 2005. But it is a little difficult to accept that police questioning could take Dr Barton much by surprise. The facts and issues affecting her have been examined by several inquiries over recent years. She must already be

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[7] Article 8 ECHR states expressly that the right to privacy can be curtained "for the protection of health ... or for the protection of the rights and freedoms of others".
[8] The Woolgar case was followed by Munby J in A Health Authority v X (Discovery: Medical Conduct) [2001] UKHRR 1213 (Family Division) and by Newman J in R (Pamplin) v The Law Society [2001] EWHC Admin 300 but they too focused on confidentiality and Article 8 ECHR.
[9] Page 36g-37a.
[10] Page 37b.

well aware of them and the consequential points that could be put to her. Moreover, I believe it would be usual for the police to give *some* (termed "initial") pre-interview disclosure to an interviewee. The police do not explain why, in the present case, this would exclude the documents covered by the four disputed heads of disclosure.

(b) The police letter also states, cryptically, that the documents covered by the four disputed heads of disclosure might reach the public, thereby affecting the fairness of a potential criminal prosecution through adverse prior publicity. How this might happen (given that any IOP hearing would almost certainly take place in private) is not explained.

(5) The criminal investigation began as long ago as September 1998 and has proceeded extraordinarily slowly. It is difficult to detect the reasons for this. Although the criminal investigation is certainly complex (mainly by virtue of the antiquity of the events and the issues of confidentiality and medical practice that have arisen) and burdensome (mainly by virtue of the number of patients and volume of documents involved), I doubt that the police could convincingly explain each period of delay. The attached chronology reveals, in detail, the lack of any sense of urgency on the part of the police. As regards the future timetable for the criminal investigation, the police letter states this in rather vague terms[11]. The (snail's) pace with which the criminal investigation has proceeded is the GMC's most potent argument. There must come a day when its (and the court's) patience is exhausted. That said, if the criminal investigation were to be completed by the end of 2005, as the police letter predicts[12], the GMC has only another seven months to wait. If the GMC were to launch proceedings against the police, a conclusion could not be expected much sooner than that.

[11] The police aim to complete "the priority cases ... by the middle of the year" but the investigation will "span the whole of 2005": paragraph 3 above.
[12] Footnote 11 above.

(6) As I understand it, the GMC is seeking only sufficient material to allow its disciplinary investigation to proceed. If the police were to charge Dr Barton and launch a criminal prosecution, the GMC would not hold a disciplinary hearing before or during the criminal trial. Rather, the GMC wants to be in a position immediately to launch the disciplinary proceedings if no charges are pressed against Dr Barton[13]. This should be made clear in any reply to the police letter.

(7) The ACPO Protocol contains some useful passages on police co-operation with professional regulatory bodies, including with the GMC under section 35A. No passage imposes any absolute duty on the police. All are subject to the exigencies of any criminal investigation and/or prosecution and the need to balance the competing factors. But the police are encouraged to co-operate as much as possible and to avoid any unnecessary delays. The passages can be cited against the police to check that the relevant considerations have been taken into account.

(8) Home Office Circular 45/1986 entitled "Police Reports of Convictions and Related Information", cited in the Woolgar case, ("the Circular") also contemplates that confidentiality can be breached by the police by disclosure of material to professional regulatory bodies in order to protect "vulnerable members of society" where there is "serious concern that a person ... is unsuited to hold a position of trust"[14]. However, it is less specific and less detailed than the ACPO Protocol and, strictly, applies only to the revelation of doctor's *convictions* rather than to material collected during a criminal investigation[15].

(9) Since the summer of 2002 the police have revealed *some* material to the GMC and the police letter offers one of the five heads of disclosure now requested. But the exact extent of that disclosure, is unclear to me.

(10) The police claim that Dr Barton is currently subject to a voluntary undertaking governing her prescription of controlled drugs. But the accuracy

[13] The longer this is left, the stronger will be an application by Dr Barton that the disciplinary proceedings should be abandoned as an abuse of process on delay grounds.
[14] See, especially, paragraphs 2 and 7 of the Circular.
[15] See, especially, paragraph 3 of schedule 2 of Annex A to the Circular.

of this claim, and the precise ambit of any such undertaking, is unclear to me[16].

(11) On three occasions, in 2001 and 2002, the IOC refused to make an interim order restricting Dr Barton's registration. Moreover, in October 2003 the screener declined to refer Dr Barton's case to the IOC for a fourth hearing (because there was no new information justifying another referral). Thus, the GMC's own committee does not consider that Dr Barton poses an unacceptable risk to the public[17].

(12) There is nothing to stop the GMC seeking its own versions of the documents covered by the four disputed heads of disclosure. It is entitled to approach Dr Barton[18] directly, seek its own interview with her, invite her written comments and obtain its own expert reports; although, of course, it would be much quicker and cheaper for the GMC to have access to the pre-existing police versions[19].

8. In my view, weighing these rival arguments, the GMC is now in a stronger position to make a formal request under section 35A, and to contest any police refusal, than it was when I first advised in May 2004. A legal challenge to such a refusal would be arguable, not risible. Principally, this is because another year has passed with very little progress. However, the challenge would be unlikely to succeed. Principally, this is because the court would be slow to interfere with the judgment of the police that the criminal investigation would be undermined, because the GMC should not have to wait very much longer for the conclusion of the criminal investigation and because even the GMC's own committee considers there to be little or no risk to the public in the meantime.

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[16] According to the attached chronology, the undertaking lapsed on 31 March 2002 and has not been reinstated.
[17] Since October 2003 there has been no material change of circumstances suggesting that the level of risk has altered.
[18] And other potential witnesses.
[19] And Dr Barton may rely on her privilege against self-incrimination and decline to co-operate with the GMC for fear of prejudicing her defence to any criminal prosecution.

The first option

9. The first option is to make a formal request to the police under section 35A, allow a reasonable time for reply (say 21 days) and then contest the predictable police refusal[20].

   (1) The advantage of this option is that it would transfer the responsibility for balancing the competing public interests from the GMC (and the police) to the court. The GMC could not be accused of passivity, should it later transpire that Dr Barton is harming patients or putting them at risk. The parallels that could be drawn with Dr Harold Shipman are obvious.

   (2) The disadvantages of this option are three-fold.

      (a) It would raise the profile of the case, drawing attention to the delays that have already occurred (since September 1998). That said, the police have more reason than the GMC to fear the embarrassment of adverse publicity in this respect.

      (b) For the reasons explained above[21], the present case is by no means the ideal one in which to test the scope of section 35A. It would be better to start with a case in which, for instance, the IOC has not already refused to make a interim order and in which the end of the criminal investigation is not (apparently) in sight. That said, there is merit in the GMC at least being *seen* to try to force the hand of the police. The mere attempt might force the pace of the criminal investigation[22].

      (c) If the GMC were to lose in court, it would probably have to pay its own costs as well as those of the police.

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[20] Section 35A does not contemplate a refusal to comply with a disclosure request. Nor, therefore, does it identify a legal procedure for challenging such a refusal. A claim for judicial review by the GMC would be the most obvious procedure. A letter before action would be needed.

[21] Paragraph 7.

[22] It may also have a precedent value beyond the present case. Other police forces, and the CPS centrally, might have a slightly greater sense of urgency in future investigations if they know that the GMC is prepared to actually to *invoke* section 35A rather than just *talk* about invoking it.

The second option

10. The second option is to defer making a formal request under section 35A but to keep the progress of the police investigation under very close review and to be prepared to activate under section 35A at short notice if the progress is not satisfactory.

(1) The progress I have in mind is very specific: namely, as contemplated by the police letter, that the criminal investigation into the priority cases should be complete by the middle of 2005 and that the investigation into all nine patients should be complete by the end of 2005. The criminal investigation should not be allowed to drift. The police should be asked for monthly reports on progress and left in no doubt that any substantial slippage in the timetable would trigger the section 35A mechanism. If possible, it would be prudent to twin this with political pressure. Representations might be made at a very senior level[23], warning of the potential for a repeat of the criticism surrounding Dr Harold Shipman (but with the police as much more of a target this time) if the present case is not resolved soon. This two-pronged approach might persuade the police to make the present case a higher priority.

(2) The advantage of this option is that it avoids a public confrontation between two public bodies, through proceedings in which both bodies would probably be criticised to some extent in the media (although the police more than the GMC)[24].

(3) The disadvantage of this option is that it might be perceived by the police as just another in a series of threats made by the GMC to use section 35A. Experience teaches that the threats do not accelerate the pace of the criminal investigation. It could be portrayed as just more GMC passivity.

Conclusion

11. Before selecting the preferred option, it would be useful to clarify eight factual matters.

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[23] Perhaps by the GMC's President to the Chief Constable of Hampshire or even at Ministerial level.

[24] It would be possible to apply for part of the hearing to be in private but it is likely that a large portion of it (the part dealing with legal submissions) would be public.

(1) The currency and ambit of the voluntary undertaking and Dr Barton's access to areas of practice which are the subject of concern[25].

(2) The precise extent of previous disclosure by the police[26].

(3) The pace of progress in the nine further cases. In particular, will the "priority cases" really be complete by the middle of 2005?

(4) The terms of the email dated 28 February 2005 from the police to the GMC. This is referred to in the first paragraph of the police letter but I am told it has never been received. It seems to be quite important because it is described as setting out "an update of the position of the [police]".

(5) Whether any approach has been made by the GMC to the UKCC to discover whether it has similar concerns as regards nursing staff at GWMH[27].

(6) Whether any approach, formal or informal, to the Department of Health and the relevant NHS Trust under section 35A has yet been made by the GMC or is contemplated[28].

(7) Do the police normally share information with the GMC while the criminal investigation is on-going? Is there a normal practice which the GMC could argue is being departed from in the present case?

(8) Does the GMC usually pursue its investigation while to criminal investigation is continuing? In the present case, what scope is there for the GMC pursue to pursue its investigation in parallel with the criminal investigation?

In addition, I should be grateful to have a complete chronological set of all communications (letters, emails, telephone memoranda, notes of meetings etc.) between the police and the GMC. I have been sent the parts relevant to each set of instructions. But I lack a comprehensive set.

12. Whatever course the GMC adopts, it should reassure the police that any information disclosed will be used solely for the purposes of carrying out the GMC's fitness to practise functions.

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[25] Paragraph 7(10) above.

[26] Paragraph 7(9) above.

[27] The last but three paragraph on page 4 of the police letter states that, at the meeting with the GMC on 13 January 2005, the police encouraged such an approach.

[28] It would be useful to secure the support of the Department and/or the Trust and/or the Chief Medical Officer.

Code A

MARK SHAW Q.C.

Blackstone Chambers

25 May 2005

DR JANE BARTON

CHRONOLOGY
(with the more important dates in bold type)

1 May 1988	Dr Barton began work as clinical assistant at GWMH.
Jul 1991	RCN convenor met nurses to discuss improper use of opiates at GWMH.
Feb-Oct 1998	Alleged mistreatment (of five patients principally) by improper use of opiates at GWMH.
Sep 1998	**Concerns first raised by Richards family. Police investigation began.**
Mar 1999	**CPS decided there was insufficient evidence to pursue criminal prosecution in respect of Mrs Richards.**
Jan 2000	NHS Independent Review Panel found that opiate doses were high but appropriate in circumstances.
?????? 2000	Health Service Ombudsman rejected complaint.
5 Jul 2000	**Dr Barton resigned from GWMH.**
27 Jul 2000	**Police notified GMC of allegation by Richards family against Dr Barton and restarted investigation. But no complaint ever made directly to GMC by any family[1].**
Mar 2001	11 other families raised similar concerns with police. Four (Page, Wilkie, Cunningham and Wilson) were investigated.
Jun 2001	**First IOC hearing. IOC considered Richards allegation and made no order.**
Aug 2001	Police passed concerns to CHI, which began investigating care at GWMH *since* 1998 (including through interviews of relatives and staff).
Feb 2002	**CPS decided not to pursue criminal prosecution in respect of four other patients (Page, Wilkie, Cunningham and Wilson). CPS papers disclosed to GMC.**

[1] All are "information", not "complaint", cases.

Feb 2002	**Barton gave voluntary undertaking to Health Authority (not to prescribe opiates or benzodiazepines).**
21 Mar 2002	**Second IOC hearing. IOC considered allegations in respect of all five patients and made no order.**
31 Mar 2002	**Dr Barton's voluntary undertaking given to Health Authority (not to prescribe opiates or benzodiazepines) lapsed.**
28 May 2002	Mrs Richards' daughter protested about lack of progress.
Jul 2002	CHI reported concerns (especially about anticipatory prescribing).
Aug - Oct 2002	**Pressure (in political quarters) created by Mrs Richards' daughter's protest led, despite some apparent reluctance, to police sending further papers to CPS and re-opening investigation to encompass all (62) patients who died while under Dr Barton's care at GWMH. GMC's investigation put on hold.**
29 Aug 2002	**PPC referred all five cases to PCC but made no referral to IOC.**
Sep 2002 - Sep 2003	Police referred all 62 patients to panel of five experts, who began investigation.
12 Sep 2002	Suspension of GMC's investigation.
19 Sep 2002	**Third IOC hearing. In response to referral by GMC's President, IOC again considered allegations[2] in respect of all five patients but again made no order (in view of the absence of any new material[3]).**
19 Sep 2002	Health Authority sent GMC file of correspondence concerning use of diamorphine in 1991.
9 Oct 2002	FFW advised that screeners would be misdirecting themselves if they were to refer Dr Barton to IOC again in light of Health Authority's disclosure.
20 Nov 2002	Meeting between GMC and police.
2 Dec 2002	Police asked GMC to removed Dr Barton's case from PCC hearing list. GMC did so[4].

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[2] It had reports from Dr Ford and Dr Mundy.
[3] The Legal Assessor advised that in the absence of "new evidence ... it would be unfair to the doctor ... to consider the matter any further": apparently a reference to the doctrine of *res judicata*.
[4] Dr Barton's case has not yet been reinstated into the list.

30 Sep 2003 **Police met GMC and stated that panel of five experts had concluded that treatment of about 25% (15-16) of patients and cause of death gave rise to concern and should be investigated further (by a single new expert, auditing and refining the work of his five predecessors). GMC sought disclosure but this was refused because of risk of disclosure to Dr Barton if her case were to return to IOC.**

2 Oct 2003 GMC letter again pressed police for disclosure.

Oct 2003 **Baker report (independent clinical audit of care of 81 patients, sampled at random, who died at GWMH from 1988 to 2000 with particular emphasis on Dr Barton's conduct) sent to CMO but not to GMC[5].**

Oct 2003 **Screener refused to refer case for a fourth time to IOC (in view of absence of new evidence).**

Jan 2004 GMC believed (wrongly according to police) that audit and refinement of conclusions of panel of five experts by another, single expert was due to be completed.

7 Jan 2004 GMC pressed police for update on progress.

28 Jan 2004 Police unable to provide any further information on progress.

6 Feb 2004 GMC confirmed to police that GMC inquiries were "on hold" pending conclusion of the police investigations.

Mid-Feb 2004 Conclusions of panel of five experts were to be communicated to relatives[6].

Feb 2004 GMC met CMO, at latter's request, to discuss Dr Barton's case.

27 Feb 2004 **Meeting between GMC, FFW and police. Police said that the investigation was still incomplete, that they did not know when it would end or when Dr Barton would be interviewed and that they would not release any information to GMC unless GMC guaranteed not to pass it on to Dr Barton.**

5 May 2004 GMC again pressed police for report on progress.

17 May 2004 Baker report sent to GMC, subject to undertaking not to copy or disseminate.

11 Jun 2004 CMO met police to discuss Dr Barton's case.

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[5] A copy was, however, passed to GMC by CMO. A summary of is attached. It should be treated as confidential because circulation of the Baker report is still strictly limited.

[6] It is unclear whether this took place.

13 Jan 2005	Meeting between GMC and police.
25 Jan 2005	GMC wrote to police seeking disclosure of material in relation to Mrs Devine, backed by reference to section 35A of the 1983 Act.
Feb 2005	Police planned to interview Dr Barton[7].
28 Feb 2005	Police email to GMC gave update.
28 Apr 2005	Police replied to GMC letter dated 25 January 2005 refusing the disclosure sought.

Code A

25 V 05

[7] Not yet occurred.

DR JANE BARTON

ADVICE

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Solicitor's ref: Toni Smerdon
Counsel's ref: BARTON – advice (25.5.5)
Tel: 020-7189-5126
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25 May 2005

13

Toni Smerdon Code A

From: Mark Shaw Code A

Sent: 08 Jun 2005 10:06

To: Toni Smerdon Code A

Subject: BARTON

Dear Toni,

Since you told me in yesterday's con that my draft Advice in this case was fine and had been circulated, I attach a final version and enclosures.

I have kept the same date because I made no changes to the 25 May version.

Hard, signed copy is on the way in the post.

Best wishes,

Mark

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General Medical Council

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To: Mr Mark Shaw
From: Paul Hylton - Code A
Fax no: Code A
Date: 25 May 2005
Pages: 3 pages inclusive
Re: Dr Jane Barton
CC: [Name]

Dear Mr Shaw

In response to your email of 23 May 2005 to Toni Smerdon requesting copies of a number of documents.

Toni has asked me to fax to you a copy of our letter of 21 April 2005 to DCS Steve Watts, please find a copy attached.

I can also confirm that the GMC does not have a copy of an email from Hants Constabulary dated 28 February 2005, and that no official note was made of the meeting between the GMC and Hants Constabulary on 13 January 2005.

If you have any further queries please do not hesitate to contact me.

Yours sincerely

Code A

Memorandum

To	**Paul Philip**
From	**Paul Hylton**
Date	**17 September 2004**
CC	**Peter Swain**

Dr Jane Barton

1. I have now had an opportunity to review the information disclosed to the GMC by Hampshire Police on 10 September 2004. The information contains medical records, clinical team screening forms, reviews of expert reports, police officer reports and case reviews by Matthew Lohn, and relates to 19 cases in which the Police and medical experts have determined that the treatment by Dr Barton was "sub-optimal". Only one of those cases, that of Eva Page, has previously been considered by the IOC and PPC.

2. Critically, the police definition of sub-optimal treatment appears to be treatment that was neither negligent nor intended to cause harm. It could be argued that given the definition of spm as outlined in the case of *Preiss -v- General Dental Council*, it could not be properly arguable that sub-optimal treatment is capable of constituting spm. However, as these matters do not concern a single isolated incident it is difficult to see how *Preiss* could apply.

3. Having reviewed the information, it would appear that in respect of 14 of the 19 patients the expert's preliminary report indicates that it may be properly arguable that Dr Barton's alleged conduct is capable of constituting spm. I have based this opinion on the comments made in the Clinical screening forms and Matthew's reviews. What we do not have at this time are any detailed expert reports, and I am currently trying to ascertain from the Police whether there are any more detailed expert reports than those already disclosed. If there are more detailed reports available then we would have to consider whether we would need to put them before the IOC or whether the reviews we currently have are sufficient.

4. The information does not include details of the other four other cases previously considered by the IOC. I am currently trying to ascertain the status of these cases. However, given the nature of the albeit limited information previously made available to us by the Police it would not be unreasonable to assume that the other 4 cases are among those cases currently being considered by the CPS.

5. I will compile a bundle to be considered by the President for referral to the IOC next week. I will also contact the Police again in order to try and obtain

any information they feel able to disclose in respect of the cases currently being considered by the CPS. Clearly, it is important that we give the IOC as full a picture as possible of the matters under investigation. If nothing else, we should try and get from the Police a statement confirming that a criminal investigation is still taking place, outlining the broad nature of the allegations, and stating how many patients are involved.

Code A

Paul Hylton
Conduct Case Presentation Section

GMC Legal

Memorandum

To	**Linda Quinn**
From	**Toni Smerdon** **Code A**
Date	**9 October, 2003**
cc:	**Jackie Smith** **Paul Philip**

Dr J A Barton (2000/2047)

1. Further to your memorandum dated 30 September 2003 to Paul Philip, I have now reviewed the case of Dr Barton in relation to a further referral to the IOC on the basis of the meeting held with the police on 30 September 2003.

2. By way of background, on 27 July 2000 Hampshire Constabulary notified the GMC that an allegation had been made by members of the family of Gladys Richards to the effect that she had been unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital during or about the period 17-21 August 1998. The police confirmed that the doctor who appeared to be responsible for the care of Mrs Richards at the time was Dr Jane Barton, a GP practising in Gosport. Dr Barton was also engaged by the Portsmouth Healthcare NHS Trust as a visiting clinical assistant at the Memorial Hospital. The police subsequently confirmed in September 2000 that the investigation was ongoing and a file was to be submitted to the Crown Prosecution Service (CPS).

3. Following receipt of statements and medical notes in June 2001 in relation to Gladys Richards, the case was referred to the IOC for consideration. The IOC made no order.

4. In February 2002, the CPS decided not to proceed with criminal proceedings. The Crown's papers were then disclosed to the GMC. The case was referred again to the IOC. The hearing took place on 21 March 2002. Again, no order was made.

5. When the police provided their papers in February 2002, it had included a report from Dr Mundy, a consultant physician and geriatrician on the management of 4 patients who had also died at the Gosport War Memorial Hospital. Those patients were Arthur Cunningham, Alice Wilkie, Robert Wilson and Eva Page. When the IOC considered Dr Barton's case on the second occasion in relation to allegations of inappropriate/irresponsible prescribing, no order was made.

6. The case was considered by the PPC on 29 August 2002. They referred the case to the PCC for public inquiry. At about the same time, the GMC was made aware that concerns had been raised on behalf of family members in relation to the view taken by the police was that there was no case to be raised against Dr Barton. In view of the concerns raised, the police decided to send the case papers to CPS.

This memo may contain legal advice and may be subject to legal professional privilege.
Do not disclose externally before consulting the In-House Legal Team.

7. In the circumstances, a referral to the IOC was made by the President and the case considered on 19 September 2002. The Committee were aware that there was no new evidence and no fresh allegations being made and that the only change of circumstances since the previous hearing in March 2002 was that the police had sent the papers to the CPS.

8. The IOC considered that no order should be made as there was no new material in the case since the previous hearing.

9. The Hampshire and Isle of Wight NHS Health Authority sent to the Council on 19 September 2002 a file of correspondence relating to concerns which had been raised by nursing staff in the use of diamorphine on patients in 1991.

10. The information was considered by Matthew Lohn at FFW as to whether this merited a further referral to the IOC.

11. Matthew Lohn provided his written advice on 9 October 2002. He said "*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".

    Although it would be open 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."

12. The police reopened their investigation and in the circumstances the GMC's own investigation was placed on hold.

13. The police decided to investigate all deaths of patients under Dr Barton's care at the Gosport War Memorial Hospital. A team of 5 medical experts was appointed – experts in the fields of toxicology, geriatric medicine, palliative care, general practice and nursing. The experts have reported on the basis of whether the treatment provided to each of the 62 patients was optimal, sub-optimal or negligent; and whether the reason for the death/harm was natural causes, unclear or unexplained by natural cause/disease.

14. At a meeting with the police on 30 September 2003, they confirmed that the medical experts findings were that 25% (approximately) were optimal; 50% (approximately) was sub-optimal by causation unclear and 25% (approximately) were negligent, cause of death unclear.

15. The police are to run a quality control check on the findings and then appoint further experts to examine in detail the 15 or 16 cases which fall into the category of

"negligent, cause of death unclear". The police have also confirmed they will not interview Dr Barton until that second team of experts has reported and that is anticipated to be January 2004 at the earliest.

16. At the meeting, the police asked whether the case could be reconsidered by the IOC on the basis of the information they had supplied. As they were aware that any papers seen by the IOC would also be disclosed to Dr Barton and her solicitors they were unable to provide full details of their investigations as it could jeopardise any further investigation and their eventual interview with Dr Barton.

17. All that the police would be able to provide is a brief written summary of the current position but that such a summary would need to be requested in writing, explaining the reasons for it and why it was in the public interest for the police to supply it and also what action the GMC envisaged taking.

18. The IOC has already considered Dr Barton's case on 3 previous occasions. The only new information which the Council now has is what the police notified to Linda Quinn at their meeting on 30 September 2003. We have no new "evidence" which could at this time justify a referral to the IOC. The IOC may only make an order in accordance with Section 41A of the Medical Act 1983 (as amended) to protect patients, public interest or a doctor's own interest. To make an order the Committee must have before it cogent and credible prima facie evidence. To support a referral back to the IOC the police will need to provide us not only with a summary of their investigation to date, but also some of the evidence upon which they intend to rely.

19. The police may be in difficulty in disclosing information upon which an IOC could properly make an order in view of the stage at which their investigation has reached and their inability to interview Dr Barton until January 2004.

20. A letter has been sent to the police specifically relating to the information that the GMC does require to support a further referral at this time to the IOC.

21. It is appropriate at this time for the matter to be considered again by a Screener who should note that all the information on file has previously been seen by an IOC on at least two occasions, save the new information from the police which is not supported by evidence, and then decide, taking into account the IOC criteria, whether a further referral should be made at this stage.

22. It would of course be open to the Screener to reconsider the matter again once any evidence has been produced by the police following the GMC's letter of 2 October. If that information is insufficient, then the matter should again be reviewed once the police have conducted their interview with Dr Barton and a decision taken whether or not charges will be preferred. Even if charges are not to be preferred the evidence which the police have obtained may support further allegations of inappropriate or irresponsible prescribing which could be considered by the PPC and added to the charges already before the PCC.

23. It is important this case is kept under close review and would suggest that regular updates are sought from the police and that depending on the information received as to whether or not the position with regards to a referral to the IOC has changed.

Code A

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~~**

FILE NOTE OF MEETING RE: DR BARTON AT FFW 3 OCTOBER 2002-10-04

Matthew Lohn, Judith Christie, Peter Swain and Michael Keegan present

ML considered use of different experts to those included in PPC and IOC reports (Ford, Mundy and Livesley) with more relevant experience, e.g. in cottage hospital. Danger of undermining earlier reports...? Rather: ask Ford to review in light of all info, e.g. Barton's responses re: nature of hospital, staffing, etc. – **JC to arrange.**

Get CHI report and background to FFW – **MK** ✓

Meet with Hampshire Police (MK and JC to attend) to obtain info and doc's, incl. Nurses' and families' statements, poss on agreement not to use any material until CPS decision made.

Further cases from Screening? PS says Michael Hudspith has cases received subsequent to Rule letter, but before PPC... info subsequently received may be included under Rule 11(2). Michael Hudspith to keep CCPS informed of any such cases for inclusion as above or for screening and referral to PPC.

Dr Lord already screened out, therefore NFA. But may be potential use as a witness.

ML advised that 1991 papers provided by Simon Tanner do not really add anything.

GMC under ongoing duty of due diligence to review new cases and consider further IOC referrals when called for.

Timescale: depends largely on CPS in the first instance, but A.S.A.P.

Hold off reporting nurses to UKCC – potential witnesses. ML will inquire whether any investigations undertaken as yet by UKCC.

MK
3 October 2002

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**~~

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Your reference: JZC/HJA/00492-14742/2145525v1
In reply please quote MK/2000/2047

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

18 December 2002

Ms Judith Chrytie
Messrs Field Fisher Waterhouse
35 Vine Street
London EC3N 2AA

Dear Judith

Dr Jane Barton

Thank you for your letter of 17 December 2002. Unfortunately neither of the attendance notes of the meetings on 3 October or 20 November were enclosed. I acknowledge receipt of the copy letter dated 2 December from DI Nigel Niven.

As discussed, I can instruct you to agree DI Niven's request that we stay proceedings pending the outcome of the criminal investigation. I am also happy to agree to your visit to CHI on 14-15 January and the adjournment of our meeting to 22 January 2003, when I am free all day. I am happy to attend at your offices if you would like to confirm a time.

I should be grateful for your thoughts on the inclusion of Mrs Carby's complaint concerning her late husband, Stanley, under Rule 11.

May I take this opportunity to wish both John and you a merry Christmas and happy New Year.

Yours sincerely

Code A

Michael Keegan
Conduct Case Presentation Section

Code A

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Memorandum

To **Miss Fiona Horlick**

From **Venessa Carroll**
Conduct Case
Presentation Section
Code A

Date **16/09/02**

IOC 19 September 2002 – Dr Barton

Miss Horlick,

1. I understand that you are representing the GMC at the IOC this week. I attach instructions for the case of Dr Barton which is to be considered on Thursday 19 September 2002 at 11.30am. I apologise for the lateness in providing this information which is due to the fact that the President only referred the case to the IOC on Friday 13 September.

2. A copy of the IOC item will be provided to you as soon as possible, but in the meantime I attach a copy of a memo which sets out the background to this case.

3. As a letter was only sent to the doctor informing her of this hearing on 13 September, it is likely that her solicitors will ask for the hearing to be adjourned.

4. Please contact me if you require any further information.

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

FIELD FISHER WATERHOUSE

IN THE MATTER OF the General Medical Council

and

IN THE MATTER OF Dr J A Barton

Note to Leading Counsel

Leading Counsel has herewith:-

1. Transcript of the Interim Orders Committee in the case of Dr Barton on Thursday 19 September 2002.

2. Bundle of Correspondence.

3. Chronology.

---

1. Leading Counsel has been instructed to advise in consultation on Wednesday 26 May 2004 in respect of the issues concerning disclosure from the police to the General Medical Council when concurrent criminal investigations are underway.

2. Instructing Solicitors have also been asked to obtain Leading Counsel's views in respect of the case of Dr J A Barton.

3. The background to this matter is set out in the Interim Orders Committee proceedings in 2002 where no order was made.

4. Despite an ongoing police investigation, no material has been made available to the GMC in order for them to be able to determine whether it remains appropriate for Dr Barton's registration to remain unrestricted.

5. Leading Counsel is asked to advise whether the position of non disclosure maintained by the police is reasonable and, if not, what steps should be taken next.

Dated: 25 May 2004
Field Fisher Waterhouse
35 Vine Street London EC3N 2AA

IN THE MATTER OF the General Medical Council

and

IN THE MATTER OF Dr J A Barton

Note to Leading Counsel

Mark Shaw QC
Blackstone Chambers
Blackstone House
Temple
London EC4Y 9BW

Field Fisher Waterhouse
35 Vine Street London EC3N 2AA
Tel: 020 7861 4000
Fax: 020 7488 0084

General Medical Council

Dr Jane Barton

Instructions to Leading Counsel to advise the General Medical Council in relation to a determination announced on 29 January 2010

Documents

Counsel will find enclosed the following documents:

1. Copy of the determinations in the above matter, both findings of fact and Serious Professional Misconduct/sanction

2. Skeleton chronology prepared by Instructing Solicitors, together with patient key

3. GMC master document used to support closing speech *(to follow)*

4. Expert reports prepared by Professor Gary Ford (on behalf of the GMC)

5. Expert reports prepared on behalf of Dr Barton

6. Bundle of testimonial evidence submitted on behalf of Dr Barton *(to follow)*

7. Press release from GMC dated 29 January 2010

In addition Instructing Solicitors have provided Counsel with an electronic copy of the transcript of the entire Fitness to Practise Panel proceedings referred to above.

Introduction

1. Instructing Solicitors act for the General Medical Council ("GMC") with whose Act and Rules Leading Counsel is familiar.

2. The GMC's Fitness to Practise Panel has recently concluded its deliberations in the above matter. Counsel is referred to enclosure 1 at which she will find the detailed findings of fact and the decision as to Serious Professional Misconduct ("SPM"). The determination as to sanction is also included and Counsel will see set out a series of conditions imposed upon the registration of Dr Jane Barton.

3. Leading Counsel is asked to advise the GMC at this stage in anticipation that the Council for Healthcare Regulatory Excellence ("CHRE") may seek to commence High Court proceedings on the basis that this sanction decision was "unduly lenient".

Background

4. Counsel is referred to the chronology at enclosure, which sets out in brief detail the background to this matter and the circumstances in which the Fitness to Practise Panel only reached a final conclusion in this matter in January 2010, the conduct having occurred approximately 10 years previously.

5. In summary, a number of police investigations followed very belatedly by a Coroner's inquest led to delays in the case being listed before the GMC. The hearing commenced in the summer of 2009 but went part heard concluding in January 2010.

6. As a result of the first referral being prior to 1 November 2004 the case was brought under the GMC's "old" rules. Under the transitional provisions this case was heard by a Fitness to Practise Panel applying the General Medical Council's Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 (as amended).

7. The matter was brought to the attention of the GMC by Hampshire Police and the charge of SPM was brought by the GMC. The families were not parties ("complainants") to the Fitness to Practise Panel proceedings.

8. The case involved the treatment of 12 patients at Gosport War Memorial Hospital in the late 1990's. The key concern being the inappropriate prescribing of drugs, including opiates and levels which were excessive, potentially hazardous and not in the patient's best interests. Multiple breaches of Good Medical Practice were established.

9. Counsel is referred to the closing speeches of both Counsel on days 37-39 of the hearing where she will find a detailed summary of the evidence in this case. She will be further assisted by the document at enclosure 3.

10. Instructing solicitors have provided only the expert reports and the testimonial evidence from the Panel bundle (enclosures 4-6). In particular those instructing do not

consider it necessary to provide medical records at this stage given the detail contained in the transcript. Further documents can be immediately provided at Counsel's request.

Potential review of determination

11. Counsel will be familiar with the powers of CHRE, which under Section 29 of the National Health Service Reform and Health Professions Act 2002, has the power to refer decisions of the Fitness to Practise Panel to the High Court where it considers that the relevant decision has been "unduly lenient, whether as to any finding of professional misconduct or fitness to practise on the part of the practitioner concerned (or lack of such a finding), or as to any penalty imposed" and "that it would be desirable for the protection of members of the public for the Council to take action under this section."

12. At the conclusion of the proceedings on Friday 29 January 2010 the families of the patients concerned expressed disquiet as to the outcome and there has been subsequent media coverage and a degree of expectation that CHRE will become involved.

13. The GMC's Chief Executive issued a press statement shortly after the Panel delivered its determination, a copy of which can be found at enclosure 7.

Instructions

14. Leading Counsel is asked to advise the GMC as to the merits of the various alternative positions it might take should CHRE proceed to refer the matter to the High Court.

15. Counsel is specifically referred to the submissions on sanction made by Tom Kark (Counsel for the GMC) on 20 January 2010. For the reasons set out the GMC were seeking erasure of Dr Barton's name from the medical register.

16. Counsel will also see in the final section of the transcript that the parties were invited to address the Panel further on the effect of the passage of time.

17. Counsel will note that the GMC's position immediately after the announcement was that the decision was *"We are surprised by the decision to apply conditions in this case. Our view is that the doctor's name should have been erased from the medical register following the Panel's finding of SPM"* (Naill Dickson, Chief Executive of the GMC)

18. Conversely Counsel will note the submissions made on behalf of Dr Barton in relation to sanction and will see from the chronology that for an extensive period of time Dr

Barton was not subject to any interim order and has subsequently been subject to interim conditions in a format similar to those imposed by way of the final sanction.

19. Dr Barton provided extensive testimonial evidence to which reference is made in the Panel's determination.

20. Instructing Solicitors anticipate that the GMC will be called upon to make a rapid response to any referral made by CHRE. The GMC will need to indicate whether it supports the referral or would intend to contest it.

21. Counsel will be exceedingly familiar with the extensive authorities that have been produced as a result of CHRE's referrals under Section 29 and will be familiar with the interpretation previously applied by the Courts in relation to the assessment of "undue lenience". She will also be familiar with the GMC's indicative sanctions guidance which has been commended by the Courts and which is appropriately referred to both in submissions and in the determination.

22. Should Counsel require any additional information she should not hesitate to contact her Instructing Solicitors. The Solicitor with day to day conduct of the matter is Rachel Cooper (0161 200 1783 rachel.cooper@ffw.com) and the Partner with conduct is Sarah Ellson (0161 200 1773 sarah.ellson@ffw.com)

Field Fisher Waterhouse – 3 February 2010

Privileged and Confidential

Case Analysis

This document sets out our advice. It contains a summary of our analysis of the evidence gathered to date. This document follows from the Case Outline. If any of the facts in the Case Outline change, then that may have an impact on the contents of this Case Analysis. Together we will keep this Case Analysis up to date as matters unfold and the case progresses.

Legal Analysis

We have prepared the following rough analysis of the strengths and weaknesses of the allegations, based on work carried out to date.

1. **Pittock**

1.1 Aged 82 on admission. One of the experts - Black - believes patient was probably terminally ill on admission.

1.2 Patient was assessed by Dr. Lord on the day before his admission - assessed his prognosis as being poor. Chances of survival slim. Unlikely to survive for long.

1.3 On transfer to Dryad Ward, Dr. Tandy, Consultant Geriatrician, had overall medical responsibility. (She worked on the Ward until late 1996.) Her responsibilities included a Ward Round once a fortnight.

1.4 Dr. Tandy saw the patient on 10 January 1996, five days after he was admitted. She prescribed 5mg Oramorph to alleviate pain and distress.

1.5 Dr. Barton, in her witness statement, "believes" (emphasis added) that she reviewed the patient on 15 January 1996 and "believes" that his condition had deteriorated with significant pain and distress.

1.6 It appears that Barton prescribed Diamorphine on 15 January 1996 - it also appears that this was without reference to Dr. Tandy.

1.7 Dr. Tandy, in her witness statement, comments that she would have used a lower dosage of Diamorphine and Midazolam - her practice being to use the lowest dose to achieve the desired outcome, and to reduce adverse effects.

1.8 Nurse Hamblin, the Sister, refers to an increased dosage of Diamorphine on 18 January, six days before the patient died.

1.9 The key clinical team observed that the patient was physically and mentally frail. The team concluded that the patient was probably Opiate toxic, but

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notwithstanding this, the dose was not reduced. Cause of death - unclear. Opiates "could" have contributed.

1.10 Two experts have reviewed the case, Dr. Wilcock, expert in Palliative Medicine, Dr. Black, a specialist in Geriatric Medicine.

1.11 As a general observation in this and the other cases, Dr. Wilcock tends to be more bullish in his conclusions compared to Dr. Black who is more circumspect.

1.12 Wilcock refers to Barton's poor medical note keeping. In her witness statement, Barton admits to this, but seeks to explain the deficiency with reference to substantial work place demands. Says that a choice had to be made between detailed note making or spending more time with the patients. Also seeks to explain the policy of "pro-active prescribing" with reference to the demands of work.

1.13 Wilcock says that the patient's pain was not appropriately assessed. We need to check how he reached this conclusion. Is it a case that there was no written assessment? Is there any evidence that a proper assessment was made, but not recorded in the notes?

1.14 Wilcock refers to the inappropriate administration of Opiates to relieve anxiety and agitation.

1.15 Wilcock refers to doses of Diamorphine in the range 40-120mgs as being excessive to the needs of the patient and far in excess of an appropriate starting dose. Says that an appropriate dose would be 10-15mgs.

1.16 Wilcock's overall conclusion is that Barton breached her duty of care to the patient by failing to provide treatment with skill and care, but "it is difficult to exclude completely the possibility that the dose of Diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death".

1.17 Wilcock also believes that the certified cause of death - Bronchopneumonia appears to be the most likely cause of death.

1.18 Dr. Black, in his report, refers to the patient's condition being extremely frail. The patient was at the end of a chronic period of disease spanning more than 20 years. The patient suffered from depression and drug related side effects.

1.19 Black refers to a problem in assessing the standard of care due to a lack of documentation. He agrees with Wilcock in that the lack of notes represents poor clinical practice.

1.20 Black refers to "suboptimal" drug management.

1.21 Black notes that the starting dose of 80mgs of Morphine was approximately three times the dose that is conventionally applied. Black also says that the combination of drugs (Diamorphine and Midazolam/Noizinan) are likely to have caused excessive sedation and may have shortened the patient's life by a short period of time - "hours to days" - "medication likely to have shortened the patient's life, but not beyond all reasonable doubt".

1.22 Other features noted include the following: the patient's own GP, Dr. Brigg, was consulted about the patient on 20 January 1996 - four days before the patient died.

1.23 Police have taken a statement from the patient's daughter, Mrs. Wiles, who is also a retired Registered Mental Nurse. Her understanding is that her father was transferred to Dryad Ward for terminal care. She believes that he died through "self neglect" - he was extremely frail and had lost the will to live. She did not take issue with the fact that her father was prescribed Morphine and she considered this to be appropriate.

Initial View

1.24 There is sufficient evidence to pursue the charges relating to inadequate note keeping, inadequate assessment (possibly) and prescribing/administering medication, including Diamorphine, in excess of the patient's needs. The conclusions of the two experts are not strong enough to sustain a charge that the standard of care resulted in premature death. Further work needs to be done with the experts to particularise the charges and to clarify whether Dr. Tandy is also culpable.

1.25 The police file contains 19 statements taken from witnesses of fact. Approximately ten of these would appear to be "key witnesses".

1.26 Our overall assessment is that this case is possibly suitable for a referral to the Fitness to Practice Panel, but is not one of the strongest cases.

2. **Lavender**

2.1 The patient was aged 83 when she was admitted to Daedelus Ward on 27 February 1996.

2.2 Her son refers to the fact that she was transferred to Daedelus from the Haslar Hospital where she had been recovering from a fall. The son says she was making an excellent recovery and the Occupational Therapist was considering a possible return of the patient to her home. She was coherent and walking with the assistance of a frame. A couple of days after admission to Daedelus Ward, Dr. Barton told the son that his mother had "come here to die". His mother

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deteriorated rapidly. The witness was not aware that Diamorphine was being administered by a syringe driver until the day prior to her death.

2.3 The patient was seen by Consultant Geriatrician, Dr. Tandy a few days before she was transferred to Daedelus Ward. The Doctor recorded that the patient had most likely suffered a brain stem stroke leading to the fall. Agreed to transfer of the patient to Daedelus Ward for rehabilitation.

2.4 Barton's statement confirms that she did an assessment on the patient's transfer to Daedelus Ward. It says that the prognosis was not good. The patient was blind, diabetic, had suffered a brain stem stroke and was immobile.

2.5 Morphine was first prescribed on 24 February. The dose was increased on 26 February because the patient's bottom was very sore (pressure sores).

2.6 Barton wrote up a "pro-active prescription" for further pain relief which included Diamorphine. It was "pro-active" on the basis that nursing staff could contact her if necessary and she could authorise dosages as necessary within the dosage range.

2.7 Barton saw the patient again on 29 February and 1 March and noted that her condition was slowly deteriorating.

2.8 On 4 March, the dosage of slow-release Oramorph was increased.

2.9 Barton saw the patient again on 5 March and claims that the pain relief was inadequate. Barton authorised the administration of Diamorphine and Midazolam by syringe driver. Barton claims that the doses were appropriate in view of the uncontrolled pain. The patient died on 6 March. Barton certified death as Cerebrovascular Accident.

2.10 Dr. Black reports that it is likely that the patient was suffering from several serious illnesses and entering the terminal phase of her life when she was admitted. He notes that she was suffering constant pain to her shoulders (in addition, there were serious abnormalities in various blood tests).

2.11 He believes that the patient was mis-diagnosed (presumably both prior to her admission to Daedelus Ward (at the Haslar Hospital) and after her admission). The patient had, in fact, suffered a quadriplegia resulting from a spinal cord injury, secondary to her fall.

2.12 Black says that negligent medical assessments took place both at the Haslar and the Gosport Hospitals. In particular, her medical diagnosis was made to determine the cause of the pain, which he says is consistent with spinal cord fracture.

2.13 Both Black and Wilcock refer to excessive doses of Diamorphine/Midazolam (Wilcock, in addition, thinks that earlier dosages of Morphine may also have been inappropriate/excessive to the type of pain experienced).

2.14 Wilcock says that the excessive doses of Morphine/Midazolam could have contributed towards her death. Black cannot say beyond all reasonable doubt that the patient's life was shortened.

Initial Views

2.15 The probability that the cause of pain was misdiagnosed, not only by Dr. Barton, but by the doctors at Haslar, before the patient was transferred to Gosport, makes this case more difficult to assess.

2.16 Further work needs to be done to determine whether a stronger case can be made relating to Dr. Barton's failure to seek specialist advice in view of the deterioration in the patient's condition leading to increased dosages of Morphine and the use of Diamorphine.

2.17 Both experts agree that at least some of the dosages of Diamorphine/Midazolam were excessive to the patient's needs. The opinions of the experts are not strong enough to sustain a charge that the patient's life was shortened.

2.18 Police took 32 witness statements and approximately 15 witnesses would fall within the category of "key witnesses".

2.19 There is sufficient evidence to refer the case on the basis of the excessive use of Diamorphine/Midazolam and possibly the failure to seek specialist advice, as part of an assessment to diagnose the underlying cause of a patient's pain.

2.20 The inappropriate prescribing of Diamorphine/Midazolam may only relate to one or two particular occasions. There may be other cases where prescribing took place over a longer period and where a stronger case may be made out.

3. **Lake**

3.1 The patient was aged 84 when she was admitted in August 1998. She had suffered a fall and broken a hip. She spent 2-3 weeks at the Haslar Hospital where she received a new hip. She was transferred to Gosport to recuperate and was expected to be discharged at some stage.

3.2 Patient died within 3 days of admission. On the first day at Gosport, she was able to talk to her family. On the second day, she became agitated and distressed. The next day, she was asleep and unable to respond either orally or through hand gestures. During the last two days of her life, she was receiving medication through a syringe driver. Despite these and other ailments, at the time of her fall, she was usually mobile, independent, and self caring. Following

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her hip replacement operation, she had problems with vomiting and shortness of breath. Blood tests revealed on-going renal impairment. On 10 August, she was reported to be unwell, drowsy and experiencing vomiting and diarrhoea. Her pulse increased and became irregular.

3.3 An x-ray revealed an infection at the base of the left lung and no heart failure. She was given antibiotics intravenously and started to improve.

3.4 Her improvement continued and on 12 August, antibiotics and intravenous fluids were discontinued. Her post-operative recovery was slow.

3.5 She was assessed by Dr. Lord who recorded "It is difficult to know how much she will improve" and she was referred to Gosport for continuing care. The summary in Dr. Lord's assessment recorded the patient as being "frail and quite unwell" and it uncertain as to "whether there will be a significant improvement".

3.6 Nursing records for 15 August record some pain due to arthritis.

3.7 On 17 August, the medical notes record that she was well, did not have a raised temperature or chest pain, that she was mobilising slowly and awaiting transfer to Gosport.

3.8 Her transfer letter written for staff at Gosport noted that she had made a slow recovery from the operation, exacerbated by bouts of angina and breathlessness.

3.9 Dr. Barton made an entry in the patient's medical notes on the day of transfer. This included reference to her operation, and past medical history including angina and congestive heart failure.

3.10 Nursing notes confirm that Morphine was administered on 18 August (5mgs) and 19 August (10mgs). The reason for the dose of Morphine on 18 August is not apparent. The nursing notes indicate that she had settled quite well and was fairly cheerful. On 19 August, she awoke very distressed and anxious and the nursing notes record that the Oramorph that had been given to her had very little effect.

3.11 The nursing notes on 19 August indicate that she was walking, albeit unsteadily. There is also reference in the notes of the patient being very breathless and complaining of chest pains.

3.12 There are various references to prescriptions for Diamorphine. The dosages ranging between 20mgs and 60mgs.

3.13 Dr. Wilcock and Dr. Black highlight a lack of information recorded in the patient's notes. Black regards this as a major problem in assessing the level of care. Both experts make assumptions that the patient was not adequately assessed by

Dr. Barton, because there is no indication in the records that a proper assessment took place.

3.14 Dr. Wilcock also assumes that a further assessment did not take place when the patient complained of chest pain.

3.15 Both Doctors are critical of the lack of justification given for the prescription of Morphine and the decision to commence the use of a syringe driver.

3.16 Dr. Wilcock states that the lack of documentation makes it difficult to understand why the patient may have deteriorated so rapidly. He says that a thorough medical assessment when the patient complained of chest pain may have (emphasis added) identified treatable causes of the pain, e.g., chest infection.

3.17 Wilcock also says that it is possible (emphasis added) that the patient's deterioration was temporary/reversible.

3.18 Wilcock refers to the apparent (emphasis added) inappropriate use of medication.

3.19 There is evidence to show that whilst this patient suffered complications following the hip replacement operation, at the time she was transferred to Gosport, there is a possibility that she would make a recovery. The experts are not able to explain the rapid deterioration in her condition leading to her death, within 3 days of transfer. The experts are hindered by the lack of documentation. They assume that thorough medical assessments have not taken place. Dr. Barton may disagree with this, but in any event, she will admit that she failed to keep proper notes.

3.20 The police took 41 statements from witnesses of fact. The statements will need to be analysed to identify the key witnesses. For present purposes, assume that approximately 15 witnesses will fall into the key witness category.

Initial Views

3.21 Lack of documentation in this case has made it difficult for the experts to reach any firm conclusions. There is certainly sufficient evidence to bring charges in relation to inadequate note keeping and possibly inadequate assessment of the patient's condition on transfer and after the patient complained of chest pains. On the available evidence, it would be more difficult to pursue charges relating to excessive use of Morphine/Diamorphine.

3.22 Further investigation will need to be undertaken to assess the role of Dr. Lord. It is possible that as the patient was only at Gosport for three days, she was not seen by Dr. Lord and Dr. Lord did not review the medication prescribed by Dr. Barton.

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4. **Wilson**

4.1 The patient was 74 when he was admitted to the Hospital in October 1998. He died four days after admission.

4.2 Admitted with a fracture to the left humerus. Before his transfer, whilst he was being cared for at the Queen Alexandra Hospital, he was prescribed Paracetamol and Codeine for pain relief.

4.3 On transfer to Gosport, Dr. Barton prescribed Oramorph despite the fact that the patient had liver and kidney problems Code A and these problems made the body more sensitive to the effects of Oramorph.

4.4 Patient deteriorated and was converted to a syringe driver and received Diamorphine. Over the next two days, the dose was increased without obvious indications.

4.5 It appears that Dr. Knapman was the GP who covered for Dr. Barton. In his police statement, he says that the prescriptions written up by Dr. Barton were not excessive.

4.6 In the days immediately preceding the patient's death, on 17 and 18 October, he was seen by Dr. Peters, a Clinical Assistant at the Haslar Hospital. Dr. Peters was covering for Dr. Barton.

4.7 Dr. Barton, in his statement, justifies writing up a "pro-active regime" of Diamorphine in the event of the patient's deterioration. She states further that it was her expectation that the nursing staff would endeavour to make contact with her or the duty doctor before starting the patient on Diamorphine at the bottom end of the dose range.

4.8 Dr. Wilcock refers to the patient's multiple medical problems - cirrhosis/liver failure, heart failure and kidney failure. Patient also suffered from dementia and depression.

4.9 Wilcock notes that the pain he experienced following his fracture progressively improved during his stay at the Queen Alexandra Hospital. The doses of Morphine given there were reduced to 3mgs.

4.10 On his transfer to Dryad, he was prescribed 5-10mgs of Morphine, as required for pain relief. He received doses of Morphine despite the general expectation that the pain from the fracture would continue to improve over time.

4.11 Dr. Wilcock refers to a lack of clear note keeping and an inadequate assessment of the patient and he places blame for this on Dr. Barton and Dr. Knapman, the Consultant.

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4.12 Dr. Wilcock also refers to doses of Diamorphine being administered - initially 20mgs, subsequently increased to 60mgs. Dr. Wilcock states that the increase in dose is "difficult to justify" as the patient was not reported to be distressed by pain.

4.13 Dr. Wilcock cannot state with any certainty that the doses of Morphine or Diamorphine contributed to the patient's death because of the possibility that heart and/or liver failure caused the death.

4.14 Dr. Black refers to "weaknesses" in the documentation of the patient's condition on admission, when strong Opiate Analgesia was commenced.

4.15 Black says that if clinical examinations were undertaken, they have not been recorded.

4.16 Black refers, in particular, to the prescription of 50mgs of Oramorph on 15 October which he believes was not an appropriate clinical response to Mr. Wilson's pain.

4.17 Further, Black considers that the medication prescribed in the period 15-16 October more than minimally contributed to the patient's death on 19 October.

4.18 Professor Baker has also prepared a report. He says firstly that the Death Certificate inaccurately recorded that Mr. Wilson died of renal failure.

4.19 Professor Baker also believes that the administration of Opiate medicine was an important factor leading to the patient's death. On the evidence available, Baker says that the initial prescribing of Opiate medication was inappropriate and the starting dose was too high.

4.20 Baker refers to the reasons for not using non-opiate drugs for pain relief are not given in the medical notes.

4.21 A further expert report has been obtained from Dr. Marshall, a Gastroenterologist. He describes the administration of high doses of Morphine as "reckless". This is because warnings about using Morphine in the context of liver disease are readily available in the Standard Prescribing Guides.

4.22 Dr. Marshal considers that the impact of regular Morphine administration is likely to have hastened the patient's decline.

4.23 Note that this patient's case was investigated by the police as part of their initial investigation into four other patients. At the earlier stage in the investigation, the police instructed two different experts, Dr. Mundy and Dr. Ford. The former is a Consultant Physician and Geriatrician, the latter is a Professor of Pharmacology.

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4.24 Mundy is critical of the standards of care given in this case - in particular, the fact that non-opiate analgesia was not initially considered and the fact that there was large dose range for Diamorphine. However, Mundy does express a view that the palliative care given in this case was appropriate.

4.25 Dr. Ford's conclusions concerning this patient need to be checked.

4.26 The summary of police evidence refers to a statement taken from Dr. Lord, the Consultant Geriatrician. She was on leave between 12 and 23 October.

Initial Views

4.27 We have the benefit of six expert reports in this case. [The reports obtained from the two experts at the outset of the police investigation need to be checked.] However, the four reports obtained during the more detailed part of the police investigation, clearly support charges relating to the excessive use of Morphine which hastened the patient's death. For this reason, this is one of the strongest cases and the evidence will support a referral to the FTP Panel.

4.28 The police obtained statements from approximately 40 witnesses of fact and a detailed examination of all the evidence will be required to determine the number of key witnesses. For present purposes, we should assume that there will be at least 20 key witnesses of fact.

5. **Spurgin**

5.1 The patient was aged 92 when she was admitted to the Hospital in March 1999.

5.2 She fractured her hip as a result of a fall, and initially was admitted to the Haslar Hospital. She underwent surgery there to repair the hip.

5.3 There were complications following the surgery and she developed a haematoma.

5.4 She experienced some pain and discomfort following her operation and, as a result of the haematoma. After transfer to Dryad Ward, she was given Oramorph. The pain persisted and it appears that her wound became infected. Dr. Barton prescribed antibiotics.

5.5 There is a suggestion that the hip may have been x-rayed. However, the results of the x-rays have not been found.

5.6 The dosage of Morphine was increased, followed by a decision to use Diamorphine with a syringe driver.

5.7 Dr. Barton prescribed a range of 20-100mgs and the patient was started on 80mgs. Dr. Reid reviewed this and reduced the dose to 40mgs.

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5.8 The summary of Dr. Barton's witness statement indicates that the starting dose of 80mgs of Diamorphine was discussed with her before it was administered by the nurses.

5.9 Dr. Wilcock, in his report, is highly critical of Dr. Barton and, to a lesser degree, Dr. Reid, the Supervising Consultant. Dr. Wilcock's criticisms include the following: insufficient assessment and documentation of the patient's pain and treatment; failing to seek an orthopaedic opinion when the pain did not improve over time, but instead increasing the dose of Morphine which is associated with undesirable side effects; the doses of Diamorphine were excessive to the patient's needs.

5.10 Further work needs to be done with the expert to give a more detailed analysis of dates, entries in notes in which Doctor (Barton/Reid) were responsible at a particular time.

5.11 Dr. Black refers to an "apparent" (emphasis added) lack of medical assessment and the lack of documentation relating to this patient.

5.12 Dr. Black is also critical of the use of Oramorph on a regular basis without considering other possible analgesic regimes.

5.13 Black believes that some of the management of the patient's pain was within acceptable practice with the exception of the starting dose of Diamorphine - 80mgs. Black describes it as being "at best poor clinical judgment".

5.14 A further report has been obtained from a Consultant Orthopaedic Surgeon, Dr. Redfern.

5.15 He is very critical of the doctors' failure to investigate the cause of the internal bleeding into the patient's thigh following her operation. Redfern criticises those responsible for her care at Gosport Hospital and at the Haslar Hospital.

Initial View

5.16 The findings of the experts support charges relating to poor note keeping, failure to assess the patient's pain and the use of excessive doses of Diamorphine. There is a complicating factor in that Dr. Reid is also criticised by the experts.

5.17 The police interviewed approximately 20 witnesses of fact. For present purposes, we should assume that the majority of these would be required to give evidence.

6. **Devine**

6.1 The patient was aged 88 at the time that she was admitted in October 1999. She died 32 days after her admission.

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6.2 The summary of the patient's medical history prior to her admission indicates that in the summer of 1999, she was well enough to provide emotional and domestic support to her daughter, who was suffering from Leukaemia. However, by October 1999, she was admitted to Queen Alexandra Hospital where she was reported to be confused and aggressive.

6.3 On 14 October 1999, she was seen by a Dr. Taylor who concluded that it was likely she was suffering from Dementia.

6.4 On 21 October 1999, she was transferred to Dryad Ward for rehabilitation/respite care under Dr. Reid.

6.5 On the day of her admission, Dr. Barton prescribed Morphine to be taken as required.

6.6 Between 25 October and 1 November 1999, she was described as being physically independent and continent although she required supervision. She remained confused and disorientated.

6.7 On 16 November, Dr. Barton referred the patient to Dr. Lusznat due to a deterioration in the patient's renal function.

6.8 On 18 November, Dr. Taylor noted that her mental health had deteriorated and she was becoming increasingly restless and aggressive. Her physical condition, at that stage, was stable.

6.9 On 19 November, Dr. Barton recorded that there had been a marked deterioration and she was then prescribed a combination of Diamorphine (40mgs) and Midazolam. On 19 November 1999, the patient's family were also informed that the patient had suffered kidney failure and was not expected to survive more than 36 hours.

6.10 A police summary records that the Registrar refused to accept the recorded cause of death which resulted in an amendment of the Certificate by Dr. Barton.

6.11 After the patient's death, the family complained about the quality of her care and this resulted in the Health Authority setting up an independent review panel.

6.12 The Panel was asked to review, inter alia, the appropriateness of the clinical response to the patient's medical condition. Oral evidence was heard from various witnesses including Dr. Barton.

6.13 The Panel found that the dosage of drugs given to the patient was appropriate - including the dose of 40mgs of Diamorphine. The Panel also found that the dosage and devices used to make Ms. Devine comfortable on 19 November were an appropriate and necessary response to an urgent medical situation.

6.14 In her police witness statement, Dr. Barton says that Dr. Lusznat, a Psychiatrist, recorded that the patient was suffering from severe Dementia. Barton says that this was confirmed by a CT scan on 18 November 1999.

6.15 The case was reviewed by three different experts: Dr. Wilcock, Dr. Black and Dr. Dudley, a Consultant Nephrologist.

6.16 Dr. Wilcock is highly critical of the standard of care, in particular, he refers to an inadequate assessment of the patient's condition and the inappropriate prescribing of medication, including Diamorphine. He describes these as being unjustified and excessive to the patient's needs.

6.17 The list of criticisms made by Dr. Wilcock would form the basis of a strong case. However, the findings of the other two experts are not critical to the same degree.

6.18 Dr. Black refers to a lack of documentation, and the difficulty of deciding whether the level of care was below an acceptable standard.

6.19 He appears to criticise certain aspects of medication regime, but expresses the view that the patient was terminally ill and appeared to receive good palliatation of her symptoms. He is not able to say that Dr. Barton's prescribing had any definite effect on shortening the patient's life in more than a minor fashion.

6.20 Dr. Dudley observes that after a period of stabilisation, the patient's condition worsened and she suffered severe renal failure. He says that although it may have been possible to stabilise her condition, this would not have materially changed the patient's prognosis as death was inevitable.

6.21 Further, Dr. Dudley considers that the patient was treated appropriately in the terminal phase of her illness with strong Opiods to ensure comfort.

Initial View

6.22 It is difficult to reconcile the views expressed by the experts in this case: Dr. Wilcock is highly critical, whereas Doctors Black and Dudley - in particular, Dr. Dudley - are far less critical. Also, the Independent Review Panel findings support Dr. Barton.

6.23 The police took approximately 60 witness statements and, further evidence was given to the Independent Review Panel. It is possible that evidence given by witnesses to the Panel has been recorded and retained.

6.24 Dr. Reid, in his police witness statement, confirms that he saw this patient on three occasions: 25 October and 1 and 15 November 1999. He says that the "as required" Oramorph was prescribed by Dr. Barton on 21 October was

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reasonable. He also claims that the use of a syringe driver to administer Diamorphine and Midazolam was appropriate in these circumstances.

6.25 The difference in views expressed by the experts in this case and the fact that Diamorphine was used in conjunction with the syringe driver only at the very end of the patient's life, makes this one of the weakest cases.

7. **Service**

7.1 The patient was 99 years old when she was admitted in June 1997.

7.2 The patient died within two days of admission. When she was admitted, she was suffering from various medical problems, including Diabetes, heart failure, confusion and sore skin.

7.3 On transfer, she was placed on sedation via a syringe driver. She became less well the following day and Diamorphine was added to the driver. (She had not required Analgesia other than Paracetamol at the Queen Alexandra Hospital, where she had been before she was transferred.)

7.4 On the day of transfer, Dr. Barton carried out an assessment and noted that the patient was suffering from heart failure, was very unwell and probably dying. In her witness statement, Dr. Barton says that the care of the patient would have been more appropriate at Queen Alexandra Hospital and a transfer by ambulance would not have been in the patient's best interest. Barton claims that Diamorphine and Midazolam were prescribed and administered solely with the intention of relieving the patient's agitation and distress. Diamorphine was also prescribed to treat symptoms of the patient's heart failure.

7.5 Dr. Wilcock casts doubt on whether the patient was dying on the day of her admission, as alleged by Dr. Barton. He refers to blood test results to support his views; however, the summary of his evidence indicates that he is not absolutely sure as to whether or not the patient was dying. He says that if she was not dying, the failure to re-hydrate her and the use of Midazolam and Diamorphine "could" (emphasis added) have contributed more than negligibly to her death.

7.6 If, on the other hand, she was in the process of dying, Dr. Wilcock concludes that it would have been reasonable not to re-hydrate her and to use Midazolam/Diamorphine.

7.7 The police obtained a further opinion from Dr. Petch, a Consultant Cardiologist. He refers to the patient's history of heart disease and states that the patient's terminal decline in 1997 was not unexpected. Further, he says that palliative care with increasing doses of Diamorphine and Midazolam was appropriate - the

patient's prognosis was "hopeless". The administration of Diamorphine and Midazolam was reasonable in the circumstances described by Dr. Barton.

7.8 Dr. Black is in no doubt that the patient was entering the terminal phase of her illness. He says that an objective assessment of the patient's clinical status is not possible from the notes made on admission. The notes were below an acceptable standard of good medical practice.

7.9 Further, Dr. Black says that the 20mgs dose of Diamorphine combined with a 40mgs dose of Midazolam was higher than necessary, and "it may have slightly shortened her life".

7.10 Police took statements from 20 witnesses of fact. Without a detailed review of the evidence, it is not possible to say, at this stage, how many of these would be regarded as "key" witnesses.

Initial View

7.11 In the light of the views expressed by the Consultant Cardiologist who considers that the use of Diamorphine and Midazolam was appropriate, there seems little prospect of success in this case.

8. **Cunningham**

8.1 The patient was aged 79 on the date of his admission in September 1998. He died within five days of admission.

8.2 When he was admitted, the patient was suffering from Parkinson's Disease, Dementia, Myelodysplasia. He also had a necrotic pressure sore.

8.3 Dr. Lord, the Supervising Consultant, prescribed Oramorph. Dr. Barton considered that this may not have been sufficient in terms of pain relief and wrote up Diamorphine on a pro-active basis with a dose range of 20-200mgs.

8.4 In her police witness statement, Dr. Barton explains that the levels of pain relief were increased as the patient continued to suffer pain and discomfort.

8.5 Dr. Wilcock is critical of Dr. Barton's practice of prescribing Diamorphine on an "as required" basis within such a large dose range, i.e., up to 200mgs. He says this unnecessarily exposes the patient to a risk of receiving excessive doses of Diamorphine.

8.6 However, in this case, Dr. Wilcock concludes that the patient was dying in an expected way and the use of Diamorphine and Midazolam were justified in view of the patient's chronic pain. The expert also concludes that although the dose range prescribed by Dr. Barton was excessive, in the event Mr. Cunningham did not receive such high doses.

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8.7 Wilcock criticised Dr. Barton's lack of clear note keeping and, on the basis of the notes, he also considers that Dr. Barton failed to adequately assess the patient.

8.8 Dr. Black regards this particular case as an example of the complex and challenging problems which arise in Geriatric Medicine. He notes that the patient suffered from multiple chronic diseases and, in Dr. Black's view, the patient was managed appropriately and this included an appropriate decision to start using a syringe driver. Dr. Black has only one concern - the increased dose of Diamorphine just before the patient's death. He says that he is unable to find any justification for the increase in dosage in the nursing or medical notes. He says that this "may" (emphasis added) have slightly shortened the patient's life, i.e., by a few hours/days.

8.9 The police took 47 statements from witnesses of fact in this case. Without a detailed analysis of the evidence, it is not possible to say how many of these can be regarded as being "key" witnesses.

Initial View

8.10 Whilst Dr. Wilcock, in particular, is critical of the large dose range prescribed by Dr. Barton, he considers that the dosages administered to the patient in this particular case were reasonable. He concludes that the patient was managed appropriately.

8.11 This case has already been referred to the FTP Panel, presumably on the basis of reports from other experts obtained earlier in the police investigation. [We will need to review the earlier reports.] However, on the basis of the opinions expressed by Dr. Black and Dr. Wilcock, there is no realistic prospect of proving that the doses of Diamorphine administered in this particular case was inappropriate.

9. **Gregory**

9.1 This patient was aged 99 when she was admitted in September 1999.

9.2 This case is slightly different from the majority of the other cases in that the patient spent nearly 3 months on Dryad Ward until her death. In the other cases, apart from Mrs. Devine who was at the Hospital for about a month before she died, all the other patients died in a period of 2-18 days.

9.3 Whilst the patient was on Dryad Ward, she was seen on various occasions in September, October and November 1999 by the Supervising Consultant, Dr. Reid. In his police statement, Dr. Reid expressed a view that whilst Dr. Barton's note keeping may have been poor, the patients were managed appropriately by Dr. Barton.

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9.4 Dr. Reid, in retrospect, feels that it was inappropriate of Dr. Barton to prescribe Diamorphine as early as 3 September 1999, in the absence of documented pain or distress. However, Dr. Reid believes that it was appropriate for Dr. Barton to prescribe Opiates on 20 November, as the patient was in the terminal stages of her life.

9.5 When the patient was admitted to Dryad Ward, she had recently fractured her femur. She had a history of heart disease. She was regularly reviewed by Dr. Barton and Dr. Reid and was noted to be suffering poor appetite, agitation, variable confusion and no significant improvement in her mobility.

9.6 Between 15 and 18 November, her condition deteriorated following a chest infection. She became distressed and breathless. Dr. Barton was abroad from 12 to 16 November, but on her return on 17 November, she prescribed Oramorph. On 18 November, she prescribed Diamorphine.

9.7 Dr. Wilcock considers that the patient's decline over a number of weeks was in keeping with the natural decline into a terminal phase of her illness. He considers the dose of Diamorphine was unlikely to have been excessive.

9.8 Dr. Black refers to the patient's history of heart failure and lung disease. The patient was very elderly and frail when she fractured her femur. Dr. Black observed that in circumstances there was a very significant risk of mortality and morbidity.

9.9 Dr. Black reports that Dr. Barton failed to record a clinical examination, apart from some brief details concerning the patient's history.

9.10 Dr. Black notes that within a short period of her transfer to Dryad Ward, it is likely that she suffered a small stroke. Essentially, she made no improvement in rehabilitation in the two months that she was in hospital.

9.11 Dr. Black refers to the patient's rapid deterioration on 18 November. He says the prescribing of oral Opiates was an appropriate response to a patient who had an extremely poor prognosis.

9.12 He also considers that a decision to start the patient on Diamorphine was a reasonable decision. He regards the dosages of Diamorphine to have been in the range of acceptable clinical practice.

9.13 He does express a concern about Dr. Barton's practice of prescribing strong Opioid Analgesia in anticipation of a patient's decline. Notwithstanding this, he concludes that no harm came to Mrs. Gregory as a result of this practice.

9.14 Apart from a lack of clinical examination (or possible failure to document such an examination), both on the date of her patient's admission and during the period

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that her condition deteriorated, Dr. Black appears to be satisfied that the dosages of Diamorphine administered in this case were reasonable. He confirms that the patient died of natural causes.

9.15 The police took 22 witness statements during their investigation relating to this patient.

Initial View

9.16 A case of inappropriate prescribing cannot be made out on the basis of the views expressed by the expert save to the limited extent that one of the experts criticises the practice of "anticipatory" prescribing.

9.17 There are additional concerns raised with regard to lack of note keeping and the possibility that clinical examinations were not carried out. This is one of the weakest cases.

10. **Packman**

10.1 The patient was aged 67 when he was admitted in August 1999. He suffered from gross morbid obesity (in April 1999, he weighed in excess of 23 stone). He was first admitted to the Queen Alexandra Hospital on 6 August 1999, having suffered a fall at his home. On admission to QAH, he was noted to have an abnormal liver function and impaired renal function. He also had leg ulcers and cellulitis (infection of the skin) and pressure sores over his buttocks and thighs.

10.2 It is not clear whether he suffered a gastrointestinal bleed whilst he was at QAH (the experts seem to think that if a bleed occurred, it was not significant or life threatening at that stage).

10.3 On his admission to Dryad Ward on 25 August 1999, he was examined by Dr. Ravindrane, a Registrar working under Dr. Reid, the Consultant.

10.4 On 25 August, he was seen by a Locum GP, Dr. Beasley (it is not clear why Dr. Beasley was involved and Dr. Beasley's name does not appear in the list of witnesses interviewed by the police).

10.5. On 26 August, the patient was seen by Dr. Ravindrane following a report that the patient had been passing blood rectally.

10.6 It appears that the patient's condition deteriorated during the course of the day on 26 August. The experts conclude that a blood test taken on that day revealed a large drop in the patient's haemoglobin, which made a significant gastrointestinal bleed likely.

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10.7 In her police statement, Dr. Barton indicated on 26 August, she was concerned that the patient might have suffered a myocardial infarction. In addition, she believed that the patient had suffered a gastrointestinal bleed.

10.8 The experts, in particular, Dr. Wilcock, criticise Dr. Barton for not transferring the patient to an acute ward for treatment for the underlying cause of the bleeding - thought by Dr. Wilcock to be a peptic ulcer.

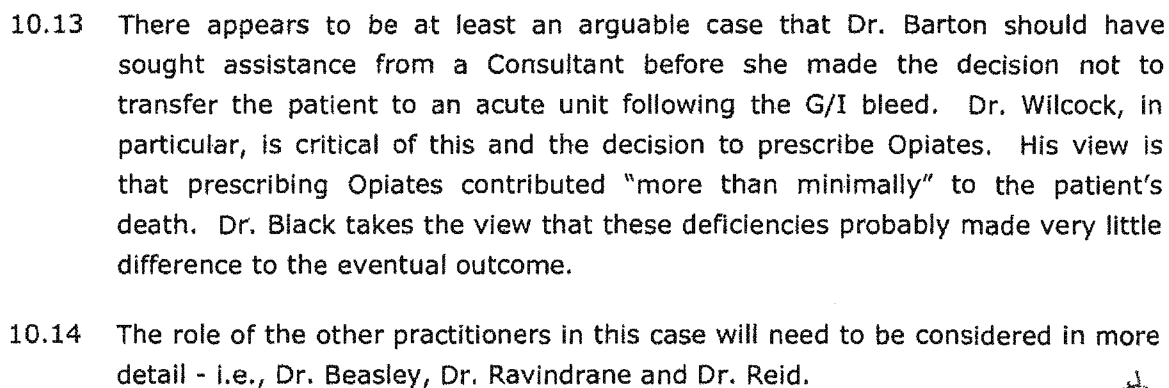
10.9 In her police statement, Dr. Barton says that the patient was very ill and a transfer to an acute unit would have been inappropriate given the likely further harmful effect on his health.

10.10 Dr. Barton does not say in her statement why she did not consult anybody - Dr. Ravindrane or Dr. Reid - before taking a decision not to transfer and/or before prescribing Diamorphine and Midazolam. Note that the police do not appear to have interviewed Dr. Reid in connection with this case, even though Dr. Wilcock, in his report, believes that Dr. Reid, albeit to a lesser degree than Dr. Barton, failed to provide treatment with a reasonable amount of skill and care. It is possible that Dr. Reid only saw the patient on one occasion, i.e., on 9 September, two days before the patient died. Therefore, it may be that Dr. Reid was unaware of the gastrointestinal bleed which occurred on 26 August 1999 - if that is the case, then Dr. Wilcock's criticism of Dr. Reid seems to be limited to the subsequent use of Opioids.

10.11 The police obtained an expert opinion from a Consultant Gastroenterologist, Dr. Marshall. He concludes that a transfer to surgery should have been considered on 26 August when the possibility of a G/I bleed was first considered. He indicates that surgery, in this case, may have resulted in the patient's death because the patient was morbidly obese.

10.12 The police obtained 27 witness statements in this case.

Initial View



10.13 There appears to be at least an arguable case that Dr. Barton should have sought assistance from a Consultant before she made the decision not to transfer the patient to an acute unit following the G/I bleed. Dr. Wilcock, in particular, is critical of this and the decision to prescribe Opiates. His view is that prescribing Opiates contributed "more than minimally" to the patient's death. Dr. Black takes the view that these deficiencies probably made very little difference to the eventual outcome.

10.14 The role of the other practitioners in this case will need to be considered in more detail - i.e., Dr. Beasley, Dr. Ravindrane and Dr. Reid.

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11. Overall, there is sufficient evidence to refer this case to the Case Examiner. **Page**

11.1 The patient was aged 80 when she was admitted in February 1998. She was a frail elderly lady with probable carcinoma of the bronchus. She also suffered from depression, dementia, ischaemic heart disease and congestive heart failure. Her health had been deteriorating during the two weeks prior to her admission to Dryad Ward.

11.2 Her son, Bernard Page, contacted the police in 2001, having first been made aware of concerns about the treatment of elderly patients from reports in the local press. In the bundle, there is a letter from the son to the GMC dated 17 May 2002 which refers to a letter sent by the son to the police on 9 April 2001. A copy of this letter is not in the papers. I will ask the police for a copy; or, alternatively, ask Mr. Page if he has retained a copy.

11.3 This is one of five cases which has already been referred to the GMC. Refer to the GMC's Rule 4 letter to Dr. Barton dated 11 July 2002, which sets out some draft allegations.

11.4 The only evidence which appears to have been collated in this particular case is the reports prepared by Dr. Mundy and Professor Ford.

11.5 The police do not appear to have taken any statements from witnesses of fact.

11.6 The draft allegations referred to in the Rule 4 letter appear to have been framed with reference to Dr. Mundy's report.

11.7 Charge2(b)(ii) alleges that at the time the patient was prescribed opiate and sedative drugs there was no indication in the medical or nursing records to indicate that the patient was distressed or in pain. However, this appears to ignore the apparent reference in the medical notes of 2 March which is a note from Dr. Barton suggesting the use of Opioids to "control fear and pain". This is referred to in paragraph 6.7 of Professor Ford's report. See also Ian Barker's letter to GMC of 27 August 2002 in response to the Rule 4 letter sent by GMC on 11 July 2002. Mr. Barker is Dr. Barton's legal representative. On page 5 of Mr. Barker's letter, he acknowledges, on Dr. Barton's behalf, that when the patient was admitted she was not in pain. However, Mr. Barker goes on to assert that by 2 March, the patient was, in fact, in pain. In the absence of other evidence, it is unlikely that the GMC will be able to prove the allegation in paragraph 2(b)(ii) of the Rule 4 letter. Take a statement from Bernard Page?

11.8 Dr. Mundy's report contains only a brief summary of the medical and nursing care in this case. He concludes that the patient was started on Opioid Analgesia inappropriately, although he does not clearly explain his reasons.

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11.9 Professor Ford's report is far more detailed. In paragraph 6.6, Professor Ford's report refers to an entry in the patient's medical notes by a Dr. Laing, Duty GP, on 28 February, being the day after the patient was admitted to Dryad Ward. Dr. Laing notes that the patient was "not in pain".

11.10 At paragraph 6.7 of the report, Professor Ford refers to Dr. Barton's note in the patient's records on 2 March - "I suggest adequate Opioids to control fear and pain". This therefore suggests that although the patient was not in pain when she was admitted on 27 February, the position had changed by 2 March. The summary of the medical notes in paragraphs 6.7, 6.8 and 6.9 of Professor Ford's report raise a number of questions. In paragraph 6.9, he refers to two doses of Diamorphine on a date or dates which he says are not discernible from the records. However, in stating this, he seems to ignore the references in the medical notes to Diamorphine being administered in paragraph 6.7 of his report. In paragraph 6.9, where he deals with a record of daily prescriptions, he omits the Diamorphine administered on 2 March; he fails to comment on the apparent fact that Diamorphine was administered shortly after the patient received Fentanyl.

11.11 In paragraph 6.9, he also makes an important assumption, which may or may not be correct. He says that the medical notes do not indicate that the Fentanyl patch was removed before the Diamorphine and Midazolam infusion was commenced.

11.12 In paragraph 6.11 of his report he comments on the prescription of Opiates on the patient's admission to the Ward, when it appears to be acknowledged that there was no evidence that the patient was in pain. However, he concludes that as the patient was suffering from inoperable carcinoma, there was a reasonable indication for the use of Opiates in the palliative care of the patient. This undermines somewhat the conclusion of Dr. Mundy in his report. It also tends to undermine the allegation in paragraph 2(b)(i) in the Rule 4 letter referred to earlier.

11.13 At paragraphs 6.15 and 6.18, Professor Ford expresses the following views: the majority of the management and prescribing decisions made by the medical and nursing staff in this case were appropriate. He notes one exception, namely, the prescription of Diamorphine and Midazolam on the day of the patient's death - 3 March. His reasons are elaborated in paragraph 6.13 of the report. He says that it was poor management to commence using both Diamorphine and Midazolam in a frail, elderly and underweight patient who has **already** received Fentanyl [emphasis added]. His view that the prescription was inappropriate, therefore appears, at least in part, to rely on an assumption that Fentanyl was being used at the same time. We need to check to see whether the conclusion would be any different if it was the case that the use of Fentanyl ceased before the use of Diamorphine and Midazolam commenced.

Initial View

11.14 Professor Ford clearly believes that most of the prescribing decisions in this case were appropriate. He is critical of only one prescription, namely the one which was given on the day that the patient died. Also, it appears that his conclusion is based on an assumption that the prescribing of Diamorphine and Midazolam was made in conjunction with an existing prescription for Fentanyl.

11.15 In paragraph 6.16 of the report, Professor Ford also expresses a view that whilst it is possible that the patient died from a drug induced respiratory depression, the patient was at high risk from dying of the effects of cancer even if she had not received sedative and Opiate drugs. Further work needs to be done on this case before a decision is made as to whether or not it is a strong enough case to have any realistic prospect of success.

12. **Wilkie**

12.1 The patient was 81 years old when she was admitted on 6 August 1998. She had a medical history of advanced dementia, urinary tract infection and dehydration. She was seen by Dr. Lord just before her transfer to Dryad Ward and Dr. Lord recorded that her overall prognosis was poor and confirmed that she should not be resuscitated.

12.2 When she was transferred to Dryad Ward on 6 August, she was seen initially by Dr. Peters, one of Dr. Barton's partners, as Dr. Barton was on sick leave at the time.

12.3 The case in respect of this patient has already been referred - see Rule 4 letter sent by the GMC to Dr. Barton on 11 July 2002 referred to earlier in the notes.

12.4 The only available evidence in support of the case against Dr. Barton is contained in reports prepared by Dr. Mundy and Professor Ford. Dr. Mundy's report is very brief. He concludes that there was no clear indication in the records for an Opioid Analgesic to be prescribed. He also notes that no simple analgesics were given and there is no documented attempt to establish the nature of the patient's pain (in any event, there appears to be only very limited reference in the records to the patient suffering from pain). Dr. Mundy is also of the view that the dose of Diamorphine that was prescribed (30mg) was excessive. He notes also that there is no evidence that the dose was reviewed prior to the patient's death. Finally, he notes that the initial prescription gave a 10-fold range from 20mg to 200mg in 24 hours (described elsewhere in the papers as "proactive prescribing").

12.5 Professor Ford's report is more detailed and he quotes from the available nursing and medical notes. One curious feature of this case is that the nursing records contain no entries in the period 6 August-17 August. The patient died on 21

August. Also, there are no entries in the medical notes from the 10 until 21 August. Clearly whilst there are good grounds to substantiate charges of poor/inadequate record keeping, the fact that there are no records for most of the period leading up to the patient's death may cause some difficulty in trying to establish that the medication prescribed and/or administered was inappropriate. Perhaps statements obtained from the relatives will fill in missing information.

12.6 Professor Ford notes that Diamorphine and Midazolam were only first administered on the day before the patient's death. There is no clear evidence that the patient was in pain at the time, although there was reference to a "marked deterioration" in her condition. Professor Ford considers that in the absence of any indication in the notes to justify the use of Diamorphine, other oral analgesics such as Paracetamol and mild opiate drugs could and should have been tried first.

12.7 Professor Ford considers it to be poor and hazardous management to initially commence both Diamorphine and Midazolam because he says this could result in profound respiratory depression. He says it would have been more appropriate to review the response to Diamorphine alone before commencing Midazolam.

12.8 Professor Ford concludes that it is possible that the patient's death was due, at least in part, to respiratory depression resulting from the Diamorphine; alternatively, Diamorphine could have led to the development of bronchopneumonia.

Initial View

12.9 We need some detailed statements from the patient's relatives to clarify the patient's condition in the period leading up to her death. We also need to take statements from Dr. Lord and Dr. Peters, although it is possible that they will have no recollection of this particular patient. In the absence of any detailed medical or nursing notes in the crucial period, Dr. Barton is going to find it difficult to justify prescribing Diamorphine and Midazolam, even if the medication was not, in fact, administered on the first occasion until the day before the patient died.

13. Richards

13.1 The patient was aged 91 when she was admitted in August 1998.

13.2 This was the first case that the police investigated, following complaints received from the patient's daughters, Mrs. MacKenzie and Mrs. Lack.

13.3 Mrs. Richards was transferred from the Haslar Hospital to GWMH following an operation to implant an artificial hip joint. This followed an accident when she

fractured her thigh bone. She appeared to be making a reasonable recovery at the Haslar. However, shortly after she arrived at GWMH she dislocated her hip. She went back to the Haslar Hospital where the dislocation of the hip was reduced. She then returned to GWMH.

13.4 There is some suggestion that the method of her transfer and/or lack of care by handlers during her transfer caused her further discomfort/injury. Following her transfer she spent a further three days at GWMH before she died. The cause of death was recorded as bronchopneumonia.

13.5 A total of three experts considered Mrs. Richards' case as part of the police investigation: Professor Livesley (who prepared reports in December 2000 and July 2001); Professor Ford who reported in December 2001 and Dr. Black who reported between May and August 2005. It is not clear why Dr. Black's report was prepared so long after the start of the police investigation and several years after both Professor Livesley and Professor Ford had issued their reports.

13.6 The principal findings in Professor Livesly's first report are recorded in paragraph 19 of the Case Outline though these details have been extracted from a summary of his evidence prepared by the Police. We do not currently have a copy of Professor Livesley's report dated December 2000. In the extract referred to in the Case Outline, Professor Livesley concluded that Dr. Barton prescribed Diamorphine and other drugs in such a manner as to cause the patient's death. He also concluded that Mrs. Richards had been unlawfully killed. In Professor Livesley's second report dated July 2001 prepared following legal advice after his first report had been prepared, he concluded that the patient's death occurred earlier than it would have done from natural causes.

13.7 In his July 2001 report, Professor Livesley makes the point in paragraph 8.3 that there is no evidence in the patient's records to show that she had any specific life threatening or terminal illness from which she could not be expected to recover. Professor Livesley also concludes that there is evidence to show that the patient was capable of receiving oral medication for the relief of pain that she experienced on the 17 August, being the date that she received Diamorphine and other drugs from a syringe driver. There is a strong inference in the conclusion to Professor Livesley's report that the administration of Diamorphine and other drugs by the syringe driver was inappropriate although he does not say so in clear terms. He makes the point that during the period that Diamorphine and the other medication was administered, the patient was not given any food or fluids to sustain her.

13.8 In Appendix A of Professor Livesley's report, he lists all the evidence which he considered during the preparation of his report. We do not appear to have received from the police everything set out in the schedule of evidence.

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13.9 Whilst the conclusions in Professor Livesley's report are clearly stated, there are a number of potential weaknesses in the report. For example, the report makes no reference to the explanations given by Dr. Barton in her witness statements concerning her management of the patient's care. Also there is very little, if any, reference to any of the evidence obtained from the other witnesses. Instead, Professor Livesley appears to have reached this conclusion totally or primarily with reference to the patient's medical records. Further, as already mentioned, Professor Livesley does not state in clear terms that the prescribing of diamorphine and other drugs by syringe driver was inappropriate; neither does he say whether the initial prescribing of Oramorph on 11 August was inappropriate. Also, he does not comment on Dr Barton's practice of prescribing a broad range of dosages. Therefore, more detailed work will be required on the report if it is decided to use Professor Livesley as a witness in this case.

13.10 Professor Ford's report in contrast to the report prepared by Professor Livesley, does contain some reference to the evidence provided by Dr Barton. However, for some reason which is not apparent, Professor Ford appears to have been provided with only a selection of the evidence which was made available to Professor Livesley [it is possible that the person instructing Professor Ford has made some assessment of the relevance of documents and only provided copies of witness statements etc which were deemed to be of particular relevance].

13.11 Professor Ford criticises the assessment of the patient's medical condition when she was first admitted to GWMH on 12 August. Professor Ford also criticises Dr Barton's apparent failure to establish whether the patient's screaming in the days following her admission was due to pain or other causes (dementia?).

13.12 In paragraph 2.21 Professor Ford considers it likely that Dr Barton's initial prescription, which included "as required" doses of Oramorph, Diarmorphine and other medication, was made at a time when the patient was not suffering any pain. Professor Ford notes that in the latter stages of the patient's treatment at the Haslar Hospital, she received intermittent doses of non-opiate pain relieving drugs. In Professor Ford's view, it was not appropriate to administer intermittent doses of Oramorph before first prescribing other types of analgesic drugs.

13.13 Professor Ford criticises Dr Barton's failure to seek assistance from a consultant geriatrician or the orthopaedic team following the dislocation of the patient's hip.

13.14 At paragraph 2.26 of his report Professor Ford states that the decision to prescribe subcutaneous Diamorphine to Mrs Richards, following her initial admission, was inappropriate because it exposed her to the risk of developing adverse affects of excessive sedation and respiratory depression. He describes the decision as "reckless".

13.15 In paragraph 2.28 Professor Ford expresses a view that the medical (and nursing) records are not of an adequate standard. He notes that the medical records failed to adequately account for the reasons why Oramorph and then infusions of Diamorphine were used.

13.16 In the conclusions to his report, Professor Ford considers it "highly likely" that the use of opiates and sedative drugs, in combination, produced respiratory depression, which led to the patient's death. In Professor Ford's opinion it is likely that the administration of the drugs hastened the patient's death. However, he goes on to qualify this by saying that there is some evidence that the patient was in pain during the last three days of her life and the administration of opiates could have been justified to deal with the pain. He also says that the patient was at high risk of developing pneumonia and it is possible that she would have died from pneumonia even if she had not been given sedative and opiate drugs.

13.17 Professor Ford and Professor Livesley therefore both conclude that the combination of drugs given to the patient in the last few days of her life resulted in premature death. Note however, that the material provided to Professor Ford included a copy of Professor Livesley's report. Therefore, there is the possibility that to a certain degree Professor Ford may have been influenced by Professor Livesley. Note also that the allegations relating to this patient in the GMC's Rule 4 Letter sent to Dr Bârton on 11 July 2002, allege that Dr Barton knew or should have known that the opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richard's condition. The allegations in the Rule 4 letter do not therefore make the more serious allegation that Dr Barton's prescribing actually hastened the patient's death.

13.18 Dr Black prepared a series of reports between May and August 2005. It appears that revisions to the first report were made with reference to additional evidence provided by the Police. The additional information supplied by the Police does not appear to have caused Dr Black to make any material amendments to his initial report.

13.19 In paragraph 6.9 Dr Black criticises Dr Barton's failure to liaise with the surgical team at the Haslar Hospital or with the patient's consultant, when the patient returned to GWMH on the second occasion, following the reduction of her dislocation, when it was evident that the patient was in significant pain.

13.20 In paragraph 6.9 Dr Black also expresses the view that as the patient was in significant *pain* at that stage, it would not be unreasonable to provide palliative care and pain relief. Note therefore a marked difference in opinion with the other two experts. However, in paragraph 6.9 Dr Black states that the starting dose of Diamorphine was "unnecessarily high".

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13.21 In paragraph 7.2 Dr Black refers to the lack of detail in the medical notes and concludes that this amounts to poor clinical practice. He also expresses concerns about the anticipatory prescription of opioid analgesia on the patient's admission to GWMH. He also confirms that the starting dose of Diamorphine prescribed on 17 August was "sub optimally high".

13.22 Finally, Dr Black expresses the view that the dose of Diamorphine did not contribute "in any significant way" to the patient's death and that her death was by natural causes.

Initial view

13.23 All of the experts are critical of Dr Barton's management of the patient. The evidence obtained from the experts supports the draft charges set out in the Rule 4 letter. We need to check that all the experts have seen all the relevant evidence, including all the witness statements and transcripts of police interviews. If having reviewed all the evidence their conclusions remain the same, there is sufficient evidence to take this case to the panel.

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Case Strategy

This document sets out in detail the actions that will be required, who will undertake each step and in what timescale. The document also sets out a budget for each step.

This document is our project management tool for the work outlined. We will use it to monitor current tasks, timescales and costs. It will form the basis for our regular update meetings. We will amend it as the case develops.

This document follows from the Case Outline. If the Case Outline changes as the case unfolds, then this will also have an impact on the Case Strategy, which will be updated appropriately.

Summary of Strategy

1. A total 13 cases have been considered in this review.

2. In summary our assessment of the individual cases is as follows:

2.1 **The Cases which have already been referred to the PCC.**

2.1.1 **Richards [August 1998]**

The Police have gathered evidence from most of the relevant witnesses of fact and expert reports have been obtained. There is some inconsistency in the evidence but overall this is a case which has a reasonable prospect of success.

2.1.2 **Cunningham [September 1998]**

This case was included in the initial Police investigation and was subject to a subsequent, more detailed, investigation. The expert evidence obtained on behalf of the Police after the case was referred to the PCC casts significant doubt on the prospects of success. We therefore recommend that this case should be considered for cancellation.

2.1.3 **Wilkie [August 1998]**

The case was referred to the PCC on the basis of two expert reports obtained by the Police during their initial investigation. The experts have referred to a lack of documentation and so at least some of the conclusions are based on assumption. The Police did not interview

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witnesses of fact as part of their investigation. If this case proceeds a detailed investigation will be required to investigate the factual background. This could either strengthen or weaken the case depending on the available evidence.

2.1.4 **Wilson [October 1998]**

The case was fully investigated by the Police, with regard to both factual and expert evidence. It is one of the strongest cases and on the basis of the available evidence has a reasonable prospect of success.

2.1.5 **Page [February 1998]**

This case was referred to the PCC on the basis of an opinion of one of the two experts used by the Police. The other expert, who prepared a more detailed report, was of the opinion that most of the patient's care was appropriate, although the expert is critical of prescribing on the day of the patient's death. The Police did not interview witnesses of fact as part of their investigation. Given the differences of opinion expressed by the experts, this is one of the weaker cases. A detailed investigation of the facts may strengthen or weaken the case.

2.2 **The cases which have not yet been referred to the PCC**

2.2.1 Of the cases which have not yet been referred we have identified four which, on the basis of the available evidence, stand a reasonable prospect of success. These are:

2.2.2 **Lavender [February 1996]**, **Pittock [January 1996]**, **Spurgin [March 1999]** and **Packman [August 1999]**.

2.3 We have prepared draft allegations in each of these cases which are attached.

2.4 In each of these cases the Police have conducted a detailed investigation of the facts and obtained reports from experts. This material is available for consideration by a case examiner.

2.5 In all of the cases, including those where the Police have interviewed and taken statements from the witnesses of fact, further investigation is required to seek additional evidence. Although the Police interviewed and took statements from a large number of witnesses many of the statements do not, in our view, cover the points in issue in sufficient detail. Having said this, the fact that statements have already been obtained in these cases will undoubtedly save time in preparing the case. It would not be necessary or indeed desirable to seek to question witnesses about the evidence which they have already given. The

purpose of re-interviewing, therefore, would be to fill in any gaps in the evidence.

2.6 Generally, the quality of the expert evidence already obtained appears to be satisfactory, and it should be possible, subject to the agreement of the experts in question, to rely on the work which they have already done. However there is a different emphasis with regard to expert evidence in GMC proceedings and evidence obtained as part of a criminal investigation. Therefore, reports will have to be reviewed and rewritten to a certain extent, and will also need to take into account any evidence obtained by way of further investigation.

2.7 The recommended strategy is to select a sample of cases to go forward to the PCC. On the basis of this review we suggest the following cases: Richards, Wilson, Lavender, Pittock, Spurgin and Packman. In our view, this is a representative sample which highlights the concerns which have been identified by the experts.

2.8 Our overall view is that this is a case which will end up focusing on allegations of prescribing opiates in excess of patients' needs. In some, but not all cases there is evidence that this practice **may** have resulted in premature death, by a matter of hours or, at the most, days. We do not believe that a case can be made out that Dr. Barton embarked on a systematic and/or deliberate course to kill patients.

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27 April 2007

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GMC V BARTON

SUGGESTED DRAFT CHARGES

RE: MRS LAVENDER

1. a. i. At all material times you were a registered medical practitioner working, as a Clinical Assistant at Gosport War Memorial Hospital.

ii. On the 22 February 1996, Mrs Lavender was transferred from the Haslar Hospital to Daedalus Ward at Gosport War Memorial Hospital for rehabilitation, having had a fall at home.

iii. Mrs Lavender suffered from long standing medical problems including Diabetes and a peripheral neuropathy.

iv. After admission to hospital, Mrs Lavender was found to be doubly incontinent; she was totally dependant, with a probable quadriplegia; she suffered constant pains down her shoulders and arms and various blood tests revealed unexplained abnormalities.

v. Subsequently, Mrs Lavender's pain, mobility and body functions deteriorated.

vi. On the 26 February 1996 you prescribed, inter alia, Diamorphine in a dose range 80-160mg and Midazolam in a dose range 40-80mg to be administered subcutaneously via a syringe driver on an "as required basis".

vii. On the 5 March 1996 you increased the prescribed range of Diamorphine to 100-200mg and increased the prescribed range of Midazolam to 40-80mg.

viii On the 5 March a subcutaneous infusion via a syringe driver was commenced with doses of 100mg of Diamorphine and 40mg of Midazolam.

b. Your prescribing of opiate and sedative drugs on 26 February and subsequent increase on 5 March within the ranges specified was inappropriate and/or unprofessional in that;

i. The doses prescribed were excessive,

ii. The dose range was unnecessarily wide,

iii. The prescription lacked clear instructions on why, when, and by how much the dose should be altered within the range specified, and by whom,

iv. It created a serious risk that dosages would be administered in amounts and combinations which were excessive and/or potentially hazardous to a patient in Mrs Lavender's condition.

c. The administration of Diamorphine and Midazolam on 5 March in the doses referred to in paragraph 1. a. viii. above was inappropriate/unprofessional in that;

i. You knew, or should have known, that the dosages and combination of drugs was excessive and potentially hazardous to a patient in Mrs Lavender's condition.

d. Your management of Mrs Lavender was unprofessional in that;

i. You failed to conduct any, or any adequate assessment of Mrs Lavender's condition on her admission to Daedalus Ward,

ii. You failed to conduct any, or any adequate assessment when Mrs Lavender's condition deteriorated,

iii. You failed to obtain advice from a specialist when Mrs Lavender's condition did not improve,

v. You failed to make clear and/or accurate and/or contemporaneous records relating to Mrs Lavender.

GMC V BARTON

SUGGESTED DRAFT CHARGES

RE: MR PITTOCK

1 a. i. Mr Pittock was an 83 year old gentleman with a long, recurrent history of severe depression when he was admitted to Dryad Ward at the Gosport Memorial Hospital on 5 January 1996 for long term care.

ii. On the 9 of January 1996, Mr Pittock had a painful right hand held in flexion, increasing anxiety and agitation and he complained of generalised pain.

iii. On the 10 January you prescribed, inter alia, Diamorphine in a dose range 40-80mg over a 24 hour period.

iv. On the 11 January, the prescription referred to in paragraph v. above was rewritten. The dose range of Diamorphine was increased to 80-120mg and Midazolam 40-80mg was added. Both drugs were to be administered subcutaneously via a syringe driver on a "prn" (as required) basis over a 24 hour period.

v. On the 15 January a subcutaneous infusion via syringe driver was commenced and doses of 80mg of Diamorphine and 60mg of Midazolam were administered over a 24 hour period.

vi. On the 17 January the doses were increased to 120mg of Diamorphine and 80mg of Midazolam.

vii. On the 18 January you prescribed 50mg of Nozinan. This was increased to 100mgs on the 20 January.

b. Your prescribing of opiate and sedative drugs on the 10 January and the subsequent increase of prescribed dosages on 11 January of Diamorphine and Midazolam, within the ranges specified was inappropriate and/or unprofessional in that;

i. The dose range was unnecessarily wide,

ii. The prescription lacked clear instructions on why, when, and by how much the dose should be altered within the range specified, and by whom,

iii. It created a serious risk that dosages would be administered in amounts and combinations which were excessive and/or potentially hazardous to a patient in Mr Pittock's condition.

c. The administration of Diamorphine, Midazolam, and Nozinan in dosages referred to in paragraphs 1.a.v, vi and vii above were inappropriate and/or unprofessional in that;

i. You knew, or should have known, that the dosages and combination of drugs were excessive and potentially hazardous to a patient in Mr Pittock's condition.

d. Your management of Mr Pittock was unprofessional in that;

i. You failed to conduct any, or any adequate, assessment of Mr Pittock following his admission to Dryad Ward,

ii. You failed to conduct any, or any adequate assessment, when Mr Pittock's condition deteriorated.

iii. You failed to seek the advice of a consultant.

iii. You failed to make clear and/or accurate and/or contemporaneous medical records relating to Mr Pittock.

GMC AND BARTON

SUGGESTED DRAFT CHARGES

RE: MRS. SPURGIN

1. a. i. On 26 March 1999, Mrs. Spurgin was transferred from the Haslar Hospital to the Dryad Ward at Gosport War Memorial Hospital ("GWMH") for rehabilitation and gentle mobilisation following surgery at the Haslar Hospital to repair a fractured right hip.

ii. Following Mrs. Spurgin's transfer to GWMH, she complained of severe pain on movement.

iii. There was no subsequent improvement in the severity of the pain and/or her mobility and Mrs. Spurgin's condition deteriorated.

iv. On 12 April 1999, you prescribed, inter alia, Diamorphine in a dose range of between 20-200mg and Midazolam in a dose range of between 20-80mg, to be administered subcutaneously via a syringe driver on a "prn" (as required) basis over a 24 hour period.

v. On 12 April 1999, a subcutaneous infusion via syringe driver was commenced with doses of 80mg of Diamorphine and 20mg of Midazolam over a 24 hour period.

b. Your prescribing of opiate and sedative drugs on 12 April within the range specified was inappropriate and/or unprofessional in that:

i. The dose range was unnecessarily wide

ii. The prescription lacked clear instructions on why, when, and by how much the dose should be altered within the range specified, and by whom.

iii. It created a serious risk that dosages would be administered in amounts and combinations which were excessive and/or potentially hazardous to a patient in Mrs. Spurgin's condition.

c. The administration of Diamorphine and Midazolam on 12 April in the dosages referred to in paragraph 1.a.v. above was inappropriate and/or unprofessional in that:

i. You knew, or should have known, that the dosages and combination of drugs was excessive and potentially hazardous to a patient in Mrs. Spurgin's condition.

d. Your management of Mrs. Spurgin was unprofessional in that:

i. You failed to conduct any, or any adequate, assessment of Mrs. Spurgin following her admission to Dryad Ward.

ii. You failed to conduct any, or any adequate assessment, when Mrs. Spurgin's condition deteriorated.

iii. You failed to obtain an orthopaedic opinion when Mrs. Spurgin's pain did not improve.

iv. You failed to make clear and/or accurate and/or contemporaneous medical records relating to Mrs. Spurgin.

v. You failed to pay sufficient regard to Mrs. Spurgin's rehabilitation needs.

GMC V BARTON

SUGGESTED DRAFT CHARGES

RE: MR PACKMAN

1. a. i. On the 23 August 1999, Mr Packman was transferred to the Gosport War Memorial Hospital where he was noted to be suffering from obesity, arthritis, immobility and pressure sores.

ii. On Mr Packman's admission to GWMH, it was recorded that his mental state was "very good" and that he had "no pain".

iii. On 25 August 1999, nursing staff reported that Mr Packman was "passing fresh blood".

iv. Mr Packman became unwell and his condition deteriorated.

v. On the 26 August, you made a decision not to transfer Mr Packman to an acute unit, on the basis that he was not well enough.

vi. On the 26 August you prescribed, inter alia, 10-20mg of oral morphine solution to be administered every 4 hours, with 20mg to be administered at night.

vii. On the 26 August you prescribed, inter alia, Diamorphine in a dose range 40-200mg and Midazolam in a dose range 20-80mg to be administered subcutaneously via a syringe driver.

viii. On the 30 August a subcutaneous syringe driver was commenced containing doses of 40mg of Diamorphine and 20mg of Midazolam.

ix. On the 1 September the Diamorphine dose in the syringe driver was increased to 60mg over a period of 24 hours and the dose of Midazolam was increased to 40mg and subsequently 60mg, over a period of 24 hours.

x. On the 2 September the Diamorphine dose in the syringe driver was increased to 90mg and the dose of Midazolam was increased to 80mg.

b. Your prescribing of oral morphine on the 26 August within the ranges specified was inappropriate and/or unprofessional in that;

i. The doses prescribed were excessive,

ii. The prescription lacked clear instructions on why, when, and by how much the dose should be altered within the range specified and by whom.

c. Your prescribing of opiate and sedative drugs on 30 August and subsequent increases on the 1 and 2 September was inappropriate and/or unprofessional in that;

i. You knew or should have known, that the dosages and combination of drugs were excessive and potentially hazardous to a patient in Mr Packman's condition.

d. Your management of Mr Packman was unprofessional in that;

i. You failed to conduct any, or any adequate assessment of Mr Packman following the deterioration in his condition on the afternoon of 26 August.

ii. You failed to conduct any, or any adequate assessment of Mr Packman when his condition acutely deteriorated on the evening of 26 August.

iii. You failed to make clear and/or accurate and/or contemporaneous contemporaneous medical records relating to Mr Packman.

iv. You failed to obtain advice from a consultant and/or a specialist regarding the deterioration in Mr Packman's condition and/or the appropriate steps to take to make a proper diagnosis of his condition and/or the appropriate course of treatment and/or your decision not to transfer him to an acute ward.

Field Fisher Waterhouse

SLE
26 NOV 2007

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.

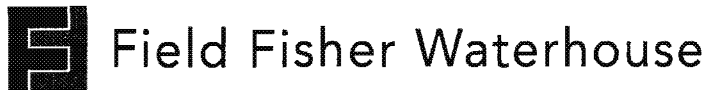
The 10 cases were ED, EL, SG, RW, ES, RL, LP, HS, GP and AC [RW and AC together with EP, AW and GR were included in the GMC rule 6 referral letter sent in 2002 after the first police referral]. There are 2 further cases where the patient's relatives have expressed an interest in the investigation.

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.

Can you speak to Juliet about Prof Black | his statement etc by Friday. GMC wants to have work to do by 14 December

Code A



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) JSB 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. Code A 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) Code A asking if we should instigate an investigation against these doctors. She was

asking TK for advice. Code A 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 Code A and Code A would be a major headache. We would only be able to criticise Code A 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 Code A and Code A 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 JSB 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. Code A 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 JSB.

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.

Tom Kark

From: Tom Kark
Sent: 25 March 2009 18:41
To: 'Ellson, Sarah'
Subject: Disclosure in Barton
Attachments: Advice on disclosure.doc

Dear Sarah,

As requested I have been trying to work through the schedules provided to us by Hampshire police in order to perform some sort of sensible preliminary disclosure exercise. I am sorry not to have done this before but my recollection is that Tamsin and I were going to have a meeting to work through the lists together to try to work out what they referred to and what you FFW actually had, but for one reason or another that meeting never took place. Many apologies in any event.

It is not an easy exercise without sight of the documents or access to the police officer to take us through his lists.

I think part of the problem here however is that our duty may have been slightly overstated by Tamsin which would have caused I suspect a degree of consternation to the police.
In her e-mail of 8th August 2008 she wrote –

i) "I am obliged to disclose all documents in my possession";
ii) "If we send the list (of documents) to the defence they have the right to request them and we will have to disclose the documents to them".

I am not sure that those comments properly reflect our duty which I have tried to set out in the attached advice.

Once you have read the advice which is generic in its terms rather than specific (for reasons that you will see) please feel free to give me a call (mobile Code A I will however be away taking a long weekend in Italy from tomorrow (Thursday) at 12 until the start of my long stint in Manchester on Monday.

Kind regards and apologies again,
Tom

GMC v Dr Barton

Advice on Police Disclosure Issues

1. I have been asked to advise on the issue of disclosure with respect to the schedule of material held by the police. The police, having provided the GMC with a number of lists of the material which they hold, have indicated their reluctance to allow even the lists to be disclosed.

2. In broad terms the GMC should try to follow the principles but not the regime of the Criminal Procedure and Investigation Act 1996 and the codes issued by the Attorney General in pursuance of the Act.

3. In broad terms our duties as Regulatory prosecutors are as follows :

i) to identify any material which may be relevant to the case;

ii) to ensure that the material is logged or scheduled in sufficient detail to enable a 3rd party to understand from it the nature of the document referred to;

iii) to examine any relevant material within the GMC's possession in order to make a decision as to disclosure within the principles described below;

iv) to provide to the defence a copy of the schedule with only sensitive material removed so that they may request any material which they regard as relevant;

v) to disclose to the defence any material which has been identified either by the prosecutor or by the defence from the schedule which may undermine the GMC's case or assist the defence which will include any previous statements of witnesses, in whatever form, which appear to contradict the account set out in any served statement.

vi) To bear in mind that material can fulfil the disclosure test by the fact that it may be of use in cross-examination or because it may lead to: the exclusion of evidence; a stay of the proceedings.

vii) To bear in mind that proper disclosure does not mean giving the defence an open ended trawl of unused material.

4. A particular difficulty arises where material is in the hands of a third party (as here). If the 3rd party is willing voluntarily to hand the material over to the GMC then the exercise described above can be undertaken.

5. Although the GMC has power under S35A to require any person who appears to be able to supply information or documentation to do so that does not mean in my view that the GMC has to do so in every case.

6. In this case the police have an enormous quantity of material much of which will be duplication of that which we already have and much of which will be irrelevant to the issues arising in this case. The GMC, I suspect, simply would not have the resources to put a sufficient number of knowledgeable people to the task of sifting through every document that the police have and assessing its capacity for disclosure. Nor, I suspect, would they be in a position to fund such an enormous task to be carried out by those instructing me or by their counsel.

7. However, some of the material held by the police may be relevant and may meet the disclosure test if considered in the appropriate light.

8. The police have indicated, as I understand it, an unwillingness to reveal even the schedules with which we have been provided. I do not understand on what basis they object to this course although I can readily understand that there could be individual entries which they would deem to be sensitive.

9. The schedules provided to us by the police are the sort of schedules which would normally be supplied to the defence as part of the prosecution's primary disclosure duty in order for the defence to make a decision as to whether to request disclosure or not.

10. The fact that the greater part of the schedules is likely to have to be disclosed to the defence does not mean in my view that they are entitled to have anything they ask for. They would have to justify each request and

the material would then have to be measured against the test described above.

11. In my view the police should be put on notice that we intend to disclose the schedules to the defence because we have a duty as prosecutors to do so.

12. We should ask what their specific objection to the schedules being disclosed is.

13. Provided there is no sensible basis upon which they do resist disclosure then in my view we should disclose the schedules to the defence but we should indicate that any requests for the documentation itself should be made directly to the police.

14. The one area where I would advise positively getting hold of the documentation itself is in relation to the following categories of material:

i) any previous statements of witnesses who we intend to call to give evidence which we do not already have;

ii) any interviews of witnesses who we intend to call to give evidence and which we do not already have.

15. If those instructing me have these schedules electronically then that would make it very much easier to search for the relevant names.

16. There are several police schedules and it may be helpful to set them out here:

    i) Statements listed with the prefix 'S';

    ii) Exhibits listed with the prefix 'X';

    iii) Officers' reports listed with the prefix 'R';

    iv) Other Documents listed with the prefix 'D';

    v) Action List (actions of specific police officers tasked with a particular duty) each document having the prefix 'A';

    vi) Finally there is a 'document' list which incorporates all of the above but also seems to include documents with the prefix 'M',

which I take to be messages, 'T' which appear to be lists of e-mails and 'Y' which appears to be lists of interviews which have taken place.

17. The police should be asked by reference to each category what their objection to disclosure of the list is and whether there is any alternative method of listing the material which would meet their approval.

18. Should the police fail to provide a reasonable objection to disclosure of the lists then the lists should be disclosed in their entirety to the defence who should be invited to request any material directly from the police.

19. Should a reasonable objection be made, then consideration would have to be given to redacting those items. Although it is tempting for me to go through the list and take an informed guess on which documents the police would object to disclosing I think that would be inappropriate as the objection must come from the police.

20. I apologise for the delay in providing this advice.

Tom Kark

QEB Hollis Whiteman Chambers

Temple, London EC4Y 9BS

25th March 2009

Dr Barton

Schedule of Complaints

Deceased / Date of Death	Relevant Wits	Strength of Complaint	PPC 30.8.02	Comment & Evershed's Analysis
Eva Page (87) 27.2.98		Eversheds – weak case, needs full investigation On basis of Prof Ford Reasonable prospect of conviction	Y	Heart disease, lung cancer. Palliative care, not for resusc. Eversheds p.33 – frail with possible carcinoma, No statements from witnesses of fact. Dr B notes that patient was in pain, though no other reference to it, Dr Mundy – Tab 19 (v. short report) a) No documentation of pain; b) started on opioid analgesia inappropriately; c) very wide range of dosage, unacceptable. . Professor Ford – Tab 20 (detailed report p.30) a) No previous history of pain; b) Immediately commenced on Opiates on admission by Dr B for anxiety and agitation - reasonable; c) Injections (by driver?) of Diamorphine on day of death by Dr B poor practice, inappropriate and hazardous d) No symptoms recorded to suggest these drugs were appropriate? e) Drugs may have resulted/likely to have resulted in fatal

				respiratory depression. (which??) If Fentanyl Patch and Oramorph was appropriate why wasn't injection of Diamorphine?
Alice Wilkie (81) 6.8.98 – 21.8.98		Eversheds – detailed investigation needed. On basis of Ford's report – Reasonable prospect of conviction	Y	Eversheds p.35 – advanced dementia, dehydration, not for resusc. No statements other than Mundy and Ford. Mundy – Tab 19 (v. short report) a) No clear indication for opioid to be prescribed; b) starting dose of 30 mgs excessive (but given by whom?); c) unusually large dose range; Ford – Tab 20 (full report p.21) a) No record made of why this patient was commenced on Diamorphine; b) No indication for the use of Diamorphine; c) undated prescription for syringe driver poor practice and very hazardous. d) Inappropriate commencement of Opiates e) Notes fall below expected level of documentation; f) No nursing entries from 6-17 August. g) No medical notes from 10-21 August. h) Poor practice to prescribe initially both Diamorphine and Midazolam Statements needed from patient's relatives.
Gladys Richards (91)		Eversheds – reasonable prospect of success; 1st complaint Agree – reasonable prospect of	Y	Eversheds p.36 – recovery from fractured thigh bone. Dislocated hip. Black – Tab 6

11.8.99		conviction		a) Bad medical and nursing notes; b) Anticipatory prescription of Opioid Analsgesia concerning; no pain killers regularly prescribed previously; Oramorph given in admission; c) doses of Diamorphine 'highly sub-optimal' prescribing; d) failure to liaise with surgical team, not unreasonable to provide palliative care, , e) death of patient was natural;
Arthur Cunningham (79) 21.9.98 – 26.9.98		Weak on basis of Black's evidence. Only criticism is re: last 2 days. Eversheds – consider for cancellation Wilcock – lack of notes, poor assessment, excessive doses prescribed but he did not receive high doses. "Other practitioners might well have followed a similar course to Dr B" Poor Care - TK to write a cancellation -	Y	Parkinson's disease. large offensive necrotic sacral ulcer. Eversheds p.28 – patient died within 5 days of admission. Black –Tab 12 complex case, patient managed appropriately except for last dose. a) Patient was managed appropriately, including starting driver medication; a reasonable management decision; b) one concern about final two days increased dose - unjustified; c) No notes to justify above increase. Dr Mundy – Tab 19 a) Morphine started with no attempt to control with non opiates, b) Using syringe driver does not appear to have been justified; c) unusually large does range given; d) as e) as
Robert Wilson (74) ✓		Eversheds – reasonable prospect	Y	Eversheds p.21 Fracture left humerus. Code A

14.10.98 – 19.10.98		of success Agree – reasonable prospect of conviction		Prescribed morphine and then syringe driver despite alcoholism Inaccurate death certificate according to Prof Baker. Dr Marshall says – high does of Morphine reckless. Black – Tab 29 a) No record of clinical examination on admission – poor clinical practice; b) Strong oral opiates started in alcoholic, with no notes made when he was on single small doses previously – this was negligent; c) Dosage of Oramorphine was too high – and negligent and contributed to death more than minimally; d) Failure to obtain senior medical opinion – poor clinical practice; Black - Para 6.10 why was the 20 mgs driver reasonable if the initial dose of Oramorph was not and see 7.3? What about Dr Peter's increase? (See below) Mundy - Tab 19 (v. short report) a) Diamorphine dose was increased by Dr Peters <u>after</u> Dr B; b) the palliative care given was appropriate.
Elsie Devine (87) 21.10.99-21.11.99		~~(Insufficent?)~~ Ag~~ree – no ca~~se Dying by time anyone takes action. No notes for 2 weeks! Evid. from Dr. Reid? Pros. on basis of notes Reasonable Prospect		Renal failure + confused and aggressive. Eversheds p.24 - Died 32 days after admission. dementia diagnosis 14.10.99. 21.10.99 admitted to Driad Ward. Dr B prescribes Morphine. "one of the weakest cases"

		Relatives are v. keen!		Cause of death refused by Registrar. Dr Black (Tab 2) – a) Lack of documentation poor clinical practice. b) Drug management sub-optimal. Starting dose higher than conventional. Not negligent or criminal. Dr Dudley – Tab 3 a) Treated appropriately in the terminal phase of illness; b) Not inappropriate to use Opioids to calm and keep comfortable.
Elsie Lavender (84) 22.2.96 – 6.3.96		Eversheds – reasonable prospect of success (charges drafted) Agree – reasonable prospect of conviction		Diabetic, quadriplegia? Blind. Eversheds p.16 Making good recovery from a fall. Dr B comment to son – your mother has come here to die. Prescribed Morphine on 24.2.96 Black – Tab 31 a) Inadequate assessment, not recorded in notes. b) Prescription on 26.2.99 of Diamorphine in excessive dose (not given) and excessive doses Midazelam and Diamorphine in last 36 hours – sub-optimal drug management. c) Para 6.10 Failure to get specialist opinion – (but whose fault was this? Not Dr B alone.) – D Barton
Sheila Gregory (91) 3.9.99 – 22.11.99		Very weak case, notes on admission only.. rest of care appropriate. Dr Wilcock disagrees and says no justification for opiates. No other witness evid. Don't add.		Eversheds p.29 – stayed on ward three months before death. Dr Reid – prescription of Diamorphine by Dr B was too early. On return from holiday Dr B prescribed Oramorph and Diamorphine. Dr Black – Tab 10, a) Poor notes on admission; b) overall clinical management just adequate;

				c) Oral opiates were appropriately given; d) Concern expressed about prescribing opiates in anticipation of patient's decline.
Enid Spurgin (92) 26.3.99 – 12.4.99		Eversheds – reasonable prospect of success (charges drafted) Agree- reasonable prospect of conviction		Femoral fracture, frail, depressed. Dr Reid also was investigated and is criticised by the experts. Eversheds p.23 – Repaired hip, haematoma, Given increasing does of Morphine. Black – Tab 34 a) Medical assessment was inadequate and/or badly recorded; b) On admission begun on Opiod analgesia, reason undocumented; c) Seen by Dr B either on 11th or 12th and syringe driver started (which was appropriate), but no medical note made by Barton. d) Starting dose of Diamorphine to 80 mgs was inappropriate, and later reduced by Consultant. Para 6.9 please explain dosage. And Para 6.12 – what was the final dose? is para 7.1 self contradictory re: failure to deal with pain and prescribing Oramorph?
Ruby Lake (84) 18.8.98 – 21.8.98		Reasonable prospect of conviction		Eversheds p.18, replacement hip recovering, previous angina, cardiac failure. Died within 3 days of admission. Prescribed Morphine on 18.8.98. Black – Tab 22 a) Failure by Dr B to record a clinical examination upon admission;

				b) Poor notes thereafter; c) Only analgesia written was Oramorphine, very poor prescribing;. d) No investigation of possible heart attack (but was this Dr B's fault?) e) Decision to start a syringe driver without documentation of a clinical diagnosis – negligent; but see para 6.14.
Leslie Pittock (83) 5.1.96 – 24.1.96		Eversheds – reasonable prospect of success (charges drafted) Agree – reasonable prospect of conviction		Evershed p.14. Dr B prescribes Diamorphine 5 days after admission. Black – Tab 24 a) Lack of documentation, major gaps in notes; b) unusual drug regimes without sufficient notes, on 15th Jan 80 mgs Diamorphine is started, 3 * the conventional dose; c) drug management sub-optimal; higher than standard doses used of Diamorphine, Midazolam, and nozinan may have shortened life; no notes of clinical justification for departing from norm, and amounts to excessive sedation.
Helena Service 3.6.97 – 5.6.97		Little prospect of success, very weak based on Prof Black's report, Dr Petch regards her treatment as appropriate and desirable Transferred to Gosport when unstable Severe breathlessness - starting dose acceptable (just)		Eversheds p.27 – died within 2 days of admission. Diabetes, heart failure, confusion. On first day put on a driver. Dr Petch says – palliative care with increased use of Morphine and Midazolam was appropriate. Dr Black – Tab 7 a) Poor admission notes; b) The combined palliative does was higher than necessary.
Geoffrey Packman (68) 23.8.99 – 3.9.99		Eversheds – reasonable prospect of success (charges drafted) Agree – reasonable prospect of conviction		Dr Reid also was investigated. Very obese patient, sacral necrotic tissue. Eversheds p.31 – Patient obese, Gastrointestinal bleeding, Dr B decided not to transfer to an acute bed.

				Dr Reid was happy with patient's management Black – Tab 15 (Report dated 20.6.06) a) very poor note of examination by Dr Barton; b) Decision to offer this patient symptomatic care only may have been correct but was one which should have had input from a consultant; (para.6.8) c) Serious criticism of drug chart keeping – para 6.9, (but whose responsibility is this?) d) A higher than conventional starting dose is used with no justification recorded. (But see para 6.10?) Later report para 6.12 states these doses were required.
Clifford Houghton		3(death natural)		
Thomas Jarman		3(death natural)		
Edwin Carter		3(death natural)		
Norma Windsor		3(death natural)		

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:-

   1 (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.

   2 (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.

5 (f) Elsie Devine:- 7. ✓

(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.

6 (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.

7 (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?

8 (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.

9 (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:- ✓

10

(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:- Gene Stevens. Edna Purnell ?

(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) Code A asking if we should instigate an investigation against these doctors. She was

asking TK for advice. Code A 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. JSB 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 JSB 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. Code A 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. JSB 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.

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Dear [ ]

General Medical Council – Dr Barton

I am writing further to your letter dated [ ]/ the telephone conversation on [ ] between [ ].

It may help if I explain that the GMC first received information about Dr Jane Barton in July 2000. The Hampshire Constabulary (the "Police") referred information to us about Dr Barton's treatment of an elderly lady who was a patient at Gosport War Memorial Hospital. At that time, the GMC decided to await the outcome of the ongoing Police investigation before considering the issues further.

In February 2002, the Police referred a further four cases to the GMC. These cases also concerned Dr Barton's treatment of elderly patients at Gosport War Memorial Hospital. The GMC continued to await the outcome of the Police investigation into these additional cases.

Later in 2002, the Police informed the GMC that, in respect of all five cases previously passed to the GMC the Crown Prosecution Service had concluded there was insufficient evidence to provide a realistic prospect of a criminal conviction. The Police also informed the GMC that they would not be conducting any further investigations at that time.

The GMC was then able to resume its own investigations into these five cases. This resulted in a referral to the GMC's Preliminary Proceedings Committee (PPC) whose responsibility was to decide whether to refer Dr Barton to a hearing into an allegation of serious professional misconduct. On 29 August 2002, the PPC decided to refer Dr Barton for a hearing by a Fitness to Practise Panel (FtPP).

Then in September 2002 the Police commenced further enquiries into Dr Barton's conduct and treatment of patients at the Gosport War Memorial Hospital. On this occasion, a total of 92 ~~additional~~ cases were investigated by the Police. During the course of this phase of the Police investigation, a multi-disciplinary team of medical experts (the "Clinical Team") examined patients' medical notes to assess the quality of care provided to each patient. The Clinical Team, using a scoring matrix, filtered each of the 92 cases into one of 3 categories: Category 1 – optimal care, Category 2 – sub-optimal care and Category 3 - negligent care.

The Clinical Team identified 14 cases which fell within Category 3 – negligent care. When the Clinical Team looked in more detail at these 14 cases, they found that the cause of death was entirely natural in 4 cases, even though there was evidence that these 4 patients did receive negligent care. These 4 cases were released from the Police investigation.

In December 2006, the Crown Prosecution Service concluded that having regard to the overall evidence in relation to the remaining 10 Category 3 cases it could not be proved that Dr

Barton was negligent to the required criminal standard. Similarly, in respect to the Category 2 cases, there was evidence of sub-optimal care, however, this was not sufficient to prove to a criminal standard negligence on the part of Dr Barton Accordingly, the Police investigation was closed and the Police notified the GMC of this decision.

While this further Police investigation had been ongoing, the GMC awaited its outcome. This was so as to ensure any GMC investigation did not prejudice case any criminal prosecution which might have followed.

In early 2007, after the conclusion of the Police investigation, the GMC with the assistance of its legal team carefully considered the information now available. The PPC had referred allegations in respect of five patients; under the statutory Rules if the Solicitor to the Council later adduces grounds for further allegations of similar kind, these can be added to the cases already referred by the PPC. Following initial review of the available evidence, the GMC commissioned an expert to review those cases in Category 3 as these were cases where the Clinical Team had had the most serious concerns. In the light of this expert report, the GMC has taken forward six additional cases from the 10 Category 3 cases. [Two of the five cases referred for hearing in 2002 were also part of the 10 Category 3 cases.]

Also, complaints in relation to two additional patients were brought to the attention of the GMC in 2007 when the selection process was ongoing. The GMC sought expert opinion in respect of these cases and on the basis of that opinion one of the cases has also been added to the case to be considered by the FtPP.

The GMC had decided the evidential basis of its case of alleged serious professional misconduct before the announcement of the 10 inquests. We awaited the outcome of the inquests in case they revealed evidence, or led to further criminal investigation, such as might impact on the way the GMC could present its case at the FtPP hearing. No such evidence emerged, and it does not appear that any further criminal investigation is contemplated. The GMC case will involve 8 of the cases for which inquests were held in March/April 2009.

The FTPP hearing is due to take place between 8 June and 28 August 2009 at the GMC's hearing centre in London. The Committee will consider allegations against Dr Barton in respect of her treatment of 12 patients. Following completion of the hearing we will be happy to forward to you a copy of the Committee's determination. Should you require a copy of the determination, please let us know.

Yours etc.

STATUTORY INSTRUMENTS

1988 No. 2255

MEDICAL PROFESSION

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

Made	21st December 1988
Laid before Parliament	22nd December 1988
Coming into force .	15th January 1989

At the Council Chamber, Whitehall, the 21st day of December 1988
By the Lords of Her Majesty's Most Honourable Privy Council

Whereas in pursuance of paragraphs 1 and 5 of schedule 4 to the Medical Act 1983(a) the General Medical Council have made the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988:

And whereas by sub-paragraph (5) of the said paragraph 1 such Rules shall not come into force until approved by Order of the Privy Council:

Now, therefore, Their Lordships, having taken the said Rules into consideration, are pleased to approve the same as set out in the Appendix to this Order.

This Order may be cited as the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988, and shall come into force on 15th January 1989.

The General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1980(b) is hereby revoked.

G I de Deney
Clerk of the Privy Council

*as amended by the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) (Amendment) Rules 1988, 1989, 1990, 1994 and 1996, the General Medical Council (Professional Performance) Rules 1997, the General Medical Council (the Professional Conduct Committee, the Health Committee, the Committee on Professional Performance) (Amendment) Rules 2000, the General Medical Council (Fitness to Practise Committees) Rules 2000 and the General Medical Council (Fitness to Practise Committees) (Amendment) Rules 2002.

(a) 1983 c.54

(b) S.I. 1980/858.

APPENDIX

THE GENERAL MEDICAL COUNCIL PRELIMINARY PROCEEDINGS COMMITTEE AND PROFESSIONAL CONDUCT COMMITTEE (PROCEDURE) RULES 1988

PART I

PRELIMINARY

1. Citation and commencement
2. Interpretation
3. Times and places of meetings of the committees

PART II

INITIAL CONSIDERATION OF CASES

4. Appointment of member to conduct initial consideration of cases
5. Allegations as to conviction
6. Allegations as to professional misconduct
7. Furnishing evidence of fitness to practise
8. Invitation to practitioner to appear before the Interim Orders Committee in certain circumstances
9. Duty to supply rules
10. (Deleted 2000)

PART III

PROCEDURE OF THE PRELIMINARY PROCEEDINGS COMMITTEE

11. Determination by Preliminary Proceedings Committee
12. Referral to Interim Orders Committee
13. Further investigations and provisional determination
14. Fresh allegations as to conviction or conduct
15. Preliminary Proceedings Committee to meet in private
16. Non-disclosure of documents or reasons in cases not referred for inquiry

PART IV

INTERMEDIATE PROCEDURES WHERE A CASE IS REFERRED TO THE PROFESSIONAL CONDUCT COMMITTEE

17. Notice of Inquiry
18. Postponement of inquiry
19. Cancellation of inquiry
20. Access to documents
21. Notice to produce documents
22. Amendment of charge before the opening of an inquiry
22A. Referral to Interim Orders Committee by the Professional Conduct Committee

PART V

PROCEDURE OF THE PROFESSIONAL CONDUCT COMMITTEE AT THE ORIGINAL HEARING OF ANY CASE

23. Procedure where the practitioner does not appear
24. Opening of inquiry - Reading of charge, submission of objections and amendment of charge
25. Cases relating to conviction
26. Circumstances, character, history and pleas in mitigation in cases relating to conviction
27. Cases relating to conduct
28. Circumstances, character, history and pleas in mitigation in cases relating to conduct
29. Finding of serious professional misconduct
30. Determination whether to make a direction
31. Directions of the Committee
32. Order for immediate suspension of registration
33. Failure to comply with interim conditional registration
33A. Orders for interim suspension or interim conditional registration
34. Announcement of findings, direction, etc. of Committee
35. Cases relating both to conviction and to conduct
36. Inquiries into charges against two or more practitioners

PART VI

RESUMED HEARINGS BY THE PROFESSIONAL CONDUCT COMMITTEE

37. Direction for resumed hearing
38. Notice of resumed hearing
39. New charge at resumed hearing
40. Procedure at resumed hearing
41. Procedure following postponement under rule 30
42. Procedure where conditional registration has been imposed
43. Procedure where registration has been suspended
44. Announcement of determination at resumed hearing
45. Subsequent application of rules where case is continued

PART VII

APPLICATIONS FOR RESTORATION AFTER ERASURE

46. Procedure for consideration of applications for restoration

PART VIIA

APPLICATIONS FOR RESTORATION AFTER ERASURE UNDER THE MEDICAL PRACTITIONERS (VOLUNTARY ERASURE AND RESTORATION) REGULATIONS 2000

46A. Procedure for consideration of applications for restoration

PART VIII

GENERAL

47. Adjournment of proceedings
48. Exclusion of public from hearings in certain cases
49. Consideration of confidential reports at resumed hearings
50. Evidence
51. Reference and transfer of cases to the Health Committee
52. Voting
53. Representation
53A. Notification of directions of the Professional Conduct Committee.
54. Postal service of documents
55. Record of proceedings
56. Revocation

SCHEDULE 1 - *Provisions as to meetings of the Preliminary Proceedings Committee and of the Professional Conduct Committee*
SCHEDULE 2 - *Form of notice of an inquiry*
SCHEDULE 3 - *Statutory Declaration to be made by an applicant for restoration to the Register*

The General Medical Council, in exercise of their powers under paragraphs 1 and 5 of Schedule 4 to the Medical Act 1983, and after consulting with such bodies of persons representing medical practitioners as appeared to the Council to be requisite, as required by those paragraphs, hereby make the following Rules:-

PART I

PRELIMINARY

Citation and commencement

1. These Rules may be cited as the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988, and shall come into operation on 15th January 1989.

Interpretation

2.—(1) In these Rules, unless the context otherwise requires:—

"the Act" means the Medical Act 1983;

"case relating to conviction" means a case where it is alleged that a practitioner has been convicted, whether while so registered or not, in the British Islands of a criminal

offence, or has been convicted elsewhere of an offence which, if committed in England or Wales, would constitute a criminal offence;

"case relating to conduct" means a case where a question arises whether conduct of a practitioner constitutes serious professional misconduct;

"the Committee" means, in Part III of the rules, the Preliminary Proceedings Committee and, in Parts IV to VIIA of the rules, the Professional Conduct Committee;

"complainant" means a body or person by whom a complaint has been made to the Council;

"the Council" means the General Medical Council or a Committee of the Council acting under delegated power;

"the Health Committee (Procedure) Rules" means Rules made by the Council in the exercise of the powers conferred on them by paragraph 1 of Schedule 4 to the Act and references to those Rules are to the Rules currently in force and, unless the contrary intention appears, to such Rules as amended;

"lay member of the Council" means a member who is nominated in accordance with paragraph 4 of Schedule 1 to the Act, and who is neither fully registered nor the holder of any qualification registrable under the Act;

"the legal assessor" means an assessor appointed by the Council under paragraph 7 of Schedule 4 to the Act;

"medical member of the Council" means a member who is elected or appointed to the Council in accordance with paragraphs 1-3 of Schedule 1 to the Act and who is fully registered, provisionally registered, or registered with limited registration;

"medical screener" means any medical member of the Council appointed under rule 4(2);

"party" has the meaning given in paragraph 13 of Schedule 4 to the Act;

"practitioner" means a person registered (in any way) under the Act and includes a person who has previously been registered and whose registration is currently suspended under section 36, 41A, 41B or 44(5) of the Act; and references to the practitioner, in relation to any complaint, information or proceedings, are references to the practitioner who is alleged to have been convicted, or whose fitness to practise or conduct is or has been called into question, as the case may be;

"the President" means the President of the Council

"the Register", in relation to fully or provisionally registered persons, means the Register of Medical Practitioners, and in relation to persons with limited registration means the Register of Medical Practitioners with limited Registration;

"the Registrar" means the Registrar of the Council;

"the Restoration Regulations" means the General Medical Council (Restoration and Registration Fees Amendment) Regulations 2003([1]);

"the Solicitor" means any Solicitor, or any firm of Solicitors, appointed by the Council or any partner of such a firm;

"the Voluntary Erasure Regulations" means the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations 2003([2]);

(1A) Any reference to a direction given under rule 37, or to the exercise of powers under that rule, by the Chairman of the Preliminary Proceedings Committee shall in relation to a case where such a direction was given or such powers exercised before 3rd August 2000 be read as a reference to a direction given or powers exercised by the President.

(2) In these Rules, unless the context otherwise requires, a reference

(a) to a numbered rule or Schedule is to the rule in or Schedule to these rules bearing that number;

(b) in a rule or Schedule to a numbered paragraph is to the paragraph in that rule or Schedule bearing that number;

(c) in a paragraph to a lettered sub-paragraph is to the sub-paragraph in that paragraph bearing that letter.

Times and places of meetings of the committees

3. The provisions of Schedule 1 shall have effect as to the times and places of meetings of the Preliminary Proceedings Committee and of the Professional Conduct Committee and the mode of summoning members.

PART II

INITIAL CONSIDERATION OF CASES

Appointment of member to conduct initial consideration of cases

4.—(1) No case shall be considered by the Preliminary Proceedings Committee unless it has first been considered—

(a) by a medical screener appointed by the Council under paragraph (2), or

(1) Scheduled to S.I. 2003/1342.
(2) Scheduled to S.I. 2003/1341.

(b) by a medical member of the Council appointed under rule 5(2) or (3) of the Health Committee (Procedure) Rules, or exercising the President's powers or functions under rule 5(4) of those Rules,

and referred by such member to the Committee.

(2) The Council shall appoint to act as medical screeners for the purposes of these Rules—

(a) the President, unless he proposes to sit on the Preliminary Proceedings Committee, the Professional Conduct Committee or the Health Committee or for any other reason he does not wish to undertake the initial consideration of cases under these Rules; and

(b) such other medical members of the Council as the President shall nominate.

(3) (Deleted 2000)

(4) (Deleted 2000)

(5) The President shall also nominate lay members of the Council, whom the Council shall appoint, to assist any medical screener.

(6) Without prejudice to the generality of the foregoing, if any time the President is absent or unable to act, anything authorised or required by this rule to be done by the President may be done by any other medical member of the Council authorised in that behalf by the President or (if the President be unable to give authority) authorised by the Council or by the Preliminary Proceedings Committee on behalf of the Council.

Allegations as to conviction

5.—(1) Where information in writing is received by the Registrar from which it appears to him that a practitioner has been convicted of a criminal offence in the British Islands or has been convicted of an offence elsewhere which, if committed in England or Wales would constitute an offence—

(a) in a case of conviction for an offence which the Registrar considers to be a minor motoring offence, the case shall not proceed further;

(b) in a case of conviction where a custodial sentence has been imposed (but excepting any case where the sentence was suspended), the Registrar may refer the case direct to the Professional Conduct Committee for inquiry unless it is his opinion that such direct referral would not be in the public interest;

(c) in any other case of conviction including any case which the Registrar has determined not to refer direct to the Professional Conduct Committee under rule 5(1)(b), the Registrar shall refer the case to the medical screener.

(1A) In a case where subparagraph (b) of paragraph (1) applies, the Registrar shall notify the practitioner as soon as practicable that the case has been referred to the Professional Conduct Committee.

(2) Unless the case is dealt with under the Health Committee (Procedure) Rules in pursuance of the proviso to rule 7 of these Rules, the medical screener shall refer every case submitted to him under this rule to the Preliminary Proceedings Committee.

(3) Where a case is referred to the Preliminary Proceedings Committee under this rule, the Registrar shall give written notice to the practitioner-

(a) that the information referred to in paragraph (1) has been received;

(b) that the case has been referred to the Preliminary Proceedings Committee and of the date of the meeting of the Committee to which the case is referred,

(c) and shall invite the practitioner to submit any observations which he may wish to offer.

(4) The Registrar shall submit to the Preliminary Proceedings Committee any observations or evidence furnished by the practitioner under this rule or rule 7.

Allegations as to professional misconduct

6.—(1) Where a complaint in writing or information in writing is received by the Registrar and it appears to him that a question arises whether conduct of a practitioner constitutes serious professional misconduct the Registrar shall submit the matter to a medical screener.

(2) (deleted 2002)

(3) Unless the case is dealt with under the Health Committee (Procedure) Rules in pursuance of the proviso to rule 7 of these Rules, the medical screener shall refer to the Preliminary Proceedings Committee a case submitted to him under paragraph (1), if he is satisfied from the material available in relation to the case that it is properly arguable that the practitioner's conduct constitutes serious professional misconduct.

(3A) The medical screener shall seek the advice of a lay member appointed under rule 4(5) in relation to any case submitted to him under paragraph (1) which he does not propose to refer to the Preliminary Proceedings Committee, and he shall direct that no further action be taken in the case only if the lay member so consulted agrees.

(4) Where the medical screener refers a case to the Preliminary Proceedings Committee under this rule he shall direct the Registrar to give written notice to the practitioner—

(a) notifying him of the receipt of a complaint or information and stating the matters which appear to raise a question as to whether the conduct of the practitioner constitutes serious professional misconduct;

(b) (deleted 2002)

(c) informing the practitioner of the date of the meeting of the Preliminary Proceedings Committee to which the case is referred; and

(d) inviting the practitioner to submit any explanation which he may have to offer.

(5) Where a case is referred to the Preliminary Proceedings Committee under this rule, the medical screener shall submit to the Committee any complaint, information, explanation or other evidence furnished under this rule or rule 7 which relates to the case.

(6) In any case where the medical screener decides not to refer a case to the Preliminary Proceedings Committee, the practitioner and the person from whom the complaint or information was received shall be informed but shall have no right of access to any document relating to the case submitted to the Council by any other person.

"(7) Subject to paragraph (8), an allegation of misconduct in a case relating to conduct may not be referred to the Preliminary Proceedings Committee under this rule if, at the time when the complaint was first made to the Council, more than five years had elapsed since the events giving rise to that allegation.

(8) Where an allegation of misconduct in a case relating to conduct is made more than five years after the events giving rise to that allegation, the medical screener may nevertheless direct that the case be referred to the Preliminary Proceedings Committee if, in his opinion, the public interest requires this in the exceptional circumstances of that case.

Furnishing evidence of fitness to practise

7. If in a case (whether relating to conviction or conduct) it appears to the medical screener that the fitness to practise of the practitioner may be seriously impaired by reason of a physical or mental condition the medical screener shall also direct the Registrar to inform the practitioner accordingly and to invite him to furnish medical evidence of his fitness to practise for consideration by the Preliminary Proceedings Committee:

Provided that nothing in these Rules shall prevent the medical screener in such a case from remitting it to the person appointed under rule 5 of the Health Committee (Procedure) Rules for action under those Rules, or, if he is himself that person, from initiating action under those Rules, as an alternative to referring the case to the Preliminary Proceedings Committee.

Invitation to practitioner to appear before the Interim Orders Committee in certain circumstances.

8. If in any case (whether relating to conviction or conduct) it appears to the medical screener that the circumstances are such that the Interim Orders Committee may wish to make an order for interim suspension or for interim conditional registration under section 41A of the Act, he shall refer the case to the Interim Orders Committee.

Duty to supply rules

9. The Registrar shall send a copy of these rules with any notice sent for the purpose of rule 5(3), 6(4) or 8.

10. (Deleted 2000)

PART III

PROCEDURE OF THE PRELIMINARY PROCEEDINGS COMMITTEE

Determination by Preliminary Proceedings Committee

11.—(1) The Committee shall consider any case referred to them under Part II of these Rules or under the provisions of the Health Committee (Procedure) Rules and, subject to those rules, determine:

(a) that the case shall be referred to the Professional Conduct Committee for inquiry, or

(b) that the case shall be referred to the Health Committee for inquiry, or

(c) that the case shall not be referred to either Committee.

(2) When referring a case to the Professional Conduct Committee the Committee shall indicate the convictions, or the matters which in their opinion appear to raise a question whether the practitioner has committed serious professional misconduct, to be so referred and to form the basis of the charge or charges:

Provided that, where the Committee refer any case relating to conduct to the Professional Conduct Committee and the Solicitor (or the complainant) 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.

(3) Before referring a case to the Health Committee the Committee may direct the Registrar to invite the practitioner to submit to examination by one or more medical examiners, to be chosen by the Chairman of the Committee from among those nominated under Schedule 2 to the Health Committee (Procedure) Rules, and to agree that such examiners should furnish to the Council reports on the practitioner's fitness to practise, either generally or on a limited basis, with recommendations for the management of his case. If the Committee consider that the information before them is sufficient to justify reference to the Health Committee, but that the Health Committee would be assisted by such reports, they may refer the case forthwith but invite the practitioner to submit to examination as aforesaid before the case is considered by the Health Committee.

(4) When referring a case to the Health Committee the Committee shall indicate the nature of the alleged condition by reason of which it appears to them that the fitness to practise of the practitioner may be seriously impaired.

(5) If the Committee decide not to refer a case to the Professional Conduct Committee or to the Health Committee, the Registrar shall inform the practitioner and the complainant (if any) of the decision in such terms as the Committee may direct.

(6) The Committee shall not consider any case relating to the conduct of a practitioner and referred to the Committee under rule 6 before the expiry of the period of 28 days beginning with the date of despatch of the notice given to the practitioner under rule 6(4) unless the practitioner consents.

Referral to Interim Orders Committee

12. If in any case it appears to the Committee that the circumstances are such that the Interim Orders Committee may wish to make an interim suspension order or an order for interim conditional registration under section 41A(1) of the Act, the Committee shall refer the case to the Interim Orders Committee.

Further investigations and provisional determination

13.—(1) Before coming to a determination under rule 11(1) the Committee may if they think fit cause to be made such further investigations, or obtain such advice or assistance from the Solicitor, as they may consider requisite.

(2) Where the Committee are of opinion that further investigations are desirable, or where at the time when the Committee are considering a case no explanation or observations have yet been received from the practitioner, they may if they think fit make a provisional determination that the case shall be referred to the Professional Conduct Committee or to the Health Committee and where they make such a determination—

(a) the Chairman of the Committee may subsequently direct either that no reference shall be made or that the Committee's determination shall become absolute;

(b) if the Committee directs that no reference shall be made, the Registrar shall inform the practitioner and the complainant (if any) in such terms respectively as the Committee may direct.

Fresh allegation as to conviction or conduct

14.—(1) This rule applies where:

(a) in any case relating to conviction the Committee determine that no inquiry shall be held; or

(b) in any case relating to conduct

(i) under rule 6(3) the medical screener decides that no reference to the Committee is to be made; or

(ii) the Committee determine that no reference for inquiry shall be made,

and the Registrar, at any time within the two years following that determination or decision, receives information that the practitioner has been convicted in the British Isles of a criminal offence or has been convicted of an offence elsewhere which, if committed in England or Wales, would constitute an offence or receives information or a complaint as to the practitioner's conduct.

(2) Where this rule applies, the medical screener may direct that the original conviction or complaint be referred, or referred again, to the Committee, as well as the later conviction, information or complaint.

(3) In any case where the decision under paragraph (1)(b)(i) was made before 3rd August 2000, the reference there to the medical screener shall be read as a reference to the President.

Preliminary Proceedings Committee to meet in private

15. The Committee shall meet in private.

Non-disclosure of documents or reasons in cases not referred for inquiry

16. Where the Committee have decided not to refer a case for inquiry no complainant, informant or practitioner shall have any right of access to any documents relating to the case submitted to the Council by any other person, nor shall the Committee be required by a complainant, informant, or practitioner to state reasons for their decision.

PART IV

INTERMEDIATE PROCEDURES WHERE A CASE IS REFERRED TO THE PROFESSIONAL CONDUCT COMMITTEE

Notice of Inquiry

17.—(1) As soon as may be after a case has been referred to the Committee for inquiry, the Registrar shall send to the practitioner in compliance with rule 54 a notice, in these rules called a 'Notice of Inquiry', which shall:

(a) specify, in the form of a charge or charges, the matters into which the inquiry is to be held, and

(b) state the day, time and place at which the inquiry is proposed to be held.

(2) In a case relating to conduct, the charge shall include a statement which identifies the alleged facts upon which the charge is based.

(3) Except with the agreement of the practitioner, the inquiry

(a) shall not be fixed for any date earlier than twenty-eight days after the date of posting of the Notice of inquiry;

(b) shall not be fixed for any date earlier than six weeks after the date of the meeting of the Preliminary Proceedings Committee at which the case was referred for inquiry.

(4) A Notice of Inquiry shall be in the form set out in Schedule 2, with such variations as circumstances may require.

(5) In any case where there is a complainant, a copy of the Notice of Inquiry shall be sent to him.

Postponement of inquiry

18.—(1) Where the Preliminary Proceedings Committee has referred a complaint or information or a conviction to the Committee for inquiry, the Chairman of the Preliminary Proceedings Committee may if he thinks fit postpone the holding of the inquiry to such later date or meeting of the Committee as he may determine.

(2)Where the Registrar has referred a conviction to the Committee for inquiry, he may if he thinks fit postpone the holding of the inquiry to such later date or meeting of the Committee as he may determine.

(3)The Registrar shall, as soon as may be after any decision to postpone an inquiry, give to all parties to whom a Notice of Inquiry has been sent notification of the decision, and shall inform them at that time or subsequently of the date fixed for the hearing of the postponed inquiry.

Cancellation of inquiry

19.—(1) Where, after the Preliminary Proceedings Committee has referred a complaint or information or a conviction to the Committee for inquiry, it appears to the Chairman of the Preliminary Proceedings Committee (having taken into account any observations of any complainant obtained pursuant to paragraph (1A)) that the inquiry should not be held, he may, after consulting a quorum of the Committee, and if they agree, direct that the inquiry shall not be held; and if at the time the direction is given no Notice of inquiry has been sent, rule 17 shall not have effect:

(1A) In any case where there is a complainant the Registrar shall, before the Preliminary Proceedings Committee considers the case under paragraph (1), communicate or endeavour to communicate with the complainant with a view to obtaining the observations of the complainant as to whether the inquiry should be held.

(2) For the purpose of consultation under paragraph (1) the Preliminary Proceedings Committee shall not be required to meet.

(3) Where, after the Registrar has referred a conviction to the Committee for inquiry, it appears to him that the inquiry should not be held, he may direct that the inquiry shall not be

held; and if at the time the direction is given no Notice of Inquiry has been sent, rule 17 shall not have effect.

(4)The Registrar shall, as soon as may be after any decision to cancel an inquiry, give notice thereof to the practitioner and to the complainant (if any).

Delegation to Deputy Chairmen

19A Anything authorised by these Rules to be done by the Chairman of the Preliminary Proceedings Committee may, if he is unavailable or otherwise unable to act, be done by a Deputy Chairman of the Committee.

Access to documents

20. Without prejudice to rule 16 the Solicitor (or the complainant as the case may be) shall on the request of any party to an inquiry and on payment of the proper charges send to him copies of any statutory declaration, affidavit, explanation, answer, admission or other statement or communication sent to the Council by a party to the inquiry or any statement in writing in the possession of the Solicitor or the complainant made by a person who may be called by the Solicitor or the complainant to give evidence at the inquiry, other than medical evidence of fitness to practise furnished in response to an invitation under rule 7 or a confidential communication sent to the Council in response to applications under rules 38(1)(a)(iii) or rule 49(1):

Provided that nothing in this rule shall compel the Solicitor to produce copies of any written advice or other document or communication sent by himself to the Council.

Notice to produce documents

21. Any party to any inquiry may at any time give to any other party notice to produce any document relevant to the inquiry alleged to be in the possession of that party.

Amendment of charge before the opening of an inquiry

22.—(1) Where before a hearing by the Committee it appears to the Chairman of the Preliminary Proceedings Committee (the Chairman) that a charge should be amended, including such amendment as contemplated under the proviso to rule 11(2), the Chairman shall give such directions for the amendment of the charge as he may think necessary to meet the circumstances of the case unless, having regard to the merits of the case, the required amendments cannot be made without injustice.

(2) Where in the opinion of the Chairman it is expedient, in consequence of the exercise by him of the powers conferred by paragraph (1), that the inquiry should be postponed, the Chairman shall give such directions in that behalf as appears necessary.

(3) The Registrar shall as soon as may be give notice in writing to the practitioner and to the complainant (if any) of any exercise by the Chairman of his powers under either paragraph (1) or (2).

Referral to Interim Orders Committee by Professional Conduct Committee

22A. If in any case (whether relating to conviction or conduct) it appears to the Professional Conduct Committee that the circumstances are such that the Interim Orders Committee may wish to make an interim suspension order or an order for interim conditional registration under section 41A(1) of the Act the Professional Conduct Committee shall refer the case to the Interim Orders Committee.

PART V

PROCEDURE OF THE PROFESSIONAL CONDUCT COMMITTEE AT THE ORIGINAL HEARING OF ANY CASE

Procedure where the practitioner does not appear

23.—(1) Where the practitioner does not appear and is not represented, the Committee may nevertheless proceed with the inquiry if the Solicitor satisfies them that all reasonable efforts have been made in compliance with rule 54 to serve the Notice of Inquiry on the Practitioner.

(2) If the Committee are so satisfied they may, if they think fit, proceed and the following provisions of these Rules shall not apply:-

rule 24(2) and (3);
rule 25(1)(c), (d), (e), (f) and (g);
rule 26(2);
rule 27(1)(a), (e), (f), (g), (h), (i) and (j); and
rule 28(2).

Opening of inquiry - Reading of charge, submission of objections and amendment of charge

24.—(1) The inquiry shall open by the reading of the charge or charges to the Committee.

(2) After the reading of the charge or charges the practitioner may submit any objection on grounds of law to any charge or part of a charge and any other party may reply to such an objection.

(3) If any objection raised under paragraph (2) is upheld no further proceedings shall be taken with regard to the charge or part of a charge to which that objection relates.

(4) Where at any stage of an inquiry it appears to the Committee that a charge should be amended, the Committee may, after hearing the parties and consulting the legal assessor, if they are satisfied that no injustice would be caused, make such amendments to the charge as appear necessary or desirable.

Cases relating to conviction

25.—(1) In cases relating to conviction, the following order of proceedings shall be observed as respects proof of convictions alleged in the charge or charges:—

(a) The Solicitor shall adduce evidence of the convictions.

(b) If, as respects any conviction, no evidence is so adduced, the Chairman of the Committee shall announce that the conviction has not been proved.

(c) The Chairman shall ask the practitioner whether he admits each conviction of which evidence is so adduced and, in respect of any conviction so admitted by the practitioner, the Chairman shall announce that the conviction has been proved.

(d) The practitioner may then, in respect of the convictions not admitted, address the Committee and may adduce evidence, oral or documentary, including his own, in his defence.

(e) At the close of the evidence for the practitioner, the Solicitor may, with the leave of the Committee, adduce evidence to rebut any evidence adduced by the practitioner.

(f) The Solicitor may then address the Committee.

(g) The practitioner may then address the Committee.

(2) On the conclusion of the proceedings under paragraph (1), the Committee shall consider every conviction alleged in the charge or charges, other than any conviction admitted by the practitioner or which the Chairman has announced has not been proved, and shall determine whether it has been proved; and the Chairman of the Committee shall announce their determination.

Circumstances, character, history and pleas in mitigation in case relating to conviction

26.—(1) Where the Committee have found that a conviction has been proved the Chairman shall invite the Solicitor to address the Committee, and to adduce evidence, as to the circumstances leading up to the conviction and as to the character and previous history of the practitioner.

(2) The Chairman shall then invite the practitioner to address the Committee by way of mitigation and to adduce evidence as aforesaid.

(3) The Committee shall then proceed in accordance with rules 30 and 31.

Cases relating to conduct

27.—(1) In cases relating to conduct, the following order of proceedings shall be observed as respects proof of the facts alleged in the charge or charges:—

(a) The Chairman shall ask the practitioner whether he admits any or all of the facts alleged in the charge or charges and, in respect of any facts so admitted by the practitioner, the Committee shall record a finding that such facts have been proved and the Chairman shall so announce. Where all the facts are admitted the remainder of this rule other than sub- paragraphs (e) and (f) of this paragraph, shall not apply.

(b) Where none, or some only, of the facts are admitted the Solicitor, or the complainant if any, shall open the case against the practitioner and present the facts alleged on which the charge or charges is or are based.

(c) The Solicitor, or the complainant, as the case may be, may adduce evidence of the facts alleged which have not been admitted by the practitioner.

(d) If as respects any charge no evidence is so adduced, the Committee shall record and the Chairman shall announce a finding that the practitioner is not guilty of serious professional misconduct in respect of the matter to which that charge relates.

(e) At the close of the case against him the practitioner may make either or both of the following submissions, namely:—

(i) in respect of any or all of the facts alleged and not admitted in the charge or charges, that no sufficient evidence has been adduced upon which the Committee could find those facts proved;

(ii) in respect of any charge, that the facts of which evidence has been adduced or which have been admitted are insufficient to support a finding of serious professional misconduct;

and where any such submission is made, the Solicitor or the complainant, as the case may be, may answer the submission and the practitioner may reply thereto.

(f) If a submission is made under the last foregoing paragraph, the Committee shall consider and determine whether the submission should be upheld; and if the Committee determine to uphold such a submission as respects any charge, they shall record, and the Chairman shall announce, a finding that the practitioner is not guilty of serious professional misconduct in respect of the matters to which the charge relates.

(g) The practitioner may then address the Committee concerning any charge which remains outstanding and may adduce evidence, oral or documentary, including his own, in his defence.

(h) At the close of the evidence for the practitioner, the Solicitor or the complainant, as the case may be, may, with the leave of the Committee, adduce evidence to rebut any evidence adduced by the practitioner.

(i) The Solicitor, or the complainant, as the case may be, may then address the Committee.

(j) The practitioner may then address the Committee.

(2) On the conclusion of proceedings under paragraph (1) the Committee shall consider and determine:

(i) which, if any, of the remaining facts alleged in the charge and not admitted by the practitioner have been proved to their satisfaction, and

(ii) whether such facts as have been so found proved or admitted would be insufficient to support a finding of serious professional misconduct, and shall record their finding.

(3) The Chairman shall announce that finding and, if as respects any charge the Committee have found that none of the facts alleged in the charge have been proved to their satisfaction, or that such facts as have been so proved would be insufficient to support a finding of serious professional misconduct, the Committee shall record and the Chairman shall announce a finding that the practitioner is not guilty of serious professional misconduct in respect of the matters to which that charge relates.

Circumstances, character, history and pleas in mitigation in cases relating to conduct

28.—(1) Where, in proceedings under rule 27, the Committee have recorded a finding, whether on the admission of the practitioner or because the evidence adduced has satisfied them to that effect, that the facts, or some of the facts, alleged in any charge have been proved, the Chairman shall invite the Solicitor or the complainant, as the case may be, to address the Committee as to the circumstances leading to those facts, the extent to which such facts are indicative of serious professional misconduct on the part of the practitioner, and as to the character and previous history of the practitioner. The Solicitor or the complainant may adduce oral or documentary evidence to support an address under this rule.

(2) The Chairman shall then invite the practitioner to address the Committee by way of mitigation and to adduce evidence as aforesaid.

Finding of serious professional misconduct

29.—(1) The Committee shall then consider and determine whether, in relation to the facts proved in proceedings under rule 27, and having regard to any evidence adduced and arguments or pleas address to them under rule 28, they find the practitioner to have been guilty of serious professional misconduct. They shall record, and the Chairman shall announce, their finding.

(2) If the Committee determine that the practitioner has not been guilty of such misconduct, they shall record, and the Chairman shall announce, a finding to that effect.

Determination whether to make a direction

30.—(1) Where in any case the Committee have found a conviction proved or have judged that a practitioner has been guilty of serious professional misconduct they may, if they think fit, postpone their determination whether to make a direction until such future date or meeting of the Committee as they may specify, in order to obtain and consider further evidence of the conduct of the practitioner. If they so decide, the Chairman shall announce that decision.

(2) If the Committee decide that no such postponement is necessary, they shall consider and determine whether it shall be sufficient to make no direction and conclude the case and, if they so determine, the Chairman shall, subject to the provisions of rule 34, announce that determination.

Directions of the Committee

31.—(1) If the Committee determine neither to postpone their determination under rule 30(1) nor that it shall be sufficient to conclude the case under rule 30(2), they shall proceed to make a direction in accordance with the following provisions of this rule.

(2) (a) The Committee shall first consider and determine whether it shall be sufficient to direct that the registration of the practitioner shall be conditional on his compliance, during such period not exceeding three years as the Committee may specify, with such requirements as the Committee may think fit to impose for the protection of members of the public or in his interests.

(b) If the Committee so determine they shall then consider and decide the nature and duration of the conditions to be imposed, and shall so direct.

(3) If the Committee determine that it will not be sufficient to impose conditions on the practitioner's registration they shall next consider and determine whether it shall be sufficient to direct that the practitioner's registration shall be suspended; and, if they so decide, they shall direct that such suspension should be for such period, not exceeding twelve months, as they may specify in the direction.

(4) If the Committee determine that it will not be sufficient to direct suspension in accordance with paragraph (3), they shall thereupon direct that the name of the practitioner shall be erased from the Register.

5) In any case where the Committee have determined that the registration of any practitioner shall be suspended or be subject to conditions for a specified period, they may, when announcing the direction to give effect to such determination, intimate that they will, at a meeting to be held before the end of such period, resume consideration of the case with a view to determining whether or not they should then direct that the period of suspension or of conditional registration should be extended or the conditions varied or that the name of the practitioner should be erased from the Register.

Order for immediate suspension of registration

32. If in any case the Committee determine to suspend the registration of a practitioner or to erase his name from the Register, the Committee shall then also consider and determine

whether it is necessary for the protection of members of the public or would be in the best interests of the practitioner to order that his registration shall be suspended forthwith.

Failure to comply with interim conditional registration

33.—(1) Where, in any case referred by the Preliminary Proceedings Committee, the Interim Orders Committee has made an order for interim conditional registration or, if at a previous hearing the Professional Conduct Committee had made such an order, the Professional Conduct Committee shall first determine whether the practitioner has failed to comply with any of the requirements imposed on him as conditions of his registration.

(2) If the Committee determine that the practitioner has not so failed to comply, they shall proceed in accordance with rule 33A.

(3) If the Committee determine that the practitioner has so failed to comply they may, if they think fit—

(a) exercise their powers under rule 33A; or, if not,

(b) direct that the registration of the practitioner shall be suspended for such period not exceeding 12 months as they may specify; or, if not,

(c) direct that the name of the practitioner shall be erased from the Register.

Orders for interim suspension or interim conditional registration

33A.—(1) Where, in any case referred by the Preliminary Proceedings Committee, an order made by the Interim Orders Committee for interim suspension or for interim conditional registration is in force, (or where an order made under this paragraph by the Professional Conduct Committee is in force), the Professional Conduct Committee may—

(a) revoke the order;

(b) revoke or vary any condition imposed by the order;

(c) if satisfied that to do so is necessary for the protection of members of the public or is otherwise in the public interest or is in the interests of the practitioner, make an order that the practitioner's registration shall be conditional on his compliance, during such period as the Committee may specify, with such requirements as the Committee may think fit to impose for the protection of members of the public or otherwise in the public interest or in his interests; or

(d) if satisfied that to do so is necessary for the protection of members of the public, or is otherwise in the public interest or is in the interests of the practitioner make an order that the practitioner's registration shall be suspended for such period as they may specify in the order.

(2) When considering whether to make an order under this rule the Committee may invite the Solicitor to address them.

(3) No order may be made under this rule unless the practitioner has been afforded an opportunity of appearing before the Professional Conduct Committee and being heard on the question whether such an order should be made in his case; and for this purpose the practitioner may be represented before the Committee as provided in rule 53(2) and may also be accompanied by his medical adviser:

Provided that, if the practitioner does not appear and is not represented, and the Solicitor satisfies the Committee that the requirements of rule 54 have been met, the Committee may make an order under this rule if they think fit, notwithstanding the practitioner's failure to appear.

(4) Any order made under paragraph (1)(c) or (d) shall specify a period not exceeding three months.

(5) Any order made under paragraph (1) shall be notified to the practitioner by the Registrar forthwith and in accordance with the requirements of rule 54.

Announcement of findings, direction, etc. of Committee

34. The Chairman shall announce any finding, determination, direction , or revocation of the Committee under these rules in such terms as the Committee may approve and, where the announcement is one that a conviction has been proved or that the practitioner has been judged guilty of serious professional misconduct but the Committee do not propose to make any direction, may, without prejudice to the terms in which any other announcement may be made, include any expression of the Committee's admonition in respect of the practitioner's behaviour giving rise to the charge or charges in question.

Cases relating both to conviction and to conduct

35. Where in the case of any inquiry it is alleged against the practitioner both that he has been convicted and that he has been guilty of serious professional misconduct, the following shall be the procedure:—

(a) The Committee shall first proceed with every charge that the practitioner has been convicted until they have completed the proceedings required by rule 25.

(b) The Committee shall then proceed with every charge that the practitioner has been guilty of such conduct as aforesaid until they have completed the proceedings required by rule 27.

(c) The Committee shall then take any proceedings required by any of rules 26 and 28 to 33.

Inquiries into charges against two or more practitioners

36. Nothing in these rules shall be construed as preventing one inquiry being held into charges against two or more practitioners; and where such an inquiry is held the foregoing rules shall apply with the necessary adaptations and subject to any directions given by the

Committee as to the order in which proceedings shall be taken under any of those rules in relation to the several practitioners.

PART VI

RESUMED HEARINGS BY THE PROFESSIONAL CONDUCT COMMITTEE

Direction for resumed hearing

37.—(1) Paragraph (1A) applies where the Committee—

(a) have determined that the registration of a practitioner shall be suspended or be subject to conditions for a specified period, but

(b) have given no intimation under rule 31(5).

(1A) If it appears to the Chairman of the Preliminary Proceedings Committee ("the Chairman"), as a consequence of the receipt during that specified period of information as to the conduct or a conviction of the practitioner since the date of the direction to give effect to the determination, that the Professional Conduct Committee should consider whether or not—

(a) the period of suspension or conditional registration should be extended; or

(b) the conditions should be varied or revoked; or

(c) the name of the practitioner should be erased from the Register

he shall direct the Registrar to notify the practitioner that the Professional Conduct Committee will resume consideration of the case at such meeting as the Chairman shall specify.

(2) Where, in any case, the Committee have—

(a) decided to postpone their determination under rule 30 for a specified period or to a specified meeting, or

(b) directed that the practitioner's registration should be subject to conditions and intimated that they will resume consideration of the case at a specified meeting or date, or

(c) suspended the practitioner's registration and intimated that they will resume consideration of the case at a specified meeting or date,

and it subsequently appears to the Chairman, in consequence of the receipt of information to the credit or discredit of the practitioner in relation to his conduct since the original hearing, or for some other reason, that the Committee should resume consideration of the case at an earlier meeting or date than that originally specified, the Chairman may direct the Registrar to

notify the practitioner that the Committee will resume consideration of the case at such meeting or date as the Chairman shall specify.

(3) Without prejudice to the generality of paragraphs (1), (1A) and (2), wherein any case the Committee have imposed conditions upon a practitioner's registration, and it appears to the Chairman from information subsequently received that the practitioner is not complying with such conditions, then, whether or not the conditions imposed by the Committee required the practitioner to reappear before them at a future date or meeting, the Chairman may direct the Registrar to notify the practitioner that the Committee will resume consideration of the case at such meeting as the Chairman shall specify.

(4) In any case in which a direction has been given under paragraphs (1) to (3) the Committee shall then resume consideration of the case on the date or at the meeting specified in the direction notwithstanding their earlier decision.

Notice of resumed hearing

38.—(1) Where the Committee are to resume a previous hearing in circumstances specified in paragraph (2) -

(a) the Registrar shall, not later than four weeks before the day fixed for the resumption of the proceedings, send to the practitioner in compliance with rule 54 a Notice which shall—

(i) specify the day, time and place at which the proceedings are to be resumed and invite him to appear thereat;

(ii) in any case where the Chairman of the Preliminary Proceedings Committee has exercised his powers under rule 37(1) to (3) state the nature of the information in consequence of which he has exercised his powers;

(iii) if the Committee have so directed, invite the practitioner to furnish the Registrar with the names and addresses of professional colleagues and other persons of standing to whom the Council will be able to apply for confidential information as to their knowledge of his conduct since the time of the original inquiry;

(b) in any case where there is a complainant a copy of the Notice shall be sent to him.

(2) The circumstances to which paragraph (1) applies shall be:

(i) where under any of the foregoing provisions of these Rules the determination of the Committee in any case stands postponed; or

(ii) where the Committee have directed that the registration of a practitioner shall be conditional or shall be suspended, and have intimated that before the end of the

period of conditional registration or suspension they will resume consideration of the case; or

(iii) where the Chairman of the Preliminary Proceedings Committee has so directed under rule 37(1) to (3); or

(iv) where, following reference of a case to the Health Committee, the Health Committee certify to the Committee under rule 51(3), their opinion that the fitness to practise of the practitioner is not seriously impaired by reason of his condition.

New charge at resumed hearing

39.—(1) If, since the original hearing, a new charge or charges against the practitioner have been referred to the Committee, the Committee shall first proceed with such new charge or charges in accordance with the provisions of rule 24 and rule 25 or 27, as the case may be.

(2) The Committee shall take any proceedings required by rule 26 or rules 28 and 29, as the case may be, in relation to such new charge or charges, concurrently with the proceedings prescribed in rule 40 and shall have regard to their findings in relation to such charge or charges in making any direction in accordance with rules 41 to 43.

Procedure at resumed hearing

40.—(1) Subject to the provisions of rule 39, at the meeting at which the proceedings are resumed, the Chairman of the Committee shall first invite the Solicitor to recall, for the information of the Committee, the position in which the case stands.

(2) If in any case the Chairman of the Preliminary Proceedings Committee has exercised his powers under rule 37, the Solicitor shall adduce evidence of the conduct or conviction of the practitioner which led to the exercise of those powers.

(3) The Committee may—

(a) hear any other party to the proceedings,

(b) receive such further oral or documentary evidence in relation to the case, or as to the conduct of the practitioner since the previous hearing, as they think fit; and nothing herein contained shall be construed as preventing the receipt by the Committee of evidence as to any conviction, not being a conviction which is the subject of a charge before the Committee.

(4) The Committee shall then proceed in accordance with the following rules, as the circumstances of the case may so require.

Procedure following postponement under rule 30

41.—(1) If at the previous hearing the Committee, under rule 30, postponed their determination whether to make a direction to enable further evidence to be considered, they

shall next consider and decide whether they should further postpone their determination: if they so decide, they may direct such further postponement until such future date or meeting of the Committee as they may specify.

(2) If the Committee decide that they should not further postpone their determination they shall proceed to consider and determine whether it shall be sufficient to make no direction and conclude the case.

(3) If the Committee determine that it shall not be sufficient to conclude the case, they shall proceed to make a direction in accordance with the provisions of paragraphs (2) to (4) of rule 31.

Procedure where conditional registration had been imposed

42.—(1) If at the previous hearing the Committee had directed that the registration of the practitioner should be subject to conditions, the Committee shall first judge whether the practitioner has failed to comply with any of the requirements imposed on him as conditions of his registration.

(2) (a) If the Committee judge that the practitioner has not so failed to comply they shall then consider and determine whether:

(i) to revoke the direction made at the previous hearing, that the registration of the practitioner be subject to conditions (in which case they shall so direct); or

(ii) to vary the conditions imposed under the direction made at the previous hearing (in which case they shall so direct); or

(iii) to make no further direction, and allow the case to conclude on the expiry of the period for which the direction made at the previous hearing applies.

(b) If the Committee determine not to revoke the direction or vary the condition or conditions imposed at the previous hearing, or to allow the case to conclude as aforesaid, they shall proceed to impose a further period of conditional registration and shall consider and decide the nature of the conditions and the further period not exceeding twelve months, for which they shall apply, and shall so direct.

(3) (a) If the Committee judge that the practitioner has so failed to comply, they shall next consider and determine whether it shall be sufficient:

(i) to vary the conditions imposed under the direction made at the previous hearing; or, if not,

(ii) to direct that the current period of conditional registration shall be extended for such further period not exceeding twelve months as they may specify, with or without variation of the conditions imposed under the direction made at the previous hearing; or, if not,

(iii) to direct that the registration of the practitioner shall be suspended for such period not exceeding twelve months as they may specify and, if they determine that one of the foregoing courses of action shall be sufficient, they shall so direct.

(b) If the Committee determine that none of the courses of action under sub-paragraph (a) shall be sufficient, they shall thereupon direct that the name of the practitioner shall be erased from the Register.

Procedure where registration has been suspended

43.—(1) Where at a previous hearing the Committee directed that the practitioner's registration should be suspended, the Committee shall consider and determine whether it shall be sufficient:

(a) to make no further direction, or, if not,

(b) to direct the registration of the practitioner shall be conditional on his compliance during such period not exceeding three years as the Committee may specify, with such requirements as the Committee may think fit to impose for the protection of members of the public or in his interests (in which case the Committee shall then consider and decide the nature and duration of the conditions to be imposed); or, if not,

(c) to direct that the current period of suspension shall be extended for such further period, not exceeding twelve months, from the time when it would otherwise expire as they may specify.

(2) If the Committee determine that it shall not be sufficient to adopt a course under paragraph (1)(a), (b) or (c) they shall direct that the name of the practitioner shall be erased from the Register.

(3) If the Committee determine to pursue a course under paragraph (1)(b), or (c) or paragraph (2) they shall make a direction to that effect.

Announcement of determination at resumed hearing

44. The Chairman shall announce the determination or determinations of the Committee under the foregoing rules in such terms as the Committee may approve.

Subsequent application of rules where case is continued

45. The provisions of rules 37 and 39 to 44 shall also apply in any case where the determination of the Committee has been further postponed at a resumed hearing or in which the Committee have previously directed at a resumed hearing that a period of suspension or conditional registration should be extended or further extended.

PART VII

APPLICATIONS FOR RESTORATION AFTER ERASURE UNDER SECTION 36

Procedure for consideration of applications for restoration

46.—(1) Where a person applies for the restoration of his name to the Register under section 41 of the Act, the following provisions shall have effect:—

(a) Subject to any direction given by the Chairman of the Professional Conduct Committee in special circumstances, an application shall not be considered by the Committee at any meeting unless, not less than twenty-one days before the first day of that meeting, there has been delivered to the Registrar a statutory declaration made by the applicant as nearly as possible in the form set out in Schedule 3.

(b) At the hearing of the application, the Chairman of the Committee shall first invite the Solicitor to recall the circumstances in which the applicant's name was erased from the Register and, if he so desires, to address the Committee and to adduce evidence as to the conduct of the applicant since the date the Committee directed that the practitioner's name should be erased from the Register.

(c) (deleted 2000)

(d) The Committee may, if they think fit, receive oral or written observations on the application from any body or person on whose complaint or information the applicant's name was erased from the Register.

(da) The Chairman shall next invite the applicant to address the Committee and, if he so desires, to adduce evidence as to his good character, his professional competence and his health since the date the Committee directed his name should be erased from the Register, and if any observations are received under sub-paragraph (d), the applicant shall have the right to address the Committee in response to those observations.

(db) Where an application is a second or subsequent application during the same period of erasure the Chairman shall invite the applicant to address the Committee on the question of whether his right to make further applications should be suspended indefinitely.

(e) The Committee may, if they think fit, adjourn consideration of any application to such future meeting as they may specify, and may require the applicant to submit evidence of his conduct since his name was erased from the Register.

(f) Subject to the foregoing provisions of this rule the procedure of the Committee in connection with such applications shall be such as they may determine.

(2) There shall be three stages in the Committee's determination of an application for restoration to the Register.

(3) At the first stage, the Committee shall determine, having regard to—

(a) the reasons why the applicant's name was erased from the Register;

(b) the application for restoration;

(c) the applicant's conduct since his name was erased from the Register; and

(d) the representations made to the Committee under paragraph (1)

whether, subject to satisfying the Committee as to his good character, professional competence and health, the applicant's name should be restored to the Register.

(4) If the Committee determine under paragraph (3) that the applicant's name should not be restored to the Register the Committee shall determine the application accordingly but, if not, the case shall proceed to the second stage.

(5) At the second stage, the Committee shall determine what assessment the applicant should undergo for the purpose of satisfying the Committee as to his good character, professional competence and health and shall order accordingly.

(6) The person who carries out the assessment of the applicant's character, professional competence and health shall report his findings in writing to the Committee.

(7) At the third stage, the Committee shall consider the report of the assessment of the applicant's fitness to practise and determine whether the applicant's name should be restored to the Register.

PART VIIA

APPLICATIONS FOR RESTORATION IN ACCORDANCE WITH THE VOLUNTARY ERASURE REGULATIONS OR THE RESTORATION REGULATIONS

Procedure for consideration of applications for restoration

46A. —(1) This Part shall apply in relation to any application by a person for restoration of his name to the Register-

(a) under regulation 3 of the Voluntary Erasure Regulations which has been referred to the Committee by the Registrar under regulation 4(8) of those regulations; or

(b) under regulation 2 of the Restoration Regulations, which has been referred to the Committee by the Registrar under regulation 3(8) of those regulations.

(2) The application shall not be considered by the Committee at any meeting unless the Registrar has given the applicant notice in writing of the date, time and place of the hearing

before the beginning of the period of 28 days ending on the day of the hearing, or such shorter period of notice as the applicant may agree, and the Registrar shall send with the notice a copy of these Rules and the Voluntary Erasure Regulations or the Restoration Regulations whichever is applicable.

(3) The notice under paragraph (2) shall—

(a) specify the grounds on which the reference has been made and include particulars of any alleged facts which are to be presented to the Committee at the hearing by the Solicitor;

(b) have attached to it copies of any reports or other documents which the Solicitor proposes to put before the Committee at the hearing;

(c) inform the applicant of his right to attend the hearing and to be represented by counsel or a solicitor, by any officer or member of any professional organisation of which he is a member or by a member of his family,

and, except where the context otherwise requires, any reference in the following provisions of this Part to the applicant shall be read as including a reference to his representative.

(4) The following provisions shall apply in relation to any meeting of the Committee to consider the application—

(a) the Chairman shall put the particulars specified in the notice in accordance with paragraph (3)(a) to the applicant and ask him whether he admits all or any of the facts alleged;

(b) any admission of any fact or facts shall be recorded by the Committee and announced by the Chairman;

(c) the Solicitor may adduce oral or documentary evidence to prove any fact specified in the particulars which is not admitted and shall in any event, where applicable, call the complainant;

(d) the applicant may adduce oral or documentary evidence relevant to any fact in respect of which the Solicitor has adduced evidence and may address the Committee on any such evidence;

(e) the Committee shall make a determination that any fact which has not been admitted, and as respects which evidence has not been adduced by the Solicitor, has not been proved, and that determination shall be announced by the Chairman;

(f) the Committee shall determine whether they find any fact as respects which the Solicitor has adduced evidence proved or not;

(g) the Solicitor may address the Committee with respect to any admission and to any fact found by the Committee to have been proved, and with respect to the character and previous history of the applicant;

(h) the applicant may address the Committee with respect to any admission and any fact found by the Committee to have been proved, and with respect to any other matter raised by the Solicitor in his address;

(i) the Committee shall consider any admissions made, any evidence adduced and the addresses of the Solicitor and the applicant, and decide whether to approve the application;

(j) if the Committee decide to approve the application, they shall direct the Registrar to restore the applicant's name forthwith to the Register;

(k) if the Committee decide not to approve the application they shall consider whether, having regard to the gravity of the case, the mandatory period of one year during which the applicant is not permitted to make another application for restoration under regulation 4(11) of the Voluntary Erasure Regulations or regulation 3(11) of the Restoration Regulations, whichever is applicable, should be extended and, if so, what the extended period should be; and

(l) the Chairman shall announce the Committee's decision under sub-paragraph (i), and under sub-paragraph (k) if applicable, in such terms as the Committee shall approve.

(5) A majority of the votes of those present shall be required for a decision that the applicant's name should be so restored and for a decision that the minimum period referred to in paragraph (4)(k) should be extended, and rule 52(3) shall have effect subject to this paragraph.

(6) Parts II, III, IV, V, VI and VII of these Rules shall not apply in relation to any application to which this Part applies, except that rule 23(1) shall apply.

(7) Part VIII of these Rules shall apply, except that rules 49, 51 and 53A shall not apply.

(8) Subject to paragraphs (2) to (7), the Committee may determine their own procedure.

(9) For the purpose of proceedings under this rule, references to the complainant in these Rules shall mean any person whose written complaint or information about the applicant's conduct has given rise to the matters that are being considered by the Committee.

46B Procedure for consideration of restoration following voluntary erasure applications made before 1st July 2003

An application for restoration which has been referred to the Committee by virtue of regulation 6(b) of the Voluntary Erasure Regulations in accordance with the Medical Practitioners (Voluntary Erasure and Restoration) Regulations 2000 shall be dealt with in accordance with rule 46A above as in force on 30th June 2003.

PART VIII

GENERAL

Adjournment of proceedings

47. The Preliminary Proceedings Committee and the Professional Conduct Committee may adjourn any of their proceedings or meetings from time to time as they think fit.

Exclusion of public from hearings in certain cases

48.—(1) Subject to the provisions of rule 50(5), and to the following paragraphs of this rule, all proceedings before the Professional Conduct Committee shall take place in the presence of all parties thereto who appear therein and shall be held in public.

(2) (a) If any party to any proceedings or any witness therein makes an application to the Committee for the public to be excluded from any proceedings or part thereof, then if it appears to the Committee that any person would suffer undue prejudice from a public hearing or that for any other reason the circumstances and nature of the case make a public hearing unnecessary or undesirable, the Committee may direct that the public shall be so excluded.

(b) Where no such application has been made the Committee may of their own initiative direct that the public shall be excluded from any proceedings or part thereof if it appears to the Committee, after hearing the views of the parties thereon, that to do so would be in the interests of justice or desirable having regard to the nature either of the case or of the evidence to be given.

(c) A direction under this paragraph shall not apply to the announcement in pursuance of any of these rules of a determination of the Committee.

(3) Subject to the provisions of paragraph 7 of Schedule 4 to the Act and of any rules made thereunder the Committee may deliberate in camera (with or without the legal assessor) at any time and for any purpose during or after the hearing of any proceedings.

Consideration of confidential reports at resumed hearings

49.—(1) Where, under rule 30 or rule 41, the Professional Conduct Committee postpone or further postpone their determination whether to make a direction or, under rule 31, rule 42 or rule 43, impose conditions upon a practitioner's registration or suspend the registration of a practitioner and give an intimation under rule 31(5), or the Chairman of the Preliminary Proceedings Committee determines under rule 37(1) to (3) that they will resume consideration of the case, or where the Committee adjourn consideration of an application under rule 46(1)(e), the Committee may require the practitioner to furnish the Registrar with the names and addresses of professional colleagues and other persons of standing to whom the Council will be able to apply for information, to be given confidentially, as to their knowledge of his conduct since the time of the original or of any previous hearing.

(2) Where any practitioner or applicant has supplied to the Committee or to the Registrar on his behalf the name of any person to whom reference may be made confidentially as to his conduct, the Committee may consider any information received from such person in consequence of such reference without disclosing the same to the practitioner.

Evidence

50.—(1) The Professional Conduct Committee may receive oral, documentary or other evidence of any fact or matter which appears to them relevant to the inquiry into the case before them:

Provided that, where any fact or matter is tendered as evidence which would not be admissible as such if the proceedings were criminal proceedings in England, the Committee shall not receive it unless, after consultation with the legal assessor, they are satisfied that their duty of making due inquiry into the case before them makes its reception desirable.

(2) Without prejudice to the generality of the last preceding paragraph the Committee may, if satisfied that the interests of justice will not thereby be prejudiced, admit in evidence without strict proof copies of documents which are themselves admissible, maps, plans, photographs, certificates of conviction and sentence, certificates of registration of birth or marriage or death, the records (including the registers) of the Council, the notes of proceedings before the Committee and before other tribunals and the records of such tribunals, and the Committee may take note without strict proof of the professional qualifications, the registration, the address and the identity of the practitioner and of any other person.

(3) The Committee may accept admissions made by any party and may in such case dispense with proof of the matters admitted.

(4) The Committee may cause any person to be called as a witness in any proceedings before them, whether or not the parties consent thereto. Questions may be put to any witness by the Committee or by the legal assessor with the leave of the Chairman.

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

Provided that this rule shall not prevent the Committee from receiving evidence relating to the posting, receipt or service of documents, the production of documents, and evidence in rebuttal of evidence given by or on behalf of the practitioner or as part of the case against him.

Reference and transfer of cases to the Health Committee

51.—(1) Notwithstanding any other provisions in these rules, where in the course of an inquiry, at either the original or a resumed hearing, it appears to the Professional Conduct Committee that a practitioner's fitness to practise may be seriously impaired by reason of his

physical or mental condition, the Committee may refer that question to the Health Committee for determination, and any such referral may be made whether or not the Professional Conduct Committee order in accordance with powers conferred by the Act that the practitioner's registration shall be conditional on his compliance with specified requirements.

(2) When referring a case under this rule to the Health Committee the Professional Conduct Committee may also direct that, before the case is considered by the Health Committee, the practitioner shall be invited to submit to examination by one or more medical practitioners to be chosen by the Chairman of the Preliminary Proceedings Committee from among those nominated under Schedule 2 to the Health Committee (Procedure) Rules, and to agree that such examiners should furnish to the Council reports on the practitioner's fitness to practise, either generally or on a limited basis, with recommendations for the management of his case.

(3) If, following a reference under this rule, the Health Committee subsequently certify to the Professional Conduct Committee their opinion that the fitness of the practitioner to practise is not seriously impaired by reason of his physical or mental condition, rule 38 shall apply, and the Professional Conduct Committee shall resume their inquiry in the case and dispose of it.

(4) If, following a reference under this rule, the Health Committee certify to the Professional Conduct Committee their opinion that the fitness of the practitioner to practise is seriously impaired by reason of his physical or mental condition, the Professional Conduct Committee shall cease to exercise their functions in relation to the case.

Voting

52.—(1) The following provisions shall have effect as to the taking of the votes of the Preliminary Proceedings Committee and the Professional Conduct Committee on any question to be determined by them:

(a) The Chairman of the Committee shall call upon the members present to signify their votes by raising their hands, signify his own vote, and declare the way in which the question appears to him to have been determined.

(b) If the result so declared by the Chairman is challenged by any member, the Chairman shall—

(i) call upon each member severally to declare his vote,

(ii) announce his own vote, and

(iii) announce the number of members of the Committee who have voted each way and the result of the vote.

(2) In proceedings of the Preliminary Proceedings Committee, or in consideration of cases by that Committee under rule 13 or rule 19, if the votes are equal, the Chairman of that Committee shall have an additional casting vote.

(3) In proceedings of the Professional Conduct Committee,

(a) the Committee shall dismiss an application under rule 46 unless a majority of the votes of those present at the hearing are in favour of allowing the application;

(b) the Committee shall dismiss a submission under rule 27(1)(e) unless a majority of the votes of those present at the hearing are in favour of allowing the submission; and

(c) in any other case if the votes are equal the question shall be deemed to have been resolved in favour of the practitioner.

For the purpose of this paragraph a determination by the Professional Conduct Committee to postpone their determination whether to make a direction shall be taken to be in favour of a practitioner unless he has indicated to the Committee that he is opposed to such postponement.

The amendments made by this paragraph shall not apply in relation to any proceedings before the Professional Conduct Committee which were begun before 3rd August 2000.

Representation

53.—(1) Any party being a body corporate or an unincorporated body of persons may appear by their clerk or other officer duly appointed for the purpose or by counsel or solicitor.

(2) Any party being an individual may appear either in person or by counsel or solicitor, or by any officer or member of any professional organisation of which he is a member, or by any member of his family, and any reference to a practitioner, complainant or other party shall be construed as including a reference to any person by whom he is represented.

Notification of directions of the Professional Conduct Committee

53A.—(1) In any case in which the Professional Conduct Committee have given a direction under these Rules for erasure, for suspension or for conditional registration or have varied the conditions imposed by a direction for conditional registration, the Registrar shall forthwith serve on the practitioner a notification of the direction and of the practitioner's right to appeal against the decision.

(2) In this rule references to a direction for suspension and a direction for conditional registration include references to a direction extending a period of suspension or a period of conditional registration.

(3) Service of the notification shall be effected in accordance with rule 54.

Postal service of documents

54. Any notice or other document required by rules 5 to 8, 12(7), 17, 18(2), 19(3) 33(3), and (4), 37, 38 and Part VIIA to be given or sent to any person shall be given or sent—

(a) by personal delivery, or by sending it to him by the Registered post service or by a postal service in which delivery or receipt is recorded at his usual or last-known address, which in the case of a doctor shall be his address in the Register or, if his last-known address differs from the address in the Register, his last-known address;

(b) in the case of a person represented by—

(i) a solicitor, by personal delivery, or by sending it to him by the Registered post service or by a postal service in which delivery or receipt is recorded at his professional address;

(ii) any other person, by personal delivery, or by sending it to him by the Registered post service or by a postal service in which delivery or receipt is recorded at his usual or last-known address.

Record of proceedings

55.—(1) The Registrar shall arrange for the proceedings of the Professional Conduct Committee to be recorded by electronic means or otherwise.

(2) Any party to the proceedings shall, on application to the Registrar, be furnished with a copy of the record of any part of the proceedings at which the party was entitled to be present.

(3) Paragraphs (1) and (2) do not apply to the deliberations of the Committee.

Revocation

56. The General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1980 are hereby revoked.

Given under the official seal of the General Medical Council this third day of November nineteen hundred and eighty-eight.

J.N. Walton
President

SCHEDULE 1

(Rule 3)

PROVISIONS AS TO MEETINGS OF THE PRELIMINARY PROCEEDINGS COMMITTEE AND OF THE PROFESSIONAL CONDUCT COMMITTEE

1. The Preliminary Proceedings Committee and Professional Conduct Committee shall each meet not less than three times a year.

2. The Committee shall each meet on such days as the Chairman, Committee or Council may determine and at such times as the Chairman may determine.

3. (deleted 1994)

. Members of the Preliminary Proceedings Committee and of the Professional Conduct Committee shall be summoned to meetings of the Committee by the Registrar, by notice addressed to each member. Except in the case of a meeting held to resume the hearing of a case which has been adjourned or postponed for less than 28 days, such notice shall be sent not less than three weeks before the meeting to which it relates.

5. (deleted 2000)

SCHEDULE 2

(Rule 17)

FORM OF NOTICE OF INQUIRY

(Date)

Dear Sir/Madam,

On behalf of the General Medical Council notice is hereby given to you that in consequence of [a complaint made against you to the Council] *or* [information received by the Council] an inquiry is to be held into the following charge (charges) against you:-

[If the charge relates to conviction] That you were on the .... day of .... at [specify court recording the conviction] convicted of [set out particulars of the conviction in sufficient detail to identify the case].

OR

[If the charge relates to conduct] That, being registered under the Medical Act, you [set out briefly the facts alleged]: and that in relation to the facts alleged you have been guilty of serious professional misconduct.

[Where there is more than one charge, the charges are to be numbered consecutively, charges relating to conviction being set out before charges relating to conduct.]

Notice is further given to you that on [day of the week] the .... day of .... 19 .... a meeting of the Professional Conduct Committee will be held at .... at .... am/pm to consider the above-mentioned charge (charges) against you, and to determine whether or not they should direct the Registrar to erase your name from the Register or to suspend you registration therein, or to impose conditions on your registration, pursuant to section 36 of the Medical Act 1983.

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

Any answer, admission, or other statement or communication, which you may desire to make with respect to the said charge (charges), should be addressed to the Solicitor to the Council.

If you desire to make any application that the inquiry should be postponed, you should send the application to us as soon as possible, stating the grounds on which you desire a postponement. Any such application will be considered by the President of the General Medical Council in accordance with rule 18 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988.

AND

(If the Notice is addressed to a practitioner whose registration is subject to an interim order made by the Preliminary Proceedings Committee under rule 12 of these Rules and currently in force). The Committee may revoke the interim order made in relation to your registration on [specify date] by the Preliminary Proceedings Committee under rule 12 of these Rules, or may exercise such other powers with respect to that order as are set out in rule 33 of these Rules.

Yours faithfully,

Solicitor to the General Medical Council

SCHEDULE 3

(Rule 46)

STATUTORY DECLARATION TO BE MADE BY AN APPLICANT FOR RESTORATION TO THE REGISTER

(NB This declaration must be made before a Commissioner for Oaths, a Solicitor authorised to administer oaths, or a Justice of the Peace.)

"I, the undersigned ....

now holding the qualification of ....

do solemnly and sincerely declare as follows:-

1. I am the person formerly registered as a medical practitioner with the name .... and with the qualifications of .... and I hereby apply for the restoration of my name to the Register.

2. At an inquiry held on the .... day of .... nineteen hundred and .... the Disciplinary Committee/Professional Conduct Committee directed my name to be erased from the Register, and the offence for which the Committee directed the erasure of my name was ....

3. Since the erasure of my name from the Register I have been residing at

....

and my occupation has been ....

4. It is my intention if my name is restored to the Register to

....

....

5. The grounds of my application are ....

....

....

And I make this declaration conscientiously believing the same to be true and by virtue of the Statutory Declarations Act 1835.

Signed ....

Declared at ....

on ....

before me ....

A Commissioner for Oaths
A Solicitor authorised to administer Oaths
A Justice of the Peace

SCHEDULE 2 Article 16(2)

TRANSITIONAL PROVISIONS

Interpretation

1. In this Schedule—

(a) a reference to an old section of or paragraph in the Act shall be construed as a reference to that provision as it had effect prior to its amendment or substitution by this Order and a reference to a new section of or new paragraph in the Act shall be construed as a reference to that provision as amended or substituted or re-enacted (with or without modification) by this Order; and

(b) "enactment" includes—

(i) an enactment comprised in, or in an instrument made under, an Act of the Scottish Parliament, and

(ii) any provision of, or any instrument made under, Northern Ireland legislation.

Registration

2.—(1) A person who, before 31st October 2003, is awarded a recognised overseas qualification which under the old section 19 of the Act would entitle him to be—

(a) fully registered under that section; or

(b) provisionally registered under the old section 21 of the Act and, on satisfying the requirements under the old section 20(2)(a) of the Act as to experience, to be fully registered under the old section 19 of the Act,

shall if he applies or has applied to the Registrar in accordance with sub-paragraph (2) or (3) below be eligible for full registration or provisional registration and subsequently full registration under the old section 19 or, as the case may be, the old section 21, as if they were still in force.

(2) An application for full registration under the old section 19 of the Act shall (except where sub-paragraph (3) applies) be made not later than 31st December 2003.

(3) An application for provisional registration under the old section 21 of the Act shall be made not later than 31st December 2003 and subsequent to that application an application for full registration may be made at any time.

(4) In this paragraph, "recognised overseas qualification" has the meaning given in the old section 19 of the Act.

3.—(1) In relation to applications under the old sections 19 and 21 of the Act—

(a) the General Council may continue to provide facilities for testing the knowledge of English of an applicant; and

(b) the old section 30(1) and the new section 30(1) of the Act shall apply as if the reference in paragraph (a) to section 19 or 20 included a reference to the old section 19 or 21 of the Act.

(2) Until article 6(11) of this Order comes into force—

(a) for section 28(2)(b) there shall be substituted—

"(b) such number of other persons (who may, but need not, be members of the General Council) as the Council may by rules prescribe and including at least—

(i) one person who is neither registered with the General Council nor a holder of any qualification registrable under this Act, and

(ii) one person who is or has been registered under Part III of the Medical Act 1956, under section 18 or 22 of the Medical Act 1978 or under section 19, 21A, 22 or 25 of this Act."; and

(b) the old section 29 of the Act shall be amended as follows—

(i) in subsection (2)(c) for the words from "by virtue of section 25" to "section 19 above" substitute "under section 25 above that he be registered under that section ", and

(ii) in subsection (3)—

(aa) in paragraph (a) for "section 20" substitute "section 19(1)(b)";

(bb) omit paragraph (b), and

(cc) in paragraph (c) omit "(a), (b),".

(3) Notwithstanding the changes to the Review Board as a result of the coming into force of sub-paragraph (2)(a) above, the new Review Board resulting from those changes shall complete any case that is being considered but has not been completed by the old Review Board before the coming into force of that sub-paragraph.

(4) Any application that is being considered by the Review Board on the date of the coming into force of article 6(11) of this Order shall be dealt with by the Review Board in accordance with the General Medical Council (Review Board for Overseas Qualified Practitioners Rules) Order of Council 1979(aaa), unless the person whose application is being considered requests that the application be transferred to a Registration Appeals Panel.

(5) If, at the date of the coming into force of article 6(11) of this Order—

(a) a decision falling within section 29(2) of the Act has been made but an application to the Review Board under section 29(1) of the Act has not been made and the period for making such an application has not expired, if any such application is made it shall be considered by a Registration Appeals Panel; or

(b) any application under section 29(1) has been made but the Review Board has not started to consider it, that case shall be considered instead by a Registration Appeals Panel.

(6) After the coming into force of article 6(11) of this Order, if a person makes an application for full registration under the old section 19 of the Act in accordance with paragraph 2(3) above, having previously been provisionally registered under the old section 21 of the Act, any decision not to direct that he shall be registered shall be an appealable registration decision for the purposes of Schedule 3A to the Act.

4. All entries in the overseas list immediately prior to the coming into force of article 9(1) of this Order shall be transferred to the principal list.

5.—(1) Any person who is fully registered or provisionally registered pursuant to the old section 19 or 21 of the Act after the coming into force of article 9(1) of this Order shall be entitled to be included in the principal list.

(2) If a person is successful in an appeal against a decision taken to erase his name from the overseas list before the coming into force of article 9(1) of this Order, the committee may, if they think fit, direct that he be included in the principal list.

Fitness to practise

6. Except as provided for in paragraphs 7 and 8 below, any allegation that has been made to the General Council concerning a medical practitioner's professional conduct, professional performance or fitness to practise prior to the coming into force of the new section 35C of this Act that has not been referred to the Professional Conduct Committee, the Committee on Professional Performance or the Health Committee shall be dealt with by the Investigation Committee in accordance with new section 35C of the Act.

7. Any case that has been referred to and is being considered by the Preliminary Proceedings Committee at the date of the coming into force of the new section 35C of this Act shall be dealt with by that Committee in accordance with old section 42 of, and old Schedule 4 to, the Act (including rules made under that Schedule), and—

(aaa) S.I. 1979/29.

(a) if the Committee decides to refer the case for inquiry, it shall be dealt with by a Fitness to Practise Panel; and

(b) the matter shall thereafter be disposed of by that Panel in accordance with paragraph 10 below.

8.—(1) Any case that has been referred to and is being considered by the Assessment Referral Committee on the date of the coming into force of the new section 35C of the Act shall be dealt with by that Committee in accordance with the rules made under the old paragraph 5A of Schedule 4 to the Act, and if the Committee decide that an assessment needs to be carried out, the matter shall be referred to the Investigation Committee to be dealt with in accordance with the new section 35C of the Act.

(2) Any case that has been referred to but has not yet been considered by the Assessment Referral Committee on the date of the coming into force of the new section 35C of the Act shall be dealt with by a Fitness to Practise Panel in accordance with the rules made under the old paragraph 5A of Schedule 4 to the Act, and if the Panel decide that an assessment needs to be carried out, the matter shall be dealt with thereafter by that Panel in accordance with the rules made under the new paragraph 5A of Schedule 4 to the Act.

9. Any reference in any enactment or instrument to a notification under the new section 35C(5) of the Act of a decision of the Investigation Committee to refer a case to a Fitness to Practise Panel shall be construed as including a reference to a notification under the old section 42(3) of the Act of a decision by the Preliminary Proceedings Committee to refer a practitioner to the Professional Conduct Committee or the Health Committee.

10. Any case which—

(a) has been referred to the Professional Conduct Committee, the Health Committee or the Committee on Professional Performance but which has not been disposed of on the date of the coming into force of the new section 35D of the Act; or

(b) is referred to a Fitness to Practise Panel after the coming into force of the new section 35D of the Act in accordance with paragraph 7 above,

shall be disposed of by a Fitness to Practise Panel either in accordance with the old sections 36 to 38 of, and the old Schedule 4 to, the Act (including rules made under that Schedule) or in accordance with the rules made under the old paragraph 5A of Schedule 4 to the Act.

11. Any reference in any enactment (including an enactment comprised in the Act) or instrument to a direction given by a Fitness to Practise Panel shall be construed as including a reference to a corresponding direction made by —

(a) the Professional Conduct Committee under the old section 36 or 38 of the Act;

(b) the Health Committee under the old section 37 or 38 of the Act;

(c) the Committee on Professional Performance under the old section 36A or 38 of, or under rules made under the old paragraph 5A of Schedule 4 to, the Act; or

(d) a Fitness to Practise Panel under either the old sections 36 to 38 of, and the old Schedule 4 to, the Act (including rules made under that Schedule) or in accordance with the rules made under the old paragraph 5A of Schedule 4 to the Act.

12. An appeal which relates to a direction or order—

(a) made under the old sections 36 to 37, 39, 41, 44 or 45 of the Act; or

(b) which was an appealable decision for the purposes of the old section 40 of the Act,

shall be dealt with in accordance with old section 40 of the Act, except as provided in paragraph 13 below.

13. Where any case would have been remitted under the old section 40(7) of the Act to the Professional Conduct Committee, the Health Committee or the Committee on Professional Performance, that case shall be remitted instead to the Registrar for him to refer it to a Fitness to Practise Panel to be dealt with under the old sections 36 to 38 of, and the old Schedule 4 to, the Act (including rules made under that Schedule) or in accordance with the rules made under the old paragraph 5A of Schedule 4 to the Act.

14.—(1) An application to the court under the old section 38 of the Act shall be dealt with in accordance with the old section 38 of the Act.

(2) An appeal from any direction of the Committee on Professional Performance given by virtue of the old paragraph 5A(3) of Schedule 4 to the Act shall lie to the court and shall be dealt with in accordance with the old paragraph 5A(4) of Schedule 4 to the Act.

15. Where, prior to the coming into force of the new section 35D of the Act—

(a) a medical practitioner has agreed to an assessment of his professional performance under rules made under the old paragraph 5A of Schedule 4 to the Act; or

(b) an assessment of a medical practitioner has to be carried out by virtue of a direction given in rules made under the old paragraph 5A of Schedule 4 to the Act,

a Fitness to Practise Panel may not direct in any proceedings relating to that assessment that his name shall be erased under the new section 35D(2) of the Act.

16. In relation to any application under the old section 41 of the Act that has not been determined by the Professional Conduct Committee on the coming into force of article 6(2) of this Order relating to a person—

(a) who was provisionally registered under old section 21 but;

(b) to whom the new section 19(2) does not apply,

the Professional Conduct Committee shall not direct that his name be restored by way of provisional registration under the new section 21 of the Act, but may instead direct that he be registered with limited registration under the new section 22 of the Act.

17. Any application under the old section 41 of the Act that has not been determined by the Professional Conduct Committee on the date of the coming into force of the new section 41 of the Act (whether or not it is brought fully into force) shall be disposed of by a Fitness to Practise Panel in accordance with the old section 41 of, and the old Schedule 4 to, the Act (including any rules made under that Schedule), but if the application relates to a person –

(a) who was provisionally registered under the old section 21 but;

(b) but to whom the new section 19(2) does not apply,

a Fitness to Practise Panel shall not direct that his name be restored by way of provisional registration under the new section 21 of the Act, but may instead direct that he be registered with limited registration under the new section 22 of the Act.

18. In relation to any application under the new section 41 of the Act relating to a person –

(a) who was provisionally registered under the old section 21 but;

(b) to whom new section 19(2) does not apply,

a Fitness to Practise Panel shall not direct that his name be restored by way of provisional registration under the new section 21 of the Act, but may instead direct that he be registered with limited registration under the new section 22 of the Act.

19. Any application under the new section 41 of the Act that has not been determined by a Fitness to Practise Panel on the date of the coming into force of the new section 41(7) of the Act shall be disposed of as if that provision were not in force.

20. Any case that is pending before the Interim Orders Committee under the old section 41A(1) or (2) of the Act on the date of the coming into force of the new section 41A of the Act shall be disposed of by an Interim Orders Panel or a Fitness to Practise Panel in accordance with the new section 41A of, and the new Schedule 4 to, the Act (including rules made under that Schedule).

21. Any case that is pending before the Interim Orders Committee, the Professional Conduct Committee, the Health Committee or the Committee on Professional Performance under the old section 41A(3) of the Act on the date of the coming into force of the new section 41A of the Act shall be disposed of by an Interim Orders Panel or a Fitness to Practise Panel in accordance with the new section 41A(3) of, and the new Schedule 4 to, the Act (including rules made under that Schedule).

22. Any application that is pending before the court under the old section 41A(6) of the Act before the date of the coming into force of the new section 41A of the Act shall be disposed of in accordance with the old section 41A of, and the old Schedule 4 to, the Act (including rules made under that Schedule).

23. Where, prior to the coming into force of the new section 41A of the Act, the Professional Conduct Committee, the Health Committee or the Committee on Professional Performance has made an order under the old section 41A(3)(c) or (d) of the Act, a Fitness to Practise Panel may in accordance with the old section 41B of, and the old Schedule 4 to, the Act (including rules made under that Schedule) do any of the things mentioned in old section 41B(2), read with the old section 41B(3), of the Act.

24. Any reference in any enactment (including an enactment comprised in the Act) or instrument to an order made by a Fitness to Practise Panel or an Interim Orders Panel under the new section 41A or 41B of the Act shall be construed as including a reference to an order made under the old section 41A or 41B of the Act by the Interim Orders Committee, the Professional Conduct Committee, the Health Committee or the Committee on Professional Performance or an order made by a Fitness to Practise Panel by virtue of paragraph 23 of this Schedule.

25. Any case that is pending before the Professional Conduct Committee under the old section 44(5) of the Act on the date of the coming into force of the new section 44 of the Act shall be disposed of by a Fitness to Practise Panel in accordance with the new section 44(5) of the Act.

26. Any case that is pending before the Professional Conduct Committee under the old section 45 of the Act on the date of the coming into force of the new section 45 of the Act shall be disposed of by a Fitness to Practise Panel in accordance with the new section 45 of the Act.

27. Any reference in the new section 45(1) of the Act to a finding of a Fitness to Practise Panel shall be construed as including a reference to a finding of a kind referred to in the old section 45(1)(a) or (b) of the Act by the Professional Conduct Committee.

28. The references in the new section 45(3) and (4) of the Act to a prohibition order under the new section 45 of the Act shall be construed as including a reference to a prohibition order imposed under the old section 45(1) of the Act.

29. For the purposes of the new section 45(6) of the Act, applications made under the old section 45 of the Act for termination of a prohibition order shall be treated as if made under the new section 45 of the Act.

30. For the purposes of the new section 45(8) of the Act, a direction under the new section 45(6) of the Act shall be construed as including a reference to a direction made under the old section 45(6) of the Act.

Miscellaneous

31. A person shall be entitled to recover any charge under the new section 46(1) of the Act notwithstanding that he does not hold a licence to practise if the charge relates to a matter which took place before the commencement of article 12(4) of this Order, and for these purposes the new section 46(3) of the Act shall apply as if the words "and holds a licence to practise" were omitted.

32. A certificate signed by a person who is fully registered but who does not hold a licence to practise shall be valid notwithstanding the new section 48 of the Act if the certificate was signed before the commencement of article 12(6) of this Order.

33. The new section 53(2) of the Act shall apply to an order of the Professional Conduct Committee, the Committee on Professional Performance or the Health Committee under the old section 38 of the Act.

34. Subject to paragraph 35, where—

(a) proceedings are pending before the Committee on Professional Performance; or

(b) an appeal against a direction of that Committee is pending,

on the date of the commencement of article 15(6)(c) of this Order in so far as it relates to the definition of "professional performance", the Committee or the court shall dispose of the proceedings as if that provision, in so far as it relates to the definition of "professional performance", were not in force.

35. An assessment carried out by virtue of the old paragraph 5A of Schedule 4 to the Act after the coming into force of article 15(6)(c) of this Order in so far as it relates to the definition of "professional performance" may include—

(a) an assessment of a registered person's professional performance at any time prior to the assessment; and

(b) an assessment of the standard of his professional performance at the time of the assessment.

36. In any case where, as a result of the provisions of this Schedule, a direction or order has been made under the made under the old sections 36 to 39, 41, 44 or 45 of the Act, any further consideration of that case otherwise than by way of an appeal shall be dealt with as if the order or direction had been made under the corresponding new sections of the Act.

37. Until the coming into force of the new section 44A(3) of the Act, if registration is refused or if a person's name is removed from the register in accordance with subsection (1) or (2) that section—

(a) the Registrar shall serve notification of the refusal or removal on that person;

(b) the Registrar shall, on request state in writing the reasons for the refusal or removal;

(c) the person may appeal by giving notice to the General Council; and

(d) any such appeal shall be determined by the General Council or, if the Council have delegated their functions under this paragraph to a committee, by that committee,

and the old paragraph 8 of Schedule 4 to the Act or the new paragraph 8 of Schedule 4 to the Act shall apply to any notification served under sub-paragraph (a) above.

38. The first Regulations made under new section 29A of the Act shall provide, except in prescribed cases or circumstances, that persons, who on the date on which any provision of those regulations comes into force are registered under the Act with full or limited registration, shall be granted a licence to practise.

IN THE MATTER OF THE MEDICAL ACT 1983

AND IN THE MATTER OF

THE GENERAL MEDICAL COUNCIL

AND

DR JANE BARTON

Patient Schedule

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

Process Server

Strictly Private & Confidential

Antony Davies

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

Rachel Cooper
Solicitor
Code A

04 June 2009

Dear Antony

General Medical Council - Dr Jane Barton

I enclose covering letters, together with original Witness Summonses and various enclosures, for the following individuals:

1. Lynn Barrett
2. Carl Jewel
3. Iain Wilson
4. Beverly Turnbull
5. Anita Tubritt
6. Margaret Couchman

I would be most grateful if you could effect personal service on the above individuals, as soon as possible and in any event prior to **4pm on Monday 8 June 2009.**

I look forward to receiving affidavits of service, at your earliest convenience and enclose a copy of the documentation to be served to assist you when preparing the affidavits.

Please do not hesitate to contact me (on either Code A should you require anything further or have any queries.

Kind regards.

Yours sincerely

Rachel Cooper
for **Field Fisher Waterhouse LLP**

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

Strictly Private & Confidential

Mr Francis Chamberlain

Code A

Our ref: RC2/00492-15579/10222805 v1
Your ref:

03 June 2009

Dear Mr Chamberlain

General Medical Council - Dr Jane Barton
Fitness to Practise Panel Hearing commencing 8 June 2009

We are instructed on behalf of the General Medical Council in respect of the above matter. We understand that you have been appointed Legal Assessor for the forthcoming hearing.

In terms of background to the case, the GMC's Counsel will forward a copy of his Opening within the next day or so, which will provide a detailed account of the events which are the subject of the allegations against Dr Barton. We trust that this will provide you will sufficient background, however, once you have reviewed Opening, should you require any further information we will be happy to provide the same.

As you will appreciate there is a large volume of documentation in relation to the case, we have therefore enclosed, with this letter, only a limited number of key documents. Copies of the Panel bundle (comprising 14 lever arch files) will be available for you at the start of the FTPP hearing, however, should you require a copy of the Panel bundle prior to this date, please let us know and one can be forwarded to you.

The documentation enclosed with this letter is as follows:

1. Notice of Hearing dated 5 May 2009

2. Professional Conduct Committee (Procedure) Rules 1988 - Rule 6(3) letter, dated 11 July 2002, from the GMC to Dr Barton.

3. Letter from the MDU to the GMC, dated 27 August 2002, in response to the Rule 6(3) letter.

4. GMC witness statements (Files 1-4).

5. Dr Barton's witness statements provided during the police investigation (File 1)

6. Expert reports and Supplemental expert reports of Professor Ford (GMC's expert) (File 1)

7. GMC witness timetable

Counsel for the GMC is Mr Tom Kark assisted by Mr Ben Fitzgerald of QEB Hollis Whiteman. Counsel for Dr Jane Barton is Mr Tim Langdale QC of 39- 40 Cloth Fair assisted by Mr Alan Jenkins of Outer Temple Chambers, instructed by the MDU.

We do not anticipate that there will be any preliminary legal arguments by either party prior to the FTP hearing commencing on 8 June 2009.

We on behalf of the GMC intend to call 34 witnesses (including our expert) to give oral evidence at the FTP hearing. We also intend to read to the FTP Panel the evidence of a further 14 witnesses, subject to Counsel's final decision and discussions with the defence. A timetable in respect of our proposed witness order is enclosed with this letter (item 7 above). You will note that the 'comments' column provides an indication of whether the witness is to attend the FTP hearing to give oral evidence or be read. A full set of witness statements is enclosed with this letter (item 4 above).

It may assist you to note that, the Preliminary Proceedings Committee decided to refer the case for inquiry before a Professional Conduct Committee of the GMC on 11 July 2002 (item 2 above). The case will, under the transitional provisions, be considered by a Fitness to Practise Panel applying the "old" rules from 1988 (as amended). By way of confirmation, the case will be subject to the criminal standard of proof.

Should you have any queries or if we can be of any more assistance, please do not hesitate to contact Rachel Cooper on 0161 200 1783, who is assisting in this matter.

Yours faithfully

Field Fisher Waterhouse LLP

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

Rachel

Christine Challis Code A

From: 3rd Floor Committee Reception Code A
Sent: 16 June 2009 11:12
To: Christine Challis Code A
Subject: RE: Dr Barton

? Gillian

Hello Christine,

I have received a call from Julian McKenzie regarding giving witness in this hearing.

Can she pleased be called back on Code A

Thanks
Ray

From: Christine Challis Code A
Sent: 16 June 2009 11:05
To: HearingCommentary-London
Subject: Dr Barton

Break for 15 mins. Mrs Couchman still under oath. Evidence in chief.

Chris

15/6/09.

RC speaking to J White (BLT) expl can't speak to GMc following GMcK's previous comments. RC read message JW to call client + find out. Call RC back.

RC taking voice-mail – JW Mrs McK does not wish to give evidence.

Rachel

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03 JUN 2009

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2 June 2009

Our Ref: 558203/000001/JCW/RICHARD/HP

Your Ref: SLE/00492-15579/102-3591 v1

Dear Sirs

Re: General Medical Council – Dr Barton
Our Client: Gillian MacKenzie

Thank you for your letter dated 1 June 2009. We are grateful for your further information. We have also passed a copy of this letter on to Mrs MacKenzie and assume that will be satisfactory.

We will, of course, let you know straight away if there is any change in respect of Mrs MacKenzie's position about giving evidence.

Thank you for your assistance.

Yours faithfu

Code A

Blake Lapth

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FILE COPY

Strictly Private & Confidential

Mr John White
Blake Lapthorn
New Kings Court
Tollgate
Chandler's Ford
Eastleigh
SO53 3LG

Our ref: SLE/00492-15579/10203591 v1
Your ref:

Sarah Ellson
Partner
Code A

01 June 2009

Dear Mr White

General Medical Council - Dr Barton
Your client: Gillian McKenzie

Thank you for your letters of 22 and 29 May 2009 and for your confirmation that you have passed on our correspondence and discussed it with Mrs McKenzie.

I note that Mrs McKenzie is quite clear that she does not want to give evidence but would like to attend as a member of the public. I do not believe that there are "passes" to be sent out in advance but I will add her name to the list of expected attendees so that she, and a representative from your firm, will be admitted to the public gallery.

It is essential that Mrs McKenzie understands that witnesses who observe the proceedings cannot subsequently expect to give evidence. Rule 35(6) of the GMC (Fitness to Practise) Rules 2004 states:

"A witness of fact shall not, without leave of the Committee or Panel, be entitled to give evidence at a hearing unless he has been excluded from the proceedings until such time as he is called."

If Mrs McKenzie attends the proceedings she is extremely unlikely to be able to give evidence if she changes her mind.

Finally as we have mentioned Mrs McKenzie did contact the GMC to stress that the Coroner considered her case to be "exceptional". As we had not seen this in writing ourselves I contacted the Coroner to confirm the position last week. His reply, for your information, was as follows:

"Ms Ellson,

I don't recall that "exceptional" was the term I used.

The circumstances of Mrs Richards death (i.e. following fall(s) and surgery) are such that had she died now rather than in my predecessor's time, I would have expected her death to be reported to me and I would have authorised an autopsy and held an Inquest. I would do this irrespective of any of the other factors relating to the other deaths at GWMH and irrespective of whether those factors might have pertained to Mrs Richards' death. In that sense, the circumstances are different to those of those other deaths. Mr Bradley shares this view with me.

I have explained this to Mrs Mackenzie, to her solicitor (Mr J White of Blake Lapthorn LLP) and to her MP. I trust that this assists you.

Please note also that I have also explained to her solicitor that I do not feel it appropriate to make representations to postpone the GMC hearing pending conclusion of the Inquest.

David C. Horsley"

The GMC asked that I pass on, via you this clarification which we have obtained. I trust this is helpful

Yours sincerely

Code A

Sarah Ellson
for **Field Fisher Waterhouse LLP**

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

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FAO: Sarah Ellson
Field Fisher Waterhouse LLP
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M1 4BD

01 JUN 2009

Our Ref: 558203/000001/JCW/RICHARD/KC

Your Ref: SLE/00492-15579/0133695

29 May 2009

Dear Sirs

General Medical Council – Dr Barton
Our Client: Gillian MacKenzie

Thank you for your letter, dated 21 May 2009.

We confirm that we forwarded copies of your letters dated 30 April 2009 and 21 May 2009 to Mrs MacKenzie. We sent a copy of your letter dated 30 April 2009 to Mrs MacKenzie on 5 May 2009 and we sent a copy of your letter dated 21 May 2009 to her on 22 May 2009.

We note that you would still like her to attend to give witness evidence on 12 June 2009. We have attempted to persuade her to give evidence, but she is adamant that she refuses to attend unless the Inquest Hearing due before the Coroner, Mr Horsley, is dealt with first. As you are aware we have contacted Mr Horsley. The only way in which this could be achieved, given the timescales, would be for the part of the GMC Hearing dealing with Gladys Richards (deceased) to be delayed. We note for the reasons you have explained that this cannot in your view be done. We have informed Mrs MacKenzie and she has also seen the correspondence as above.

Mrs MacKenzie did leave a message with ourselves that she had made a complaint to the Law Society about your firm concerning "inconsistent advice". This, we understand, relates to the contrast in approach between delaying the GMC Hearings until after the Inquest in respect of the other families, but not in the case of Gladys Richards (deceased). Insofar as there could be any question about communicating your position, we have no complaint whatsoever. You have been clear about your position in our discussions and correspondence.

We understand that Mrs MacKenzie would still like to attend the Hearing, but obviously this will only now be in the capacity as an observer. Please can you obtain "pass" for her and we will supply this to her. We would be grateful also if you could provide a pass for a representative from ourselves.

We look forward to hearing from you.

Yours faithfully

Code A

Blake Lapthorn

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22 May 2009

Our Ref: 558203/000001/JCW/RICHARD/HP

Your Ref:

2 6 MAY 2009

Dear Sirs

Re: Gosport Inquest
General Medical Council – Dr Barton
Our Client: Gillian MacKenzie

Thank you for your letter dated 21 May 2009, received by email.

We will consider this and discuss it with Mrs MacKenzie and then return to you. Thank you for your assistance.

Yours faith

Code A

Blake Lap

Regulated by the Solicitors Regulation Authority. A full list of partners is available at all of our offices.

Matter: BARTON Date: 21/5/9

Attending: MRS MCKENZIE

MESSAGE ON ~~A~~ VOICEMAIL OVERNIGHT.

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

Solicitor says
He has not heard anything about my case
Heard ~~&~~ via the press that we will go
ahead whether there or not you are there
~~[illegible]~~ + GMC gave inconsistent ~~complaint~~ advice - from
2002 making a formal complaint via the GMC
You have been informed that Mr Hawley

has said my ---- (phone cut out)

Action to be taken:

Time occupied: ______ Initials: ______

4145818 v1

Ellson, Sarah

From: Ellson, Sarah
Sent: 21 May 2009 12:03
To: Code A
Subject: Please see attached letter re G McKenzie
Attachments: Ltr to John White Blake Lapthorn 21.05.09 - 10133695_1.DOC

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
Code A

Ellson, Sarah

From: White, John Code A
To: Ellson, Sarah
Sent: 21 May 2009 16:20
Subject: Read: Please see attached letter re G McKenzie

Your message

To: Code A
Subject:

was read on 21/05/2009 16:20.

Strictly Private & Confidential

Mr John White
Blake Lapthorn
New Kings Court
Tollgate
Chandler's Ford
Eastleigh
SO53 3LG

Our ref: SLE/00492-15579/10133695 v1
Your ref:

Sarah Ellson
Partner

Code A

21 May 2009

Dear Mr White

General Medical Council - Dr Barton
Your client: Gillian McKenzie

I write further to our telephone conversation on 15 May and my earlier letter of 30 April 2009.

When we spoke last week you were understanding of the GMC position and were expecting to speak with Mrs McKenzie this week on Wednesday. At the time of our conversation Mrs McKenzie had indicated to you that she was adamant that she did not intend to attend the GMC hearing as a witness. You were going to discuss this with her again to ensure that she was aware of the options available to her should she change her mind. As I have indicated we consider we are able to run the case, including that part which relates to her mother, with or without her attendance. Although we have a power to summons a witness we would not do so in this case and very much consider it to be Mrs McKenzie's choice.

Although we have been asked to direct all communications via you, Mrs McKenzie telephoned and spoke to the GMC Investigation Officer (Juliet StBernard) last Friday (15 May). In that call she expressed concern that we had put other cases on hold to await the outcome of the Inquests but that we have not put her mother's case (Gladys Richards) on hold to await the outcome of the Inquest into her death. It was clear that she had been told of our decision (presumably most recently as a result of my letter to you and our discussion) to proceed with the GMC case, including her mother's case. She was particularly anxious as the Coroner had told her that the issues in her mother's case are different from the rest and the case is exceptional, Apparently she has had this confirmed in writing and believes I am aware of the document. (Just to clarify, it is only something she has mentioned to me that she was told – I am not aware of any written confirmation. As I understand it this was the Coroner's reason for hearing her mother's inquest separately but I have not been advised (and nor I thought has Mrs McKenzie) as to what makes it "exceptional"). From our perspective the allegations for the GMC proceedings are remarkably similar to the other cases we will be considering and relate to appropriate/inappropriate prescribing.

Mrs McKenzie requested a further explanation from the GMC in writing as to why her mother's case is not being put on hold to await the Inquest and that this should be sent to you.

Field Fisher Waterhouse LLP 27 th Floor City Tower Piccadilly Plaza Manchester M1 4BD
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We use the term partner to refer to a member of Field Fisher Waterhouse LLP, or an employee or consultant with equivalent standing and qualifications.

In addition, last night I received a telephone voice message from Mrs McKenzie confirming that she has reported me to the Law Society in relation to this matter. That is a matter I and my firm will respond to in due course. I was concerned that in her message she reported that her solicitor (you) had not heard anything about her case and that she had heard only via the press that we intend to proceed with her mother's case whether or not she is there.

The GMC have asked that I write to you again to respond to Mrs McKenzie's request for a written explanation. No doubt you will also refer her to my earlier letter of 30 April.

The decision we made to adjourn the GMC case in the summer of 2008, when the Coroner announced ten inquests and the GMC case was provisionally listed for September 2008 was the result of a different set of circumstances. Many of our witnesses were likely to be giving evidence in the Coroner's inquiry and since it then seemed likely that there could be a clash of dates, we thought it sensible to wait for them to go first. In particular, at the time we were using Professor Black as our expert witness and we knew he was giving evidence to the Coroner's Inquest. We wanted him to give evidence there first in order to ascertain the strength of our case which was based in part on his evidence. Also, and very importantly Dr Barton could not be in two places at once and so it would have been inappropriate to proceed if there was a significant danger that we would have to halt proceedings whilst the Inquiry heard her evidence.

However the current circumstances are very different. The passage of time, and the principle that we should seek to avoid delay in regulatory disciplinary hearings, provides a presumption that the case should go ahead as soon as possible. The Coroner has confirmed that he will not list the Inquest of Gladys Richards at the same time as the GMC proceedings so the issue of a "clash" has been avoided. If we try now to adjourn the entire GMC proceedings again, not only would we face very strong resistance from the defence but we would risk an abuse of process when the case re-starts which would inevitably be in 2010 due to listing schedules. We would not consider bringing a case against Dr Barton in respect of one patient alone because it is important to demonstrate a pattern of conduct.

If we were to sever Gladys Richard's case we do not consider that it would be appropriate to continue it separately on another occasion. As I explained in my earlier correspondence either Dr Barton would already have been found guilty of serious professional misconduct and a sanction imposed, in which case it would not be appropriate to proceed against her again, or, in the alternative, she would have been found not guilty of serious professional misconduct and equally it would be wrong to proceed on a single case which would seem bound to fail.

As you and I have discussed the Coroner's findings are not admissible in the GMC proceedings as the two inquiries have different roles and jurisdictions. A small window time between the conclusion of the inquests and the start of the GMC proceedings was deliberately scheduled to enable the parties to consider their position. Had the police announced a re-opening of their investigation both Dr Barton and the GMC might have had to consider whether it was appropriate to proceed. However at this stage, and with only 11 working days before the hearing commences, everyone is ready and prepared to proceed.

I hope that you can share this letter with Mrs McKenzie in response to her request for a written explanation. If there is anything further I can do to assist please let me know.

Yours sincerely

Sarah Ellson
for **Field Fisher Waterhouse LLP**

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

Matter: BARTON　　　Date: 15/5/9

Attending: John White - BLAPTHORN

Telephone call　IN (circled)　OUT　　In Person

Had long call with Mrs McKenzie
Explained we had weighed up case and were going to proceed you think (between us) in best interests for her to attend but at present she is adamant she will not.
I suggest only legal route wd be JR but no ground really
Balanced decision - you think - + you will continue to try + explain. We discuss power to summons but I will not do that for C. McKenzie
Send witness pack via you - you will continue to talk to her
We think Friday 12 June best day
3. stages - I agree most unpredictable is sanction/mitigation stage
Your Counsel. not spoken to but sure he will help if Tom wants to discuss what Dr B like to cross examine. You ask for

Action to be taken:
Packman + daughter. (Betty + Victoria) (Day 8)
Charles - Farthing + 1 (wife or friend) (Cunningham) Day
Mr Ian Wilson - (Ron Wilson) (Day 6)

Time occupied: ______　Initials: ______

Pauline Gregory x　　Diane Mussell + 1 (Ruby Lake)

Discuss ranges of dose. #take a pos. - AVMA Peter Walsh
- really v. high in your view

You'd like a pass to attend hearing in London (0.4)

Matter: BARTON

Date: 8/5/9

Attending: JOHN WHITE

BLAKE LAPTHORN 023 8085 7329

Telephone call | IN | OUT | In Person | ☐

[illegible].30 TCO Left message

4.40 TCI. Outline issues as per yesterday C. McKenzie has said to go via you all the time now. Her mothers case is to be part of GMC case. it was referred + we plan to include. We have her sister attending + staff records + expert so up to QM. if she wishes to attend (we would not summons her). If her case were not included th[illegible] very unlikely would ever get GMC hearing because either Dr Barton erased or 2ND GMC case would be abuse of process. GMC not prepared to adjourn whole case for this reason do not think necessary or appropriate to

Action to be taken: do so.

Time occupied: ____________ Initials: ____________

Her instructions to you were to dig your heels in but you understand "the train is leaving" and we are saying it is her choice whether to be involved

We discuss expert

I am authorised today to say it will be Ford - that changed back in Dec. due to Black's availability to attend this summer.

If we do have sister on board - she wants GMC case to go ahead. To the extent she has changed her view about dinner... may be questioned but may not be particularly important

Stress we look at GMP and falling below NOT so much at effect / outcome - can have a GMC case with no harm just near miss.

Will be criminal standard of proof. Discuss Inquest findings did not/will not be admissible at GMC also GMC finding does not directly answer any inquest questions - they are different. Yes we could have SPM and not strike off eg/conditions will depend on all evidence + mitigation will affect sanction eg 10 years ago. Swap names of Counsel in case they want to speak. (0.5)

→ PATRICK SADD + TOM LEEPER (Outer Temple

Matter: BARTON   Date: 7/5/9.

Attending: John White.

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

V. brief (you have to leave)

C. McKenzie has been calling wants us to speak to you. You have our letter. She v. angry we may go ahead with her case at GMC. Problem is her sister wants case to run. Also if not heard in summer may not get heard at all

Action to be taken: Can we discuss tomorrow

Time occupied: Code A   Initials: O-1

4145818 v1

FILE COPY

Strictly Private & Confidential

Ms Gillian McKenzie
Code A

Our ref: SLE/GML/00492-15579/9932927 v1
Your ref:

Sarah Ellson
Partner
Code A

01 May 2009

Dear Ms McKenzie

General Medical Council - Dr Jane Barton

I refer to our recent telephone conversation in relation to this matter.

By way of update, Tamsin Hall is currently on maternity leave and I am now being assisted by Rachel Cooper and Adele Watson, although Adele is leaving the firm at the end of May.

My colleagues and I are in the final stages of preparing the case for a hearing before the GMC's Fitness to Practise Panel ("FTPP"). The FTPP hearing is listed to begin on Monday 8 June 2009, at the GMC's hearing centre in London.

We are currently finalising, with Counsel, a list of those individuals who will be required to attend and give evidence at the FTPP hearing. The list may change depending on whether Dr Barton admits any of the allegations that are the subject of the GMC investigation.

We expect that the witnesses, called on behalf of the GMC, will be required to attend the hearing for one, or possibly two days, between **8 June and 3 July 2009**. I would be most grateful if you could inform either Rachel Cooper (telephone: Code A or email: Code A or Adele Watson (telephone: Code A or email Code A of any dates on which you will not be available during this period. My apologies if you have done this previously but we thought it would be best to have an up to date list.

May I request that you contact Rachel or Adele as soon as possible. In the event that we do not hear from you, we will work on the basis that you are available throughout the whole period. Please note that, although every effort will be made to work around your availability, there may be circumstances when this is not possible.

We expect to be in a position to finalise the witness running order within the next two weeks. Once the running order is finalised, we will be in touch with you to confirm the date on which you will be required to attend the FTPP hearing and arrangements for your travel and, if necessary, accommodation.

If it transpires that you are not required to attend the FTPP hearing as a witness, it would assist us greatly if you could please confirm whether it is your intention to attend the hearing as an observer. It is very hard to estimate what will happen on each day of the hearing. At the beginning we will outline the charge of serious professional misconduct against Dr Barton and then over the following weeks we will call evidence of the individual patient cases. Each patient's case will be considered several times during the hearing as family, nursing and expert witnesses give evidence and then the defence's witnesses, expert and Dr Barton respond. At this stage it would be impossible to say on which days any particular patient case would be considered.

Yours sincerely

Sarah Ellson
for **Field Fisher Waterhouse LLP**

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

FILE COPY

Strictly Private & Confidential

Mr John White
Blake Lapthorn
Code A

Our ref: SLE/GML/00492-15579/9976132 v1
Your ref:

Sarah Ellson
Partner
Code A

30 April 2009

Dear Mr White

General Medical Council - Dr Barton

I write further to our telephone conversation on 24 April 2009.

I understand that you act for Ms Gillian McKenzie whose mother was Gladys Richards.

We are both aware that Mr Horsley, HM Coroner for Portsmouth and South East Hampshire, has indicated that there is to be an Inquest concerning the death of Gladys Richards at some stage.

Mr Horsley has not explained to us why the matter was not joined with the other cases recently considered at inquest. He has indicated to us that the inquest is unlikely to be in June or July and we have advised him that it should not be held at the same time as Dr Barton's General Medical Council case which is provisionally listed from 8 June 2009 for ten weeks. Although we have received no formal confirmation it appears impractical to us that the inquest will be held during May, at this late stage.

In our telephone conversation I confirmed that the General Medical Council and its advisers are of the view that there is no reason why the GMC case should not now proceed. The case involves a single allegation of "serious professional misconduct" against Dr Jane Barton. The details of the case will include her treatment of a number of patients including her treatment of Gladys Richards. It is our intention to proceed with the entirety of the GMC case.

As you may be aware the case of Gladys Richards was one of the first reported by the police to the General Medical Council and was referred by a Preliminary Proceedings Committee at an early stage. We therefore will be including this case amongst others when the case opens on 8 June 2009. We do

consider it important that the case proceeds without delay and including all those example cases which we have prepared for consideration at the hearing.

The ultimate decision for the Panel will be whether Dr Barton is guilty of serious professional misconduct and if they find this proved they will go on to consider whether any steps should be taken in relation to Dr Barton's registration with the General Medical Council. One option available to them is for Dr Barton's name to be removed from the register – she would then cease to be registered or under the jurisdiction of the GMC.

You asked me to confirm the above matters in writing. As you are aware Mrs McKenzie is a witness and therefore we have been corresponding with her directly in relation to her evidence and plans in relation to her attendance at the hearing. Unless I hear to the contrary I will continue to deal with her directly on all other matters.

Yours sincerely

Sarah Ellson
for **Field Fisher Waterhouse LLP**

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

FILE COPY

Strictly Private & Confidential

Mr John White
Blake Lapthorn

Code A

Our ref: SLE/GML/00492-15579/9977002 v1
Your ref:

Sarah Ellson
Partner

Code A

30 April 2009

Dear Mr White

General Medical Council - Dr Barton

I write further to our telephone conversation on 24 April 2009.

I understand that you act for five of the ten families who were directly involved in the recent Inquests relating to Gosport War Memorial Hospital.

You enquired as to the role and any representation of the families at the forthcoming General Medical Council hearing.

The case was originally referred to the General Medical Council by the police as a "person acting in a public capacity" under the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 (as amended at the appropriate time). The only parties to the proceedings are therefore Dr Barton (as the person to whose registration the proceedings relate) and the General Medical Council who will be represented by ourselves and Counsel.

There are no provisions which allow for the representation of witnesses, families or "interested persons" given the route by which this case came to the attention of the General Medical Council. We appreciate that you and your colleagues have invested significant time and resources into investigating this matter. We too have worked very carefully to prepare the case for the General Medical Council's hearing which, of course, will primarily relate to principles of Good Medical Practise. We have been preparing the case for some time with expert assistance and will also have the benefit of transcripts from the recent Inquest.

I agreed I would clarify this for you and your clients. If you have further questions or I can be of assistance please do not hesitate to contact me.

Yours sincerely

Sarah Ellson
for **Field Fisher Waterhouse LLP**

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

Code A

T:
F: Code A

Location:
Southampton

John White
Senior solicitor
E: Code A

Dr John Charles White is dual-qualified as a solicitor and doctor. He has an established track record of successfully bringing high value complex clinical negligence cases on behalf of clients. He is a member of the Law Society Clinical Negligence Panel and has higher rights of audience for civil cases. He worked as a doctor in the NHS for five years, becoming a member of the Royal College of Physicians in 1994.

Matter: BARTON

Date: 24/4/9

Attending: JOHN WHITE

Telephone call: IN (circled) | OUT

In Person: [ ]

On train

You act for 5 families + G. McKenzie. 2 issues

① McKenzie - Richards inquest - she wants inquest first

all we know is won't be at same time - explain the

issue is not Gill Mc but Dr Barton who cannot not

be at both. Gill M is a witness. Case is SPM nor

Mother's care is one of matters originally referred we

intend to include it as an example - its all one case

hers cannot go 'last/later'. You not sure you can do

much about it can I write to confirm.

Action to be taken: ② Input for other families at GMC hearing

Time occupied: ____________ Initials: ____________

You'd also like to represent them - I explain not

complainants no locus no 'interested persons' we have

prep'd & will read transcripts - no role really

again write to confirm (6.4)

Det Supt Dave Williams
Hampshire Constabulary

Date 20 December 2006
Your ref
Our ref 4/LXM
Direct dial Code A
Direct fax
Code A

Dear Det Supt Williams

Operation Rochester

Further to the stakeholder meeting of yesterday, as we discussed we are keen to progress the GMC's investigation swiftly. Therefore, I would be grateful if you could provide, or make available to us to inspect at your offices:

1) the summary document that we discussed yesterday outlining the evidence in respect of the 10 cases that were identified for the CPS to consider, namely Elsie Devine, Elsie Lavender, Leslie Pittock, Ruby Lake, Arthur Cunningham, Robert Wilson, Enid Spurgin, Geoffrey Packman, Helene Service, and Sheila Gregory.

2) all witness statements, expert evidence, transcripts of police interviews and medical records relevant to the investigation of the above 10 cases together with any evidence that remains in your possession relating to Eva Page, Alice Wilkie and Gladys Richards.

3) an index of all evidence obtained to date.

I understand that you are awaiting consent from family members in respect of some of the documentation, but request that you provide such documentation as is available as soon as possible, even if that means providing the information in a piecemeal fashion. This will then enable the GMC to make an early assessment of the individual cases.

I look forward to hearing from you.

Yours sincerely

Luisa Morris
FOR EVERSHEDS LLP

Eversheds LLP
1 Callaghan Square
Cardiff
CF10 5BT

Tel 0845 497 9797
Fax 0845 498 7333
Int Code A
Code A
www.eversheds.com

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Index of papers

Item	Page No.
Item considered by the Preliminary Proceedings Committee on 29 August 2002	Pages 1 to 399
Index of exhibits	3
GMC letter setting out allegations	4 - 8
Correspondence received from Hampshire Constabulary (07/00 - 02/02)	9 - 18
Expert opinion of Prof Livesley (case of Richards)	19 - 52
Expert opinion of Dr Mundy (cases of Cunningham, Wilkie, Wilson, Page)	53 - 58
Expert opinion of Prof Ford (cases of Richards, Cunningham, Wilkie, Wilson, Page)	59 - 97
Letter received from Gillian MacKenzie (daughter of Gladys Richards)	98 - 99
Letter received from Charles Farthing (step-son of Arthur Cunningham)	100
Letter received from Mrs M Jackson (daughter of Alice Wilkie)	101 - 103
Letter received from Iain Wilson (son of Robert Wilson)	104
Letter received from Bernard Page (son of Eva Page)	105
The following documents relate specifically to the case of Gladys Richards	
Witness statement of Lesley Lack	106 - 125
Witness statement of Gillian MacKenzie	126 - 152
Statement of Dr Jane Barton	153 - 163
Record of police interview with Dr Althea Lord (Consultant in Elderly Medicine)	164 - 233
Record of police interview with Philips Beed (Clinical Manager/Charge Nurse)	234 - 399
Electronic copy of a letter to Dr Barton dated 11 July 2002, informing her that information from Hampshire Constabulary had been referred to the Preliminary Proceedings Committee	400 - 403
Letter from the MDU dated 27 August 2004 on behalf of Dr Barton as response to the GMC letter of 11 July 2002	404 - 431
Notification of the decision of the Preliminary Proceedings Committee to refer the information from Hampshire Constabulary to the Professional Conduct Committee dated 12 September 2002	432 - 436
Transcript of the IOC hearing on 19 September 2002	437 - 455
Electronic copy of a witness statement from Hampshire Police received 30 September 2004	456 - 466

Item	Page No.
A summary of patient records and a brief expert review of patient records for the following patients:	467 - 507

Harry Hadley
Alan Hobday
Eva Page
Gwendoline Parr
Edna Purnell
Daphne Taylor
Victor Abatt
Dennis Amey
Charles Batty
Dennis Brickwood
Charles Hall
Catherine Lee
Stanley Carby
Walter Clissold

Copies of the patient records are not in the papers but will be available to the Committee at the hearing.

Note of telephone conversation with Gillian Mackenzie

The contact centre transferred a telephone call from Gillian Mackenzie the daughter of the late Gladys Richards to me.

Mrs Mackenzie informed me that Sarah Ellson's secretary had advised her that Mike Hudspith is dealing with this case, I advised Mrs Mackenzie that I was dealing with the case and I had spoken to her last year around the time that the case had been transferred from Paul Hylton to me.

Mrs Mackenzie advised that she had concerns about a witness statement that FFW had asked her to sign. She explained that Tamsin Hall had come to see her on 19 February 2008 to take a statement and was now on sick leave. She further explained that Sarah Ellson had sent her the witness statement for signature on 7 May 2008. Mrs Mackenzie informed me that he she was not prepared to sign the witness statement as it is fictitious, contains many errors, is out of order and not logical. Further, the statement refers to enclosures that she has not seen. She considers that someone should come to see her again so that the statement can be re-done.

Mrs Mackenzie is also concerned about the delay in time between FFW taking a statement from her and sending the statement to her for signature.

Mrs Mackenzie expressed concern that the GMC case is going to be considered before the FTP case. She informed me that she asked David Horsley why her mother's case was not going to be included in the Inquest and his view is, if you don't like it take me to the High Court, which she considered to be unsatisfactory.

Mrs Mackenzie also informed that she is of the view that the police had lied in the CHI report.

Mrs Mackenzie informed me that she had asked Sarah's secretary to tape record their telephone conversation this morning so that Sarah will be aware of her concerns. The secretary confirmed that the conversation was being taped. I advised Mrs Mackenzie that Sarah was currently out of the country and expected back on Thursday and I would also discuss this matter with her. I also gave Mrs Mackenzie my direct telephone number.

A few minutes later Mrs MacKenzie rang me again. She advised that she knew I wouldn't be able to comment but wanted to let me know that someone had informed her that when Matthew Lohn was assisting with the police investigation he would not sign off the case as finished. Before I could make any comment, Mrs Mackenzie thanked me and terminated the call.

Code A
2 June 2008

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

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

Fax: 023 9268 8331

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

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
Tel: Code A
Email: Code A

cc Mr A Bradley

General Medical Council

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:

   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.

SIGNED: ......Code A........ DATED: 27 February 2008

Peter Swain
Head of Case Presentation

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

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
P016 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

20 APR 2010

QEB
HOLLIS
WHITEMAN

Regards from
Tom Kark QC.

With Compliments

QEB Hollis Whiteman
3rd Floor, Queen Elizabeth Building, Temple, London EC4Y 9BS
Code A Telephone 020 7583 5766 Fax 020 7353 0339
barristers@qebholliswhiteman.co.uk www.qebholliswhiteman.co.uk

COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE
NOTE OF SECTION 29 CASE MEETING ON 23 MARCH AND 29 MARCH 2010

DR. JANE ANN BARTON

PRESENT: Harry Cayton (in the Chair)
Michael Andrews
Tim Bailey

IN ATTENDANCE: 23 March 2010
Briony Mills (Senior Scrutiny Officer, CHRE)
Bethan Bagshaw (s29 Legal Secondee, CHRE)
Joanna Ludlam (Baker & McKenzie LLP, Legal Advisor)
Peter Mant (Counsel, 39 Essex Street, Legal Advisor)

29 March 2010
Briony Mills (Senior Scrutiny Officer, CHRE)
Bethan Bagshaw (s29 Legal Secondee, CHRE)
Tom Cassels (Baker & McKenzie LLP, Legal Advisor)
Mark Richardson (Baker & McKenzie LLP, Legal Advisor)
Peter Mant (Counsel, 39 Essex Street, Legal Advisor)

1. DEFINITIONS

In this note the following abbreviations will apply:

"CHRE"	The Council for Healthcare Regulatory Excellence
the "Members"	CHRE as constituted for this Section 29 case meeting
"*Ruscillo*"	The decision of the Court of Appeal in CHRE v Ruscillo [2004] EWCA Civ 1356
the "2002 Act"	The National Health Service Reform and Health Care Professions Act 2002
the "Panel"	The Fitness to Practice Panel of the General Medical Council
the "GMC"	The General Medical Council

2. THE RELEVANT DECISION

The relevant decision is the Panel's determination on 29 January 2010 that Dr Barton was guilty of multiple incidences of serious professional misconduct, and imposing conditions on Dr Barton's registration for a period of three years.

3. DOCUMENTS BEFORE THE MEETING

The following documents were available to the Members:

3.1 Transcripts of the hearing dated between 8 June 2009 and 20 August 2009 and 20 - 29 January 2010;

3.2 Exhibits put before the Panel;

3.3 Determination of the Panel dated 29 January 2010;

3.4 Correspondence received from the public, including a letter from Blake Lapthorn dated 23 March 2010, received at the start of the meeting;

3.5 GMC's Good Medical Practice;

3.6 Section 29 Process and Guidelines;

3.7 GMC's Indicative Sanctions Guidance;

3.8 Order of the Interim Orders Panel dated 12 November 2009;

3.9 Lawyers' report prepared by Baker & McKenzie LLP dated 9 March 2010;

3.10 Note of Advice prepared by Counsel dated 2 March 2010; and

3.11 Supplementary Note to Advice prepared by Counsel dated 9 March 2010.

4. CONFLICTS OF INTEREST

The Chair asked whether the Members had any apparent conflict of interest. No conflicts were declared. The Chair confirmed that the Members convened had no conflicts of interest and none were registered.

5. JURISDICTION

The Members confirmed that they were satisfied that CHRE had jurisdiction to consider this case under Section 29 of the 2002 Act, and noted that this section 29 case meeting was taking place within the statutory time for an appeal, which would expire on 5 April 2010. As 5 April 2010 falls on Easter Monday, the last day to lodge an appeal will be 1 April 2010.

The purpose of this section 29 case meeting was to consider this case in full under Section 29 of the 2002 Act.

6. APPLYING SECTION 29 OF THE 2002 ACT

Undue Leniency

The Members noted that the test they had to apply when considering "undue leniency" is whether the decision was one which the Panel, having regard to the relevant facts and to the objective of the disciplinary proceedings, could reasonably have imposed.

The question is whether the decision of the Panel was "manifestly inappropriate" having regard to Dr Barton's conduct and the interests of the public (*Ruscillo*). The Members noted that it was not enough that they themselves might have come to a different view.

The Members considered the legal principles governing sanctions. They noted that the purpose is not to punish the practitioner for misconduct, but to protect the public (which included protection of patients, maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour).

The Members noted that, when assessing public protection, the Panel must have regard to the Indicative Sanctions Guidance, although it was accepted that the Indicative Sanctions Guidance is not a rigid tariff. They also noted that the Panel should consider all aggravating and mitigating factors. Mitigation might consist of evidence of the doctor's understanding of the problem and attempts to address it, as well as evidence of the practitioner's overall adherence to important principles of good practice. Mitigation could also relate to the circumstances leading up to the incidents, testimonials, lack of training or supervision at work.

The Members then considered the series of points set out in the Guidance, most or all of which should be present for conditions to be imposed. The points are as follows:

- No evidence of harmful deep-seated personality or attitudinal problems.
- Identifiable areas of the doctor's practice in need of retraining.
- Potential and willingness to respond to retraining.
- Willingness to be open and honest with patients if things go wrong.
- Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.
- It is possible to formulate appropriate and practical conditions.

The Members went on to consider the evidence relevant to sanction, noting that the Panel had the benefit of hearing the evidence first-hand, and that the Members should accord due respect to this fact.

The Members observed that Dr Barton had stated, in evidence, that she would not do anything differently if she was presented with the same circumstances today. They noted the Panel's finding that she displayed a "worrying lack of insight" and its concern at her intransigence. Although the Members noted that Dr Barton had admitted certain allegations (such as the range of doses being too wide), they considered that the admissions were in fact limited, and that there was no admission in relation to key findings. In particular, she did not admit that any of her actions had not been in the best interests of her patients.

The Members further noted Dr Barton's disregard for guidelines, and considered the evidence suggested that it was arguable that Dr Barton had an attitudinal problem. The Members doubted whether, if she considered she had done nothing wrong, it was possible for Dr Barton to be retrained.

When undertaking the consideration as to whether the decision of the Panel was unduly lenient, the Members noted the mitigating factors that had been raised in Dr Barton's favour. In particular, Members noted the evidence regarding Dr Barton's working conditions, the lack of regular consultant cover and Dr Barton's evidence that her prescribing practices were necessitated by circumstances. However they also noted that in stating that she had done nothing wrong and that she would do the same again Dr Barton was not claiming that her working circumstances were the only reason for her practice.

The Members noted that failing to keep accurate patient records is a serious matter. They noted the Panel's comment that poor record keeping by Dr Barton had contributed to the difficulties in deciding the case. The Members observed that this failing might well apply to all aspects of Dr Barton's practice, not just in the context of palliative care. The Members further observed that the conditions, as drafted by the Panel, were arguably not wide enough to embrace the concerns as to record keeping in Dr Barton's general practice. Practising in a group of at least four doctors did not guarantee appropriate record keeping by Dr Barton. On the other hand the Members noted the testimonials from Dr Barton's peers, observing that the appraisers had not raised any concerns as to Dr Barton's note-taking.

The Members made similar observations in relation to the Panel's finding that Dr Barton had fallen short of maintaining trust by respecting the views of patients. Again, this failing might conceivably apply to Dr Barton's general practice, not just her conduct in the context of palliative care, and it was not certain that the conditions, as formulated by the Panel, are sufficiently broad and specific to protect individual patients and the public. The Members once again noted, however, the positive testimonials of Dr Barton's peers.

The Members considered that it was practically possible to draft appropriate conditions to address the failings of Dr Barton. The Members noted, however, the numerous findings of serious professional misconduct, and expressed their concern that the conditions, as drafted, fail to address all the matters where Dr Barton's conduct fell short of being acceptable, especially in relation to her failure to keep proper medical records, to respect patients' views and to assess properly a patient's condition before prescribing. These were all areas which were relevant to Dr Barton's general practice as well as palliative care. Nevertheless, Members also stated that it would be difficult to conclude that the conditions were inadequate to meet their objectives, which would be required in order to conclude that they were a manifestly inappropriate sanction to impose in the circumstances.

The Members were concerned by the findings of the Panel in relation to Dr Barton's lack of insight and her failure to acknowledge her mistakes and apologise for them.

The Members noted the seriousness of the case, affecting as many as twelve aged and vulnerable patients. They noted the Indicative Sanctions Guidance applicable to erasure which set out a series of bullet points, any of which "may well" make erasure the appropriate sanction, in particular "persistent lack of insight into seriousness of actions or consequences". The Members considered that these bullet points could be said to apply to Dr Barton but did not feel able to draw a final conclusion on the issue of undue leniency without obtaining further legal advice.

Public Protection

The Members then considered the question of whether the imposition of conditional registration was appropriate to protect individual patients and the wider public interest (including upholding the reputation of the profession and declaring and upholding standards). The Members expressed their grave concern at the number of patients involved, the breadth and seriousness of the findings of serious professional misconduct and Dr Barton's cavalier attitude to the guidelines. Members considered that there remains a possibility that Dr Barton's attitude, views and practice could give rise to different dangers in another context. The Members observed that a doctor who does not follow evidence-based guidelines may be seen to put her patients at risk.

The Members adjourned in order to take the required advice, which would include advice on the likely prospects of an appeal being upheld, and will reconvene as soon as that legal advice is available and in any event in order to take a decision before 1 April 2010.

7. RECONVENED MEETING ON MONDAY 29 MARCH 2010

The Chair asked whether any events had taken place which presented a conflict of interest since the meeting was adjourned on 23 March 2010.

No conflicts were declared. The Chair confirmed that the Members convened still had no conflicts of interest and none were registered.
The Chair opened the reconvened meeting by informing the Members that two issues had arisen since the meeting was adjourned:

1. Additional legal advice had been obtained from Robert Jay Q.C.; and
2. Confirmation of Dr Barton's current employment status had been obtained.

As to the second point listed above, the Members noted that CHRE had been informed that Dr Barton had resigned from her GP practice and intended to retire on 31 March 2010. Members observed that although Dr Barton currently remains on the GMC's register, it would appear that it is her intention not to return to practise.

Undue Leniency

Members expressed some concern that certain elements of the Indicative Sanctions Guidance pointed toward erasure as being the most appropriate sanction to reflect Dr Barton's actions. However, Members concluded that the findings of the Panel were not fundamentally incompatible with her continued practise as a doctor. It was also noted by Members that a measure of deference should be accorded to the Panel in a decision of this nature, where a detailed assessment of the registrant's medical practice is required.

Having taken legal advice, plus all of the other materials that had been put before them, Members concluded that although the sanction imposed on Dr Barton was lenient, it was not unduly lenient according to the established tests laid down in *Ruscillo* and subsequent cases.

Public Protection

Members noted the new information that Dr Barton was due to retire from practice within the next couple of days. Members noted that this did not mean that she would be unable to practise but that she would remain under the same conditions if she did so. Members considered this when determining the public protection issues that arose.

Members noted some concern that erasure may be required to uphold the reputation of the profession. It was agreed that the test to be applied was whether an informed member of the public would demand that Dr Barton be erased. Although Members agreed that this was not a straightforward decision, they concluded that this test would not be met on the facts.

In reaching this conclusion, Members took into account a number of considerations, including the mitigating factors that Dr Barton was able to put before the Panel, which had to be considered both when determining whether serious professional misconduct had occurred and when considering the sanction imposed.

There were two types of mitigation; the circumstances in which Dr Barton was working at the time of her misconduct and the testimonials from both patients and colleagues that she had practised safely in the interim.

These would also have to be included in the informed member of the public test. Members also noted that, for the same reasons, an appeal to Court would be unlikely to be upheld and that an informed member of the public would consider that the costs to the public purse would not justify referral to Court.

Members also noted that there was no convincing evidence that Dr Barton posed a threat to the public or individual patients, particularly in the light of the restrictions imposed by the conditions and by her impending retirement. As such, the threat of any repetition by Dr Barton of her misconduct was low and a referral was not required to protect members of the public or individual patients.

8. CONCLUSIONS

Members concluded that they considered erasure to be the most appropriate sanction in the circumstances of this case. There were three factors that influenced this determination:

1. The leniency of imposing conditions on Dr Barton's registration given the facts of the case
2. The need to uphold confidence in the medical professions: and
3. The need to maintain public confidence in the regulation of the medical professions.

Nevertheless, Members concluded that the tests for referral under s29 of the 2002 Act, as developed in subsequent case law, had not been met in this case.

As there were no further issues for consideration, the Chair declared the meeting closed.

Signed: Code A

Date: 31 March 2010

Harry Cayton
Chair

STATEMENT

Immediate: 31 March 2010

Dr Jane Barton: GMC Panel decision 'lenient but not unreasonable in law' review finds.

The Council for Healthcare Regulatory Excellence (CHRE) has reviewed the decision of the GMC Fitness to Practise Panel to allow Dr Jane Barton to continue practising as a doctor under conditions[1].

CHRE has every sympathy with the families concerned with the deaths of patients treated by Dr Barton at Gosport Memorial Hospital and understands the strong feelings they and many others have. Medical regulation, however, is not about punishment or blame but about whether or not a doctor is fit to practise medicine.

The GMC panel found that, although Dr Barton made many errors in the past, she could practise safely with the restrictions that the panel placed on her work.

It is the opinion of CHRE that erasure should have been the result of this case. Erasure would have ensured that patients were fully protected. Erasure would have maintained confidence in the medical profession and ensured that the public retained trust in the system of regulation. The GMC panel's decision in our view was lenient but not so unreasonable that it could be appealed.

We have carefully reviewed all the evidence and the panel's thinking. We have concluded that although we do not agree with their decision it was reasonable in law for them to reach that conclusion.

We note that Dr Barton has retired from clinical practice although she remains on the GMC register and that, if she were to work, the restrictions set by the panel would remain in force.

The legal test that we must pass has not been met[2] and therefore CHRE cannot refer the decision to the High Court.

ENDS

[1] Decision of the GMC Fitness to Practise Panel, 29 January 2010

[2] For CHRE to refer a decision by a health professional regulator to the High Court it must find the regulator's decision to be 'unduly lenient' and 'manifestly inappropriate'. It must also be necessary for the protection of the public.

NOTES TO THE EDITOR

1. The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies that set standards for training and conduct of health professionals.

   We share good practice and knowledge with the regulatory bodies, conduct research, and introduce new ideas about regulation to the sector. We monitor policy in the UK and Europe and advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

2. The Council for Healthcare Regulatory Excellence (CHRE) is the overarching, independent body overseeing the regulatory work of nine regulatory bodies:

   - The General Chiropractic Council
   - The General Dental Council
   - The General Medical Council
   - The General Optical Council
   - The General Osteopathic Council
   - The Health Professions Council
   - The Nursing and Midwifery Council
   - The Pharmaceutical Society of Northern Ireland
   - The Royal Pharmaceutical Society of Great Britain.

3 For further details of CHRE's work please visit or to view the full report of CHRE's case meeting visit : www.chre.org.uk

GENERAL MEDICAL COUNCIL

DR JANE BARTON

STATEMENT

Responding to the CHRE's decision, Niall Dickson, Chief Executive of the General Medical Council said:-

"This was a complicated and difficult case which has caused anguish and upset to a great many people. We understand and support the view of the CHRE that Dr Barton should have been erased from the medical register but also understand and accept the legal position in relation to an appeal."

Rachel Cooper. ✓

COPY
Field Fisher Waterhouse

Code A
General Medical Council
3 Hardman Street
Manchester M3 3AW

Code A

21 APR 2010

15 April 2010

Dear Code A

Thank you for your letter 1 April under reference VB/2000/2047/02 together with a copy of the Council for Healthcare Regulatory Excellence (CHRE) statement in respect of Dr. Barton;s case.

I note the Chief Executive, Mr. Dickson's response to the decision – I do not know who is responsible for the GMC public relations but in view of the Panel's extraordinary decision , a personal letter from Mr. Dickson to each of the families involved would have been more appropriate. I can only assume that Mr. Dickson is unaware of the incompetence of some of his staff in not informing the Panel or perhaps Field Fisher Waterhouse of action taken in the past . I hope you were also informed as the second Case worker involved the case since 1999. Paul Hylton was the first but was taken off the case. The shambles of switching Solicitors to Eversheds and back again I understand was your decision – and of course I am aware that at least one other case was put forward to the GMC (Mike Wilson)

I think it is particularly relevant that the Panel should have been made aware of the fact that sanctions were imposed on Dr. Barton when dealing with my case during the 2000-2002 period and these were only lifted when the CPS decided there was insufficient evidence for my case in 2001 and the Hampshire Constabulary refused to investigate other cases. Dr. Barton accompanied by Dr. Lord visited the GMC for an interview and was told the sanctions would be lifted. In response Dr. Barton suggested that the sanctions could carry on, on a voluntary basis "earning herself brownie points" – indeed she did . With the voluntary sanctions in place she had a clean bill of health for the last ten years. In addition she had resigned from the Gosport War Memorial Hospital. This resignation had nothing to do with pressure of work but due to a difficult interview with the police when she realised the complaints brought to the attention of the Health Authority were not going to go away. In addition she resigned from the Rowan House Hospice. I dread to think how many cancer patients were also "hurried on their way". In view of the fact that she was involved in Rowan House she would have been well aware of the analgesic ladder and guidelines in palliative and terminal care drugs. She should have been aware also of the work of Dame Cecily Saunders and her guidelines adopted throughout the world. Cecily would be turning in her grave. Who was responsible for Barton's appointment there and who supervised her ? Anyone dealing with death and bereavement in the field of counselling has to have a trained "supervisor" If trained counsellors are deemed to be at risk of developing stress or psychological problems why is it assumed that Doctors are immune which is not in the best interests of the patients and can lead to a lack of empathy with the family members. The personality problems presented at the GMC hearing appear to have been glossed over by the Panel - never was a description more true than that the Panel was made up of "lay" members – I would put it more strongly.

I would further emphasise that Dr. Barton was well aware that Mrs. Lack and myself had made complaints from the beginning but carried on and further deaths occurred. This was further complicated by the Hampshire Police incompetence from the beginning. No doubt you are aware that two formal complaints against officers were upheld in my case by the PCA and the IPCC.

I am far from confident that the sanctions imposed safeguard the safety of the public. Should Dr. Barton apply to practise again may I be confident that the families involved would be advised although any employer taking such a risk should not be involved in recruitment ? May I also add quite vehemently that the 12 families were the least of my concerns, what about the other 80 families who approached the police - they certainly did not have their cases investigated thoroughly.

I can only hope that eventually cases will be heard in the criminal Court followed by the Public Inquiry when the part played by the GMC and other "safe practice" organisations will be fully examined. Confidence in the medical profession or the GMC has not been enhanced by these cases or the Panel's decision.

I am sending a copy of this letter to Mr. Dickson – the buck stops at his desk. I hope he will have the good manners to respond, for this matter has not ended for the GMC, members of his staff or himself.

Yours sincerely.

G.M.Mackenzie

CC . Mr. N.Dickson
Field Fisher Waterhous

Code A

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.

Code A

Signature: Date: 9 July 2008

4.22 There is no explanation in the notes for the apparently high doses of drugs used to relieve her symptoms considering her age of 88 years and her previous lack of use of analgesia. It is possible that the medication did shorten her life by a short period of time but she was also out of distress for the last 58 hours.

5. OPINION

5.1 Mrs Elsie Devine presents an example of the most complex and challenging problems in geriatric medicine. This incluluded progressive medical and physical problems causing major clinical and behavioural management problems to all the care staff she comes into contact with.

5.2 However there were significant failing in the medical care provided to Mrs Devine, in particular:

- The failure to undertake a physical examination of the patient on admission to the Gosport War Memorial Hospital, or if it was undertaken the failure to record in the notes.
- The prescription of PRN Oramorphine in admission to the Gosport War Memorial Hospital in a patient with no recorded pain or condition likely to need Oramorphine.
- The failure to see the patient between the 1st – 15th November yet to order blood tests and antibiotics, or if she was seen, to make a record in the notes.
- The failure to make any medical notes or explanation on the 18th November as to why Fentanyl was started and why the dose chosen was used.
- The failure to provide any explanation for the use of Diamorphine and the choice of an apparently high starting dose in the syringe driver.

5.3 There was also deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, in particular:

- The 'Regular' prescription of Fentanyl is never crossed off the drug chart although replaced by the syringe driver.
- Prescribing a range of doses of both Diamorphine and Midazolam on the regular side of the drug chart.
- The failure to write dosages of controlled drugs in words and figures as well as total dosages given.

6. EXPERTS' DECLARATION

4.17 She is then written up for Diamorphine and Midazolam by subcutaneous infusion and the Fentanyl patch prescribed the previous day is removed. There was a three-hour overlap in the prescription of these drugs but this is unlikely to have had a major clinical effect. There is also a discussion regarding her status with a member of her family. There appears to be no dissent as to the appropriateness of her proposed care with either the nurses or the family.

4.18 Two drugs are used, Diamorphine and Midazolam intravenous infusion pump. The main reason for using both was terminal restlessness. There is no doubt that Midazolam is widely used subcutaneously in doses from 5 – 80 mgs per 24 hours. The dose of Midazolam used was 40 mgs per 24 hours, which is within current guidance although many believe that elderly patients may need a lower dose of 5 – 20 mgs per 24 hours (Palliative Care. Chapter 23 in Brocklehurst's Text Book of Geriatric Medicine 6th Edition 2003).

4.19 The addition of Diamorphine is more contentious. Although there was serious restlessness and agitation in this lady, no pain was definitively documented and Diamorphine is particularly used for pain in terminal care. Diamorphine is compatible with Midazolam and can be mixed in the same syringe driver. However, despite the lack of pain Diamorphine is widely used, and believed to be a useful drug, in supporting patients in the terminal phase of restlessness. One study of patients on a long stay ward (Wilson J.A et al Palliative Medicine 1987; 149 – 153) found that 56% of terminally ill patients on a long-stay ward received opiate analgesia. The dose of Diamorphine actually prescribed was 40 mgs. The normal starting dose for pain, of morphine, is 30 – 60 mgs and Diamorphine subcutaneously is usually given at a maximum ratio of 1:2 (i.e. 15 – 30 mgs). Mrs Devine was prescribed on an unusually high starting dose of Diamorphine although probably equivalent to the dose of Fentanyl already started. There is no explanation of this decision in the notes.

4.20 24 hours later Mrs Devine is reported to be comfortable and without distress, she finally dies approximately 58 hours after starting the mixture of Diamorphine and Midazolam, and as far as can be deciphered from the notes, without distress.

4.21 The prediction how long a terminally ill patient will live is virtually impossible and even palliative care experts show enormous variation (Higginson I.J. and Costantini M. Accuracy of Prognosis Estimates by 4 Palliative Care teams: A Prospective Cohort Study. BMC Palliative Care 2002 1:1.) I believe that it is certainly possible; that without any treatment, considering her creatinine of 360 on 16th November, she would have been dead on the 21st November.

4.13 There is no doubt this lady is now very seriously ill. The question that would have to be answered between the 15th and 19th,was this a further acute event that could be easily reversed. The straightforward investigations had been performed and the decision would presumably be to have to return the lady to the District General Hospital for further investigation and management, possibly even on a high dependency unit. The other possible decision to be made was that this was a progression of a number of incurable problems and actually she was terminally ill. In these circumstances the decision would then be to decide what form of symptomatic or palliative care was most appropriate.

Mrs Devine was seen by Dr Reid on 15th and Dr Barton may have seen her on the on 18th, the day Fentanyl was started. This should be clarified as no clinical note is made on the 18th. This is poor practice.

4.14 It may have been in the mind of the doctor who (possibly) saw her on 18th that she probably was terminally ill. Evidence for this is that she started her on a Fentanyl patch on top of the regular Thioridazine, which she was already receiving. However, the logic of starting the Fentanyl patch is not explained in the notes, and the psychiatric doctor who saw her the same day thought her physical condition "was stable". Further Fentanyl is a slow release opioid analgesic, which the BNF states it is not suitable for acute pain or when rapid changes in analgesia are required. The reason is that although Fentanyl 25 is the equivalent of 90 mgs of Morphine a day it will take several days to get to a steady state drug leve. However, the normal starting dose of Morphine for pain is 30 – 60 mgs a day thus the lack of explanation for the choice of Fentanyl, or the dose chosen, in a patient without documented pain is poor clinical practice.

4.15 It is my opinion, certainly by the 19th November, this lady was terminally ill and it was a reasonable decision to come to this conclusion. However, it is possible that her more rapid deterioration was due to the use of Fentanyl on top of her other medical problems. Equally not all clinicians would come to exactly the same conclusion and some might have referred her back to the DGH when a creatinine of 360 was noted on 16th November. However, on balance I believe that many clinicians would come to the same conclusion after a month in hospital.

4.16 Having made the decision that the lady was terminally ill, the next decision was whether or not to offer palliative care. Mrs Devine was reported as extremely restless and aggressive and in some distress. In my view it would now be appropriate to provide high quality palliative care.

she had an extremely low albumin of 18, probably one of the strongest markers of a poor outcome. Serum albumin is an indirect marker of nutritional status, in particular a marker of protein metabolism. A low albumin and poor nutritional status makes a patient highly susceptible to infection, pressure sores and an inability to cope with the physiological stresses.

4.9 On 25th October she appears to be stable in the ward environment at Gosport, however, by the 1st November there has been a deterioration and she is noted to have become quite confused and is wandering again.

4.10 On admission under the routine drugs that were prescribed, it is noted that both Hyoscine and a dose of Diamorphine were written up prn. No explanation of this management decision is made in the notes, nor has any pain been recorded in the notes.

4.11 There are no medical notes between the 1st November and the 15th November at which time she is noted to be very aggressive and very restless, there must have been clinical deterioration over that period of time. Blood tests are sent on 9th November (289) and an MSU has also been sent and reported on 11th November (363) although this is normal. It is unlikely that these tests would have been done if there had not been a significant change in her condition. Indeed, it appears that she was put on antibiotics for a presumed (subsequently proved mistakenly) urinary tract infection. Either the tests and antibiotics prescription were undertaken without seeing the patient, or the patient was seen and no record was made in the notes. Both would be poor medical practice.

The drug chart analysis also demonstrates she was now receiving regular Thioridazine, an anti-psychotic medication which is often prescribed for significantly disturbed behaviour in older patients. The change in behaviour noted, the new medication started, the antibiotics prescribed (277,276) and the blood and urine tests carried out (289,363) all suggest a significant change in condition. Yet the lack of medical notes makes a proper assessment of the situation difficult and is poor clinical practice.

4.12 The simple investigations and pragmatic management does not work though. By 18th November she has deteriorated further, is very restless and confused and is now refusing medication. Further blood tests have been carried out on 16th November that now show that creatinine has almost doubled to 360 and her potassium is 5.6. She is now in established acute on chronic renal failure. A patient who is already frail and running with a creatinine of over 200 can extremely rapidly decompensate and become seriously ill. On 19th November there is further marked deterioration overnight.

the year. Such confusion is often missed in hospital appointments, although the comment that she did not bring her drugs or know what drugs she was taking in September 1999 (40) is a marker of probable mental impairment. The notes fail to come to any definitive diagnosis as to whether this is Alzheimer's disease or vascular dementia. This is difficult and cannot be criticised. It is probably more likely to be vascular dementia on its basis of its moderately rapid progression, and that she had another systematic illness going on identified by the renal physician as probable glomerulonenephritis.

4.6 When admitted to the Queen Alexandra Hospital with significant behavioural problems the original working assumption was that this was an acute event, caused by a probable underlying infection. However, no infection was ever demonstrated on the investigations ordered, and no pyrexia was identified, although the admission notes are missing. It is likely that her behaviour had gradually been deteriorating, the crisis then occurred with the social crisis in her family. Admitting patients acutely to hospital will often exacerbate confusion in an already underlying dementing illness.

4.7 The natural history of most dementia's is of some fluctuation on a downward course, both in terms of symptoms and progression of the underlying disease. When seen by the mental health team on 15th October (28), though her behaviour was not seriously disturbed at that time, they documented a mini-mental state examination of 9/30 indicating moderate to severe underlying dementia. The mental decline had been rapidly progressive over the same year, as had her physical decline. Although she received Haloperidol at Queen Alexandra, and Thioridazine at Gosport I think it is unlikely that any therapeutic intervention significantly altered the progression of either her mental or her physical deterioration.

4.8 On admission to Gosport Dr Barton writes in the notes that the patient has Myeloma (a malignant disease) rather than the Paraproteinaemia (a pre-malignant condition) that has actually been diagnosed. She may have mistakenly believed that she had a progressive cancer as well as her dementia and renal failure. This (not uncommon mistake by non-specialists) might have influenced the management of care, by making Dr Barton think the patient had an untreated malignant condition.

There is no physical examination of the patient on admission, or if there was, it is not recorded in the notes.

When transferred to the Gosport Hospital on 21st October, probably to await nursing home placement, she had a number of markers suggesting a very high risk of in-hospital death. She had been in hospital over two weeks, the longer you are in hospital the more likely you are to die in hospital. She had a possibility of delirium on top of a rapidly progressive dementing illness, again a marker of high in-hospital mortality and finally,

		2.5 – 5 mls PRN		
Fentanyl	18/11	25 µg Skin – 3 days Regular	Barton	18/11 0915
POSSIBLE NEW DRUG CHART				
Diamorphine	19/11	40 - 80 mgs S/C in 24 hours Regular	Barton	19/11 0925 40 mgs 20/11 0735 40 mgs 21/11 0715 40 mgs
Midazolam	19/11	80 – 120 mgs S/C in 24 hours PRN	Barton	19/11 0925 40 mgs 20/11 0735 40 mgs 21/11 0715 40 mgs

4. TECHNICAL BACKGROUND / EXAMINATION OF THE FACTS IN ISSUE

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

4.2 In particular I will discuss:
a) whether it was appropriate to decide on 19th November that Mrs Devine was terminally ill and if so whether symptomatic treatment was appropriate and
b) whether the treatment that was provided was then appropriate.

4.3 Mrs Devine had progressive mental and physical deterioration starting in January 1999. Before that she had had relatively minor medical problems, a normal haemoglobin and creatinine and was put on a waiting list for a knee replacement at the end of 1998. Orthopaedic surgeons do not generally list people for knee replacements if they look or are significantly frail. Such patients tend to make poor functional recoveries.

4.4 Mrs Devine's physical deterioration can be marked by her slowly falling haemoglobin from 13 in 1998 (317) to 9.9 (289) in November 1999. Her albumin also falls and is documented at 22 in July 1999 (52) then extremely low at 18 (349) on admission to Gosport. At the same time her creatinine rises over the course of the year from 90 in 1998 to 160 in June 1999 and around 200 on admission to the Queen Alexandra Hospital in October 1999. The physicians, including the renal physician and the haematologist that she saw, all conclude this was a progressive problem with no easily treatable or remedial cause. The small kidneys shown on ultrasound usually suggest irreversible kidney pathology. I would agree with that assessment.

4.5 The history taken by the mental health team from her daughter, also describe mental deterioration and increasing confusion over the course of

(156). The nursing notes (222) confirm marked deterioration over last 24 hours. "Chlorpromazine given IM. 9.25. Subcut syringe commenced Diamorphine 40 mgs and Midazolam 40 mgs, Fentanyl patch removed. Son seen by Dr Barton at 13.00 and situation explained to him. He will contact his sister regarding and inform her of Elsie's poor condition. 20.00 daughter visited and seen by Dr Barton. Nocte: peaceful night syringe driver recharged at 07.25."

3.17 20th November the nursing notes (223) state, "condition remains poor, family have visited and are aware of poorly condition. Seen by Pastor Mary. Nocte: peaceful night extremities remain oedematous, skin mottling, syringe driver changed at 07.15. Dose of Diamorphine 40 mgs. Midazolam 40."

3.18 21st November. Nursing notes (223), "condition continues to deteriorate slowly. Asked to see at 20.30 hours patient died peacefully"

3.19 Barthel scores are recorded on 21st October 8; 31st October 16, 17th November 10; 14th November 10; 21st November 1 (202) Her weight on 21st October was 52.5 kgs (200).

Drug Chart analysis: 1 dose of Haloperidol was given in the Queen Elizabeth hospital on the 13th October (269). Drug chart at Gosport showed a single dose of Chlorpromazine given at 08.30 on 19th November (277) confirming the nurses' cardex.

The patient had received regular doses of Thioridazine (often given for confused behaviour) from the 11th November up unto 17th November (277). A small dose of prn 2.5 – 5 mgs Oramorphine had been written up on admission to Gosport but had never been prescribed. Hyoscine had also been written up and not prescribed.

Trimethoprim (for a presumed urinary tract infection) is prescribed on 11th November (277 & 276) and continued until 15th November. A 25-microgram patch per hour of Fentanyl is written up on the 18th November and a single patch is prescribed at 9.15 on 18th November (276). The evidence from the nursing cardex is that the Fentanyl patch is removed on the morning of the 19th (223) at 12.30 (275) 3 hours after the time the subcutaneous infusion was started.

A new drug chart is written up on 19th November for Diamorphine 40 – 80 mgs subcut in 24 hours and Midazolam 20 – 80 mgs subcut in 24 hours. The drug card (279) confirms that 40 mgs is put into the syringe driver at 09.25 19th, 7.35 on 20th and 7.15 on 21st and 40 mgs of Midazolam at each of those times. All other drugs had been stopped.

Drug	Date prescribed	Prescribed as	Prescriber	Given
Oramorphine	21/10	10 mgs in 5 mls	Barton	---

who noted the history of confusion and disorientation and a 10 months history of mental deterioration (28). She was confused and disorientated but no longer aggressive. She was now mostly co-operative and friendly but tended to get lost, he also noted she was deaf. Her Mini Mental Test Score was 9/30, indicating moderate to severe dementia and he suggested that she would need ongoing institutional care. On the 18th October her creatinine was 201 (171).

3.9 On 20th October, there is a letter of an assessment from a locum consultant geriatrician (20). Who notes that she can stand, may have had a urinary tract infection on top of her chronic renal failure and that she was quite alert.

3.10 She is then transferred to the Gosport War Memorial Hospital with a discharge summary (24) that states she has chronic renal failure, paraproteinaemia, multiple infarct disease and an Abbreviated Mental Test Score of 3/10.

3.11 On 21st October she is transferred to the Gosport War Memorial Hospital and is for "continuing care" (154). Her Barthel dependency is noted to be 8 with a Mini Mental Score of 9/30. Dr Barton incorrectly writes that she has 'Myeloma' (154) in the notes.

3.12 On 25th October she is mobile unaided, washes with supervision, remains confused.

3.13 On the 1st November she is quite confused (155) and is wandering. On the 9th November investigations show haemoglobin of 9.9, white cell count of 12.6 (289) and a creatinine of 200 (349). An M.S.U reported on 11th November (363) shows no growth.

3.14 15th November she is noted to be very aggressive, very restless (155) and "is on treatment for a urinary tract infection". However, it is noted that the MSU from 11th November showed no growth. The medical note for the 15th is unsigned, I presume to be Dr Reid.

3.15 18th November (156) she is seen by the mental health team who note that in their view that "this lady has deteriorated and become more restless and aggressive, is refusing medication and not eating" but also noted "her physical condition is stable". She is put on the waiting list for Mulberry Ward. Creatinine on 16th November is 360 and a potassium 5.6 (349).

3.16 19th November there has been marked deterioration over night. The notes state "confused, aggressive, Creatinine 360, Fentanyl patch commences yesterday, today further deterioration in general condition needs subcut analgesia with Midazolam. Son seen and aware of condition and diagnosis, hence make comfortable. I am happy for nursing staff to confirm death"

3.1 In March 1998 (120) Mrs Devine was seen in a geriatric outpatient department with cellulitis, mild hypothyroidism, mild CCF, haemoglobin of 13 (317) and a creatinine of 90 (337).

3.2 In December 1998 she was seen in an orthopaedic clinic (102) and was found to be clinically fit for a knee replacement.

3.3 In March 1999 her haemoglobin was 12.8 (311) and her creatinine in February was 143 (325).

3.4 In April she was seen by a consultant geriatrician where she was found to be "moderately frail" although also noted to be "bright mentally" (84). Her weight was 58.8 kgs (144), her haemoglobin 11.5 (307) and a creatinine 151 (84).

3.5 She was referred to a renal physician and was also seen by a haematologist between June 1999 and September 1999. In June 1999 (60) her creatinine was 160, her haemoglobin 11.2 (297), her weight was 55.4 kgs (151). In July 1991 (50) the haematologist found 6% plasma cells and an albumen of 22 (52), immune paresis (70) and suggested a watch and wait approach. In September 1999 her renal physician noted that she had chronic renal failure with small kidneys and nephrotic syndrome with marked oedema. It was thought likely that this was on a background of progressive glumerulonenephritis (60) and she had an incidental IgA paraproteinaemia. Her Creatinine was 192 and her haemoglobin 10.5 (295).

3.6 On 9th October, she was admitted to the Queen Alexandra Hospital following a social crisis at home as Mrs Devine lived with her daughter and son-in-law. Mrs Devine's son-in-law had cancer and her daughter could no longer cope. There was a story of confusion and aggression, which was suggested, had become worse prior to her admission. The clinical diagnosis was of a possible urinary tract infection, with an underlying dementing illness. However, Mrs Devine was never documented to be pyrexial (256) and the mid-stream urine sample had no growth (367). There is no full blood count available in the notes for the 9th October. The admission clerking, which would be expected to be available, either before page 31 or around pages 157 and 158 also appears to be missing from the notes.

3.7 On the 12th October (31) she is noted to be distressed and agitated and undergoes a CT scan of her head, which shows involutional changes only (24). She receives a single dose of Haloperidol (160) (267). On the 13th October her haemoglobin is 10.8 with a white cell count of 14.5 (293).

3.8 On the 15th October she is noted to be wandering (166) on the same day she is assessed by Dr Taylor, Clinical Assistant for the Mental Health Team

Version 3 of complete report – June 02 2008 – Elsie Devine

SUMMARY OF CONCLUSIONS

Elsie DEVINE
DOB: Code A
DOD: 21/11/1999

Mrs Elsie Devine was an 88-year-old lady admitted to the Queen Alexandra Hospital following a crisis at home on the 9th October 1999. She has symptoms of confusion and aggression on a background of known chronic renal failure, IgA Paraproteinaemia, Hypothyroidism and a dementing illness. There was little improvement in the Queen Alexandra Hospital and she was transferred to the Gosport War Memorial Hospital on 21st October for continuing care.

In the Gosport War Memorial Hospital she deteriorates over the first two weeks in November and by 19th November is terminally ill. She receives palliation including subcutaneous Diamorphine and Midazolam and dies 21st November 1999.

However there were significant failings in the medical care provided to Mrs Devine as well as deficiencies in the use of the drug chart at Gosport War Memorial Hospital.

1. INSTRUCTIONS

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

2. ISSUES

2.1. Was the standard of care afforded to this patient in the days leading up to her death in keeping with the acceptable standard of the day.
2.2. If the care is found to be suboptimal what treatment should normally have been proffered in this case.

3. CHRONOLOGY/CASE ABSTRACT. (The numbers in brackets refer to the page of evidence)

2 3 JAN 2009

Gosport War Memorial Hospital
Pre-Inquest Hearing Report
19th January 2009 10am
Portsmouth Guild Hall

Those Attending:

Ms Hill of Blake Lapthorn
John White Blake Lapthorn
Alan Jenkins MDU for Dr Barton
Stuart Knowles Mills & Reeve
Ms Bhoghl The PCC
Michael Tyrer for Charles Farthing
Elaine Williams for Hampshire PCT
Deborah Watts from Mills & Reeve
Dennis Blake BBC
Pauline Gregory
Ian Wilson
Alan Lavender
Betty Packman
Vicky Packman
Peter Mellor

1.Properly Interested Persons

Dr Barton
The families of the deceased
The Health Trust
The PCT

2.Witness Schedule:
see attached.

3. Document Bundle
This will be prepared by the Coroners Office and circulated prior to the Inquest.

4. Hospital Notes
have now been annotated and copies were made available to the properly interested persons.

5. The Drug Register
will be annotated by Mills & Reeve and copies made available.

6. Jury Proforma.
This was prepared by The Coroner but will be expanded to include background information of each deceased giving an outline of dates, condition etc and that will be circulated as soon as it is prepared.

7. A working bundle of documents in addition to the advanced disclosure will be prepared and an Index circulated.

a. The Wessex guidelines are to be sent to the Coroners Office from the PCT and copies of those are to go to the Experts.

b. It was fully accepted that Professor Black is an appropriate expert but doubt was expressed about the suitability of Dr Wilcock. The Coroners Office will contact Dr Wilcock to express those concerns and will await his comments.

c. The Ford & Munday Reports are to be disclosed by the police.

d. This is not an Article 2 Inquest.

e. Concern was expressed about any possible Rule 43 Reports. This is not a case where it would be appropriate on the basis of the previous care to request a report under Rule 43.

Witness Schedule

March 18th
Opening Jury and Submissions
19. Lavender
20. Pittock

23. Service
24. Professor Black
25. Professor Black
26. Lake
27. Cunningham

30. Wilson
31. Wilson & Hamblin

April
1. Spurgeon
2. Packman
3. Devine

6. Dr Wilcock
7. Dr Wilcock
8. Devine
9. Gregory

14. Dr Barton
And onwards

General
Medical
Council

Regulating doctors
Ensuring good medical practice

Fitness to Practise Panel

Dr Jane Ann BARTON

Determination on Serious Professional Misconduct and Sanction

29 January 2010

Mr Jenkins

The Panel has considered Dr Barton's case in accordance with the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 (Old Rules). As a consequence, when determining whether the facts alleged had been proved, the Panel applied the criminal standard of proof. This means that it had to be satisfied beyond reasonable doubt of the facts alleged before it could find them proved.

The Panel wishes to make clear at this stage that it is not a criminal court and that it is no part of its role to punish anyone in respect of any facts it may find proved.

At the outset of the hearing, Mr Langdale QC admitted a number of parts of the allegation on Dr Barton's behalf and the Panel found those facts proved. The Panel made further findings in relation to the unadmitted parts of the allegation and gave detailed reasons for those findings in its earlier determination on the facts.

Serious Professional Misconduct

The task for the Panel at this stage of the hearing is first to determine whether, on the basis of the facts found proved, Dr Barton has been guilty of Serious Professional Misconduct. If the Panel finds that she has been guilty of Serious Professional Misconduct, it is then required to consider what action, if any, to take in respect of that misconduct.

In making this first decision, the Panel has considered whether the actions and omissions found proved in relation to Dr Barton's care of the 12 patients who have featured in this case amounted to misconduct which offends against the professional standards of doctors. If it did, the Panel has then determined whether that misconduct was serious.

The Panel has taken into account all the evidence it has heard and read throughout this hearing. It has referred to its determination on the facts found proved and the reasons for its findings, as well as the GMC's publication 'Good Medical Practice' (1995 edition)

which was applicable at the time. Further, the Panel has had regard to the context and circumstances in which Dr Barton was then working.

The Panel considered the submissions made by Mr Kark on behalf the General Medical Council (GMC) and by Mr Langdale and yourself on Dr Barton's behalf, and accepted the advice of the Legal Assessor.

Mr Kark submitted that Serious Professional Misconduct should be viewed historically. He reminded the Panel that while there is no definition of serious professional misconduct the test to apply is whether, when looking at all the facts that have been admitted and found proved, Dr Barton's conduct amounts to a serious falling below the standard which might be expected of a doctor practising in the same field of medicine in similar circumstances.

Mr Langdale concurred.

The Panel took account of the above and exercised its own judgment, having regard to the principle of proportionality and the need to balance the protection of patients, the public interest and Dr Barton's own interests.

The Panel made multiple findings of fact which were critical of Dr Barton's acts and omissions. These included but were not limited to:

- The issuing of prescriptions for drugs at levels which were excessive to patients' needs and which were inappropriate, potentially hazardous and not in the patients' best interests,
- the issuing of prescriptions for drugs with dose ranges that were too wide and created a situation whereby drugs could be administered which were excessive to the patient's needs,
- the issuing of prescriptions for opiates when there was insufficient clinical justification,
- acts and omissions in relation to the management of patients which were inadequate and not in their best interests. These included failure to conduct adequate assessments, examinations and/or investigations and failure to assess appropriately patients' conditions before prescribing opiates,
- failure to consult colleagues when appropriate,
- acts and omissions in relation to keeping notes which were not in the best interests of patients, including failure to keep clear, accurate and contemporaneous notes in relation to patients, and in particular, in relation to examinations, assessments, decisions, and drug regimes.

The Panel has concluded that Dr Barton failed to follow the relevant edition of 'Good Medical Practice' in relation to the following aspects of her practice:

- Undertaking an adequate assessment of the patient's condition based on the history and clinical signs, including where necessary, an appropriate examination,
- providing or arranging investigations or treatment where necessary,
- referring the patient to another practitioner where indicated,
- enabling persons not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor,
- keeping clear accurate and contemporaneous patient records,
- keeping colleagues well informed when sharing the care of patients,
- ensure suitable arrangements are made for her patients' medical care when she is off duty,
- prescribing only the treatment, drugs or appliances that serve patients' needs,
- being competent when making diagnoses and when giving or arranging treatment,
- keeping up to date,
- maintaining trust by
    - listening to patients and respecting their views,
    - treating patients politely and considerately,
    - giving patients the information they ask for or need about their condition, treatment and prognosis,
    - giving information to patients in a way they can understand,
    - respecting the right of patients to be fully informed in decisions about their care,
    - respecting the right of patients to refuse treatment,
    - respecting the right of patients to a second opinion,
- abusing her professional position by deliberately withholding appropriate investigation, treatment or referral.

Further, Dr Barton failed to recognise the limits of her professional competence.

The Panel has already commented at length on Dr Barton's defective prescribing practices, her inadequate note taking and her failures with regard to consultation, assessment, examination and investigation. It does not refrain from emphasising and holding her to account for creating the risks and dangers attendant upon such conduct and omissions.

As a consequence of the Panel's findings of fact as outlined above, Dr Barton's departures from Good Medical Practice as outlined above, and the attendant risks and dangers previously commented on, the Panel has concluded that she has been guilty of multiple instances of Serious Professional Misconduct.

The Panel then went on to consider, in the light of those findings, what if any action, it should take. The Panel considered:

- the submissions made by both counsel,
- the advice of the Legal Assessor,
- the facts found proved,
- the aggravating and mitigating features of those facts,
- the passage of time between the events giving rise to the complaint and the determination of the issues,

- Dr Barton's good character and other matters of personal mitigation including the bundle of testimonials submitted on her behalf.

Punishment

The Panel accepted the advice of the Legal Assessor that it is neither the role of this Panel nor the purpose of sanctions to punish, though sanctions may have that effect.

Proportionality

The Panel accepted the advice of the Legal Assessor that "This is a balancing exercise", where Dr Barton's interests must be weighed against the public interest in order to produce a fair and proportionate response.

The public interest

Both the Legal Assessor and Mr Kark addressed the Panel on the meaning to be ascribed to the phrase, "the public interest". The Panel accepted that the public interest includes:

- the protection of patients,
- the maintenance of public confidence in the profession,
- the declaring and upholding of proper standards of conduct and behaviour,
- on occasions, the doctor's safe return to work, but bearing in mind that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors.

The ambit of enquiry

The Panel accepted the Legal Assessor's advice that its task is to make judgments in the case against Dr Barton alone. It is no part of this Panel's role to make findings in respect of other persons who might have been the subject of criticism during the course of the evidence.

The Panel further accepted the Legal Assessor's advice that Dr Barton's actions should not be judged in isolation. An injustice would occur were she to be judged the scapegoat for possible systemic failings beyond her control. Her actions must be judged in context. The Panel has had the benefit of hearing a great deal of evidence in that regard, and is well placed to define that context. This in no way detracts from Dr Barton's own personal responsibilities as a medical practitioner however.

Looking to the future

The Panel accepted the advice of the Legal Assessor that where the Panel has found Serious Professional Misconduct, it must look forward when considering the appropriate response to those findings, and is open to the criticism that it is exercising retributive justice if it fails to do so.

Matters found proved

As indicated above, the Panel made multiple adverse findings of fact in respect of Dr Barton's prescribing practices, note keeping, consulting colleagues, assessments, examinations and investigations. Further, the Panel concluded that she had been guilty of multiple instances of Serious Professional Misconduct.

Aggravating and mitigating features

In accordance with the Legal Assessor's advice the Panel went on to consider both the aggravating and the mitigating features of the facts found proved. It took into account also the evidence contained in the testimonials and character evidence called.

i. Aggravating (offence)

- Although Dr Barton conceded that, with hindsight, she should have refused to continue to work in a situation that was becoming increasingly dangerous for patients, she insisted that, in the circumstances of the time, her actions had been correct.
- She told the Panel that were the situation and circumstances of the time to repeat themselves today, she would do nothing different.
- The Panel concluded that this response indicated a worrying lack of insight. It was particularly concerned by Dr Barton's intransigence over matters such as the issue of balancing the joint objectives of keeping a patient both pain-free and alert.
- This, combined with her denigration of senior colleagues and guidelines, produced an image of a doctor convinced that her way had been the right way and that there had been no need to entertain seriously the views of others.

ii Mitigating (offence)

- The Panel noted that the nature and volume of Dr Barton's work and responsibilities increased greatly between the date of her appointment and the time with which this Panel is concerned.
- In particular, the Panel notes that increased and often inappropriate referrals from acute wards to her own put Dr Barton, her staff and resources under unreasonable pressure.
- The Panel noted that Dr Barton was operating in a situation where she was denied the levels of supervision and safeguard, guidance, support, resources and training necessary to ensure that she was working within safe limits. Even when there was Consultant cover it was often of a calibre which gave rise to criticism during the course of evidence.

- The Panel accepted Mr Langdale's submission that the response of hospital management and senior colleagues to complaints against Dr Barton was such that she did, quite reasonably, feel that she was acting with the approval and sanction of her superiors.

- Dr Barton's practice of anticipatory prescribing of variable doses of diamorphine for delivery by syringe driver was validated by a protocol evidenced in a letter from Barbara Robinson, Senior Manager at Gosport War Memorial Hospital dated 27 October 1999.

iii Personal mitigation

- Over a period of ten years since the events in question Dr Barton has continued in safe practice as an NHS GP;

- She has already been under what has been described by GMC counsel as her "own voluntary sanction" for eight years, and for the last two years under formal conditions imposed by the Interim Orders Panel of the GMC;

- The bundle of testimonials from colleagues and patients as to her current working practices and her positive good character.

The passing of time

In considering the appropriate response to its findings of Serious Professional Misconduct the Panel recognised that it was faced with a most unusual set of circumstances:

- There had been a gap of ten years between the events in question and the date of this hearing,
- during that period Dr Barton had continued in safe practice as a GP in the community,
- for the first eight of the ten years she practised under self-imposed conditions of her own devising; for the latter two years, under conditions directed by the GMC's Interim Orders Panel,
- the Panel had received a large bundle of testimonials on Dr Barton's behalf which attested to details of her safe working practice in that period.

In the circumstances the Panel considered it to be important that it receive advice on the appropriate weight that should be attached to the issue of elapsed time, the principles to be applied to its consideration in these circumstances and whether any binding authority could be found. None was.

Mr Kark submitted that the Panel should follow the Indicative Sanctions Guidance and that no party should be disadvantaged by reason of the delay.

You submitted that:

- The Panel should consider the misconduct in the context of the guidance and standards applicable at the time.

- Dr Barton's working conditions at the relevant time differed from any that a hospital doctor would be expected to accept today. You suggested that clinical governance has moved on dramatically since then and that the Panel could conclude that in that respect Dr Barton could no longer pose any risk to patients.

The Legal Assessor advised that the passing of time served the Panel well in that it provides a context in which Dr Barton's attitudes and practices could be viewed and judged. It allowed the Panel to judge the efficacy of conditions as a workable sanction by opening a ten year window through which to view it.

Response

The Legal Assessor advised that in determining the appropriate response to Dr Barton's Serious Professional Misconduct the Panel should consider:

- the aggravating and mitigating features of the facts found proved
- the passing of time between the events which gave rise to the findings against her and the date of this hearing
- her performance during that time
- the Indicative Sanctions Guidance
- the protection of patients and the public interest.

i. No action or Reprimand

- Having found that Dr Barton has been guilty of multiple instances of Serious Professional Misconduct, the Panel considered whether in all the circumstances it would be sufficient, appropriate and proportionate either to take no action or to issue her with a reprimand.
- The Panel had no hesitation in concluding that given the seriousness and multiple instances of her professional misconduct it would be insufficient, inappropriate and not proportionate either to take no action or to issue her with a reprimand.

ii. Conditions

The protection of patients

Mr Kark submitted that Dr Barton has demonstrated neither remorse nor insight in respect of the matters found proved and that her departures from the principles set out in *Good Medical Practice* were particularly serious. He submitted that, in those circumstances she presented a continuing risk to patients, and urged the Panel to conclude that, despite the long delay, her case should be dealt with by way of erasure.

Mr Langdale submitted that:

- Dr Barton presents no continuing risk to patients. He said this was proved by her safe practice as a GP throughout the ten years since her departure from the Gosport War Memorial Hospital.

- This view was further supported by the many testimonials of both patients and professional colleagues who commented on her current working practices as well as her qualities as a GP.

- The authors of the nearly two hundred written testimonials were informed in that they were aware of the allegations against Dr Barton, the findings of the Panel, and indeed the adverse publicity this case has attracted.

The Panel accepted that it was unrealistic to consider that Dr Barton could ever again find herself in the situation she faced at the Gosport War Memorial Hospital.

Given the seriousness of the Panel's multiple findings against Dr Barton, and the aggravating features of those findings noted above, in particular her intransigence and lack of insight, the Panel was unable to accept that she no longer posed any risk to patients.

However, the Panel did accept that in the light of the mitigating features listed above, and the fact that she has been in safe practice for ten years – with eight of them operating under conditions of her own devising and two under conditions imposed by the GMC's Interim Orders Panel – it might be possible to formulate conditions which would be sufficient for the protection of patients.

The maintenance of public confidence in the profession.

Mr Langdale submitted that public trust and confidence in the profession meant the trust and confidence of the informed public. He said that while the authors of the testimonials received by the Panel were informed members of the public, this case has attracted much media attention and that there have been ill-informed and unjustified media comparisons with an unrelated but infamous case involving a doctor accused of deliberately causing multiple patient deaths.

The Panel wishes to make it clear that this is not such a case. However, the GMC have alleged and the Panel has found proved that there have been instances when Dr Barton's acts and omissions have put patients at increased risk of premature death.

The Panel takes an extremely serious view of any acts or omissions which put patients at risk. It had no hesitation in concluding that Dr Barton's Serious Professional Misconduct was such that it is necessary, even after ten years of safe and exemplary post-event practice, to take action against her registration in order to maintain public confidence in the profession.

The Panel considered that taking action against Dr Barton's registration would send a message to the public that the profession will not tolerate Serious Professional Misconduct.

The declaring and upholding of proper standards of conduct and behaviour.

For the same reasons and having carefully considered all the circumstances, the Panel is satisfied that it might be possible to formulate a series of conditions which would be sufficient both to maintain public confidence in the profession and uphold proper standards of conduct and behaviour.

The public interest in preserving the services of a capable and popular GP.

The Panel was greatly impressed by the many compelling testimonials which detailed Dr Barton's safe practice over the last ten years and the high regard in which she is held by numerous colleagues and patients.

The Panel noted Mr Langdale's assurance that the authors of the testimonials were either colleagues and/or patients who were aware of the allegations against Dr Barton, this Panel's findings on facts, and the media coverage of the case.

The Panel was mindful of the fact that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors. However, the Panel was satisfied that there is an informed body of public opinion which supports the contention that preserving Dr Barton's services as a GP is in the public interest.

Order

The Panel has formulated a series of conditions. In all the circumstances, the Panel is satisfied that it is sufficient for the protection of patients and is appropriate and proportionate to direct that Dr Barton's registration be subject to conditions for a period of three years.

The following conditions relate to Dr Barton's practice and will be published:

1 She must notify the GMC promptly of any post she accepts for which registration with the GMC is required and provide the GMC with the contact details of her employer and the PCT on whose Medical Performers List she is included.

2 At any time that she is providing medical services, which require her to be registered with the GMC, she must agree to the appointment of a workplace reporter nominated by her employer, or contracting body, and approved by the GMC.

3 She must allow the GMC to exchange information with her employer or any contracting body for which she provides medical services.

4 She must inform the GMC of any formal disciplinary proceedings taken against her, from the date of this determination.

5 She must inform the GMC if she applies for medical employment outside the UK.

6. a. She must not prescribe or administer opiates by injection. If she prescribes opiates for administration by any other route she must maintain a log of all her

prescriptions for opiates including clear written justification for her drug treatment. Her prescriptions must comply with the BNF guidelines for such drugs.

b. She must provide a copy of this log to the GMC on a six monthly basis or, alternatively, confirm that there have been no such cases.

7. She must confine her medical practice to general practice posts in a group practice of at least four members (including herself).

8. She must obtain the approval of the GMC before accepting any post for which registration with the GMC is required.

9. She must attend at least one CPD validated course on the use of prescribing guidelines within three months of the date from which these conditions become effective and forward evidence of her attendance to the GMC within one week of completion.

10. She must not undertake Palliative Care.

11. She must inform the following parties that her registration is subject to the conditions, listed at (1) to (10), above:

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

In deciding on the length of conditional registration, the Panel took into account the fact that Dr Barton has been practising safely in general practice for the past ten years. During that time she has complied with the prescribing restrictions which she initiated and which were subsequently formalised by the GMC's Interim Orders Panel. This Panel is satisfied, looking forward, that the conditions it has directed provide further safeguards for the protection of patients, and therefore concluded that it was appropriate and proportionate to impose the conditions for the maximum period.

Shortly before the end of the period of conditional registration, Dr Barton's case will be reviewed by a Fitness to Practise Panel. A letter will be sent to her about the arrangements for that review hearing. Prior to the review hearing Dr Barton should provide the GMC with copies of her annual appraisals from the date of this hearing.

The effect of the foregoing direction is that, unless Dr Barton exercises her right of appeal, her registration will be made subject to conditions 28 days from the date on which written notice of this decision is deemed to have been served upon her.

Dr Barton is the subject of an interim order of conditions. The Panel proposes, subject to any submissions to the contrary, in accordance with Rule 33A of the 1998 rules, to vary the existing order by substituting its conditions with the conditions contained in this determination.

That concludes the case.

Code B

Code B

Code A

10th January 2010

Ref: VB/2000/2047/02

Dear Code A

In response to your letter dated the 8th January I would like you to review these additional points.

With regards to Professor Ford's decision not to comment; I would like confirmation therefore from the GMC that you submitted the below to Professor Ford as part of the documentation for his review:

1. The Film of the Brain Scan
2. The confirmation regarding the deafness of Mrs. Elsie Devine
3. The series of MMS (as I do not have this)
4. The reports for Elsie Devine's ADLS'
5. The assessment reports from the Occupational Therapist, as to Elsie Devine's daily living
6. The clinical diagnosis based on progressive deterioration

With regards to your paragraph :

"In respect of your requests for access to various pieces of evidence being considered by the Fitness to PracticePanel, we are prepared to consider these requests once the hearing has completed. It is potentially prejudicial to the statutory proceedings before the Fitness to Practice Panel to do so while those proceedings are in train"

I would like for you to confirm which specific requests you refer to and elaborate on how they are potentially prejudicial. It is imperative that I am clear as to your response. You should reference my specific questions in your reply.

Finally and on a separate point, I would like to know why the GMC requested a copy of the medical file from me in 2002 when it could have been requested from the PCT? Was this, and is this in line with your current practices?

I look forward to your response.

Regards

Code A

Cooper, Rachel

From: Cooper, Rachel
Sent: 12 January 2010 09:37
To: Code A
Subject: RE: Jane Barton

Dear Code A

Thank you for your email.

By way of confirmation, the FTP hearing will resume on Monday 18 January 2010. The Panel will spend the first 2 days, in private session, reading relevant documentation. The public will be admitted at around 9.30am on Wednesday 20 January 2010. On this day, both parties will give their submissions concerning serious professional misconduct and sanction. It is anticipated that both parties will complete their submissions on Wednesday, however, it is possible that we may slip into Thursday morning. Following the parties submissions, the Legal Assessor will provide his advice, following which the Panel will go back into private session to deliberate and prepare its determination.

It is impossible to estimate how long the Panel will take to reach, and draft, its determination. We would hope to give at least overnight notice to yourself, and the other family members, in terms of the reading out of the Panel's determination.

I trust that the above information assist you, should you require any further information, please let me know.

Kind regards

Rachel

Rachel Cooper | Associate
for Field Fisher Waterhouse LLP
dd: Code A

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

From: Code A
Sent: Tuesday, January 05, 2010 6:26 PM
To: Cooper, Rachel
Cc: Code A
Subject: Jane Barton

Dear Ms Cooper

I am writing to you, in order to gain clarification on the final stages of the GMC hearing in the case of Jane Barton. I am sure you can appreciate after taking planned leave to be present I, and my family require the GMC's cooperation in order to attend.

I spoke to Code A and she informs me that it starts on the 18th January and finishes on the 29th January, I can attend on the 19th January up until the panel resides again in private. I also asked her:

1. Is the conclusion date of the 29th likely or could it be earlier? She did not know.
2. a) Are we going to receive notice to attend? She did not know.
   b) Would it be reasonable to expect at least 24 hours notice? She hoped so, but could not confirm.

In light of this please can you give me the GMC's position on the above.

Regards

Code A

--
Please sign up:

http://petitions.number10.gov.uk/Elsies-Law/

Freedom of Information Act 2000 (FOIA), applies:

Section 40(2) by virtue of section 40(3)(a)(i) of the FOIA - Personal information of a third party. This relates to information requested which is the personal data of a third party, and the disclosure of which would be in breach of the Principles of the DPA. In this instance we believe that the disclosure of this type of information would breach the First Principle, which requires that the processing of personal data is fair and lawful. This exemption is absolute, which means that it is not subject to a public interest test.

You do have the right of appeal against this decision. If you wish to appeal, please set out in writing your grounds and send to Julian Graves, Information Access Manager, at Code A You also have the right of appeal to the Information Commissioner, the independent regulator of the FOIA. If appropriate, Mr Graves would provide the relevant contact details.

Yours sincerely

Code A

From: Code A
Sent: 08 December 2009 13:42
To: Code A Julian Graves Code A
Cc:
Subject: Dr Barton/GMC

Ms Code A

Thank you for your response and thank you for confirming that in 2002 the decision was based on the information given to the GMC by me.

In light of your response;

1. Please can you particularise on that information that the GMC relied upon.
2. Why did you not obtain an Expert Report at that time, it was the duty of the GMC to do so in the public interest?
3. Please inform me what qualifications the medical screener had who took this decision? The prescription was far too high and without justification for my elderly frail mother,any lay person would realise let alone a medically qualified screener.
4. Why did the GMC disregard my complaint against Dr Barton when they already had other cases against her that the GMC were considering?

I refer you to the **"Acting fairly document"** please see attachment.

1. Para 10 "The public and the profession rightly expect the GMC to have processes which enable it to take fair, timely and effective action against the small minority of doctors who put patients at risk and undermine public confidence in their colleagues". It is clear that the GMC took the wrong decision in 2002 since the same data resulted in a current prosecution. It is quite obvious that the GMC should admit that the screeners misdirected themselves.

2. It is clear that the allegations made to the GMC were a flagrant breach of Good Medical Practise. Moreover, no reasonable doctor would have prescribed the level of medication given to my mother. As the screener discarded the complaint, we assume that the screener felt the level of medication was adequate. If this is so, the medical screener is also responsible for a flagrant breach of Good Medical Practise and as such should be

admonished and disciplined by the General Medical Council given the current Expert Reports.

3. Point 11 of enclosed document provides the Roles of the GMC at the time. "The safe care of patients by doctors is at the heart of everything the GMC does" and ".To deal firmly and fairly with doctors whose conduct, performance or health may bring their registration into question". It appears that the GMC violated their own stated role.

4. Point 13 "The Merrison Committee2 said that 'the GMC should be able to take action in relation to the registration of a doctor...in the interest of the public', and that the public interest had 'two closely interwoven strands: the particular need to protect the individual patient, and the collective need to maintain the confidence of the public in their doctors'3. In the context of the PCC case in 1998 concerning children's heart surgery in Bristol the Privy Council confirmed that view, holding that the public interest included, but was not limited to, the protection of individual members of the public. Other factors were the maintenance of public confidence in the profession and declaring and upholding proper standards of conduct.4 The proposals in this document are based on the premise that the fundamentalpurpose of the fitness to practise procedures is to promote and safeguard the public interest, understood in these terms"

The GMC are "Independent" if they are turning to the PCT or HO opinions, because they themselves cannot make a decision, as it appears in this case, then they clearly are not Independent. The GMC are suppose to act firmly and fairly with doctors, the GMC are suppose to set general standards of good practice for doctors, which they have clearly failed in this case against Dr Barton.

It is clear that in 2002, the GMC failed to act in the public's interest, given the current situation.

It is a total insult to this family,my mother and others involved that the GMC disregarded the serious allegations without respect, as they continue to allow Dr Barton to practice.

Regards

Code A

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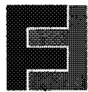
 Field Fisher Waterhouse

Case Report
June 2009

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor and Counsel:	Sarah Ellson/Rachel Cooper Tom Kark and Ben Fitzgerald
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:	IOP conditions in place – expire 10 January 2010

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). In April 2008 we added JS. Counsel has advised that there is not enough evidence to proceed regarding SG, HS and EP.

Investigations: Both parties evidence was completed by day 39 of the hearing. The Panel went into camera to consider its determination of facts on 6 August 2009. The Panel is expected deliver its determination on 17 August 2009. We have participated in a conference with the GMC and Counsel in order to discuss matters arising in relation to our submission on SPM and sanction. All press inquiries have been directed to GMC Press Office.

Recommendation: Attend hearing.

Listing time estimate: 10–12 weeks (LONDON) commencing on 8 June 2009

Prospects of Success: Good

10818299 v1

The GMC

and

Dr Jane Barton

Opening

INTRODUCTION

1. This case concerns the treatment provided to twelve patients at the Gosport War Memorial Hospital all of whom were in-patients there between 1996 and 1999. Dr Barton was employed during the period as a clinical assistant which meant that she had day-to-day care of the patients on the two relevant wards which were Daedalus and Dryad.

2. The Hampshire Primary Care Trust boasted four hospitals at the relevant time in the Portsmouth Area. The Queen Alexandra Hospital which has a number of sites clustered around the top of Portsmouth; St Mary's Hospital which is in Portsmouth itself; the Royal Haslar Hospital which was once the Royal Naval Hospital, the first version of which was built in the middle of the 18th Century; and finally the Gosport War Memorial Hospital (GWMH).

3. The GWMH was opened in 1923. Since then it has occasionally been extended. At the relevant time that you will be asked to consider, the

GWMH was effectively a cottage hospital which would receive patients who required longer term or rehabilitative care. Prior to the period we are considering the GWMH had been spread around a number of sites, but by the relevant time period it was centred in a single building.

4. It was a community hospital and did not have an acute ward nor any emergency facilities. Originally palliative care patients or those terminally ill were cared for in part of the Gosport War Memorial Hospital (GWMH) called the Redcliffe Annex which was some miles from the main hospital. That was a geriatric ward for patients who could not cope on their own, it was closed in 1995 and all of their patients were sent to Dryad Ward which was one of three wards at the GWMH. The other two elderly care wards being called Daedalus and Sultan Ward.

5. Emergencies arising on the wards of the Gosport War Memorial Hospital would have to be transferred by ambulance to one of the local hospitals where emergency treatment could be provided.

6. Dr Barton was a local GP practising in Gosport in Hampshire. She qualified at Oxford University in 1972 as a Bachelor of Medicine and a Bachelor of Chemistry. She became a GP, initially as an assistant and then as a partner. In 1980 she was appointed to the General Practitioner medical staff at the GWMH (see - Samuel) and in 1988 she applied for and was appointed to the post of Clinical Assistant at the Gosport War Memorial Hospital. The period of her employment there upon which this case will focus was between 1996 and 1999.

7. During her period at the hospital she continued in her full time post as a GP doing morning surgeries every day and evening surgeries on a rota basis with her other GP partners. She was also doing one night a fortnight on call and one weekend on call in four (police statement of Dr Barton re: Gladys Richards).

8. Dr Barton had not specialised in either Geriatric or Palliative medicine and had no specific training of which we are aware other than her experience over the years. Dr Barton's main job was as a GP in a local Gosport practice. She would conduct ward rounds at GWMH as a general rule between 7.30 and 8 a.m. Monday to Friday on a daily basis (Barrett). She would also, according to the witness Philip Beed and according to the statement Dr Barton made subsequently to the police, attend at midday to clerk any new admissions. She would be fairly reliant on nursing staff to flag up any problems and would not necessarily see every patient every day (Beed, Interview 7/25).

9. There are two wards at the GWMH to which all of the twelve patients upon whom we are focussing were admitted.

10. Dryad Ward which was an elderly care ward consisted of 20 beds.

11. Daedalus Ward was a 24 bed ward. 8 of those beds were for slow stream stroke patients and the remaining beds were for the continuing care of elderly patients. Many of the patients admitted to these wards were expected to be rehabilitated sufficiently so that they could either return home or to care homes. This was not a hospice although of course some patients were very ill and inevitably were not going to leave hospital.

12. Additionally GWMH had an old age psychiatric ward by the name of Mulberry.

13. Dr Barton appears to have developed a practice on the two wards Dryad and Daedalus, of prescribing large quantities of opiates on an 'in-case' or, as she called it, an 'anticipatory' basis. 'In case' the patient found themselves to be in pain or 'in case' the patient's pain was uncontrolled by the opiates already given, or in case Dr Barton was away or it was a weekend. Many of the patients you are going to hear about were opiate naïve, in other words, until they set foot inside the GWMH, they had never been given opiates as a form of pain relief. In the view of the GMC expert Professor Ford none of the patients, about whom you are going to hear, were properly and appropriately prescribed opiates by Dr Barton.

14. There was a series of failures which led to patients being over medicated and unnecessarily anaesthetised. The failures included a lack of proper assessment before opiates were prescribed and a wholly irresponsible method of prescribing opiates. There was an almost universal failure by Dr Barton to make proper notes either of assessment of the patients if such assessments were taking place or to justify her actions in prescribing opiates. Frequently opiate medication was increased with no explanation noted.

15. The favoured method of prescribing to these patients was to provide for a variable dose of the drugs Diamorphine and Midazolam which were to be administered by way of syringe driver. The dose range prescribed by Dr Barton was, in each case that you are going to consider, far too wide and breached acceptable medical practice.

16. Prior to the syringe driver being administered many of the patients were unnecessarily prescribed oral morphine in the form of liquid morphine called 'Oramorph' or slow release Morphine tablets (MSTs).

17. Philip Beed one of the nurses and Clinical Manager of Daedalus Ward puts it in this way (police interview p.28/37) – "it's the nursing staff who really have the full picture of how a patient has been and then we would discuss and talk about how we would do it with the medical staff making decisions about care. We would call a doctor if we needed to, but we would have discussed the patient's ongoing care and prognosis on each occasion we saw the doctor so we are empowered to initiate a syringe driver. The syringe driver would be written up and the instruction would be 'if this patient's condition worsens you can utilise the syringe driver to keep that patient pain free'". There appears therefore to have been considerable discretion left with the nursing staff as to commencement of the syringe drivers and the quantity of opiate to administer.

18. When the patients became agitated they were then administered increasing quantities of Diamorphine and Midazolam by the nurses under Dr Barton's prescriptions, until they were agitated no more. Many of the patients who are described in the nursing notes as 'calm and peaceful' were, in fact, according to Professor Ford, in 'drug induced comas'.

19. Professor Ford is the Professor of Pharmacology of old Age at the University of Newcastle upon Tyne and practices as a consultant Physician in clinical Pharmacology at the Freeman Hospital. He is the co-editor of Drugs and the Older Population published in July 2000.

20. He has examined each of the cases which we have placed before you and he is highly critical of Dr Barton's practice in terms of her prescribing, her lack of assessment of patients and her failure to make relevant and necessary notes.

21. Dr Barton may claim that she was entitled to rely on the experience of the nurses when prescribing the huge quantities of Diamorphine and Midazolam which she did. She may say that she was entitled to rely on the nurses not to provide the medication which she was prescribing unless it was necessary. However, there was a lack of a proper system to ensure that patients were not overmedicated and in the view of Professor Ford, over-medication was a frequent and recurring problem. Dr Barton effectively delegated responsibility for her patients in relation to the administration of opiates to the care of the nurses and there were frequent occasions when the nurses went on to use those prescriptions inappropriately.

22. As she said in her police statement – "on a day to day basis mine was the only medical input".

CONSULTANTS

23. There were three consultants who had duties in relation to these two wards. The wards were visited on a weekly basis by one consultant or the other. However in general they were reliant upon what they were told about the patient by Dr Barton.

24. The consultants were Dr Tandy, Dr Reid and Dr Lord. None of them saw the patients more than once a week on the wards and the day to day control was left to Dr Barton and her nursing staff. Dr Tandy was away on maternity leave from April 1998 until February 1999 and her post was not filled by a locum.

25. **Dr Jane Tandy** was a Consultant Geriatrician at the Queen Alexandra Hospital Portsmouth who was ostensibly responsible for Dryad Ward at GWMH as consultant from 1994. She was away on sick leave for a month from 11 July to 12 August 1996 and again from 16 September to 22 November. From the 23 November 1996 to 1 September 1997 she went on maternity leave. When she was there she carried out a ward round once every two weeks on Wednesdays. She was only there during the period when patients A and B were on the ward and would have left by the time patient C arrived.

26. She describes Dr Barton as more experienced than her in long term and palliative care.

27. **Dr Reid** was based at the Queen Alexandra Hospital in Portsmouth. He was a consultant Geriatrician. He carried out one session a week at the Dolphin Day Hospital and from February 1999 was the consultant in

charge of Dryad Ward. He was in post at the times that Patient I, J and K + L were admitted to Dryad Ward.

28. He would carry out a ward round on Monday afternoon. On alternate weeks Dr Barton would accompany him. He would therefore only see her once a fortnight. He was not aware that Dr Barton was writing up prescriptions for patients with a variable dose in advance of them complaining of pain. He spoke to her on one occasion about a variable dose he saw and appears to have accepted her explanation.

29. He was aware that Dr Barton was working very hard and believed that without her GWMH would not have been able to function.

30. **Dr Lord** would carry out a consultant ward-round once a week alternating between Dryad and Daedalus (Beed).

31. She is in New Zealand and careful consideration has been given as to whether she should be called as a witness. A review of the notes of the twelve patients with whom you are specifically concerned reveals that although she provided medical services to a number of them prior to their transfer to the GWMH her input post transfer was very limited indeed. She had no role in the prescribing treatment at GWMH for Patients A, B, E, F, H, I, J, K or L.

32. Her role in relation to patients C, D, G was very limited as you will hear and is in any event revealed by the notes. In the circumstances it has been decided that she will not be called by the GMC.

33. Dr Barton may say she was overworked and under pressure and if that is shown to be true, that may be some mitigation for what occurred, but it

does not provide a defence for some of the practices which built up and which were directly contrary to Good Medical Practice.

34. In due course Dr Barton did resign apparently because of the pressures of work but there was unfortunately quite clearly a period of time under her management when her patients were receiving very substandard care.

THE DRUGS + PROTOCOLS

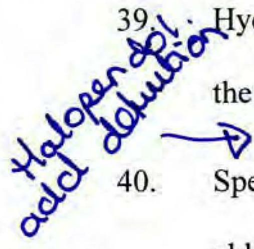
35. Of the drugs that you will be hearing about there are four which are central to this case: Oramorph, Diamorphine, Midazolam and Hyoscine. + Haloperodol.

36. Oramorph is an oral solution of Morphine. It is suitable to be given as an opiate where the patient is able to swallow. It has the effect of depressing respiration and causing hypotension. It should be avoided for acute alcoholics.

37. Diamorphine, as you will know, is what drugs users call 'Heroin'. It is a powerful opioid analgesic and is given via syringe. Apart from removing the sensation of pain it has a depressive effect on the vital functions and frequently causes nausea and vomiting. Its use should be avoided in the case of acute alcoholism. Great care has to be taken when exchanging oral morphine for subcutaneously delivered Diamorphine. The dosage delivered subcutaneously should, according to the BNF, be one third to one half of the oral dose of Morphine. So an oral dose of 30 mgs Morphine over 24 hours should be replaced by a dose of 10-15 mgs as a subcutaneous infusion over 24 hours (Ford).

38. Midazolam is a sedative and anti-epileptic and said to be suitable for the very restless patient. It can be mixed in a syringe driver with Diamorphine. Midazolam can cause respiratory and cardiovascular depression, hypotension and ultimately death.

39. Hyoscine has the effect of reducing salivary and respiratory excretions. In the elderly particularly it can cause drowsiness.



40. Specific advice is given in the BNF (File 1 Tab 3 page 7) that dosages for elderly patients should generally be substantially lower than for younger patients. Doses should generally start with 50% less than the normal adult dose.

41. Drugs may be prescribed 'PRN' (pro re nata) or 'as the occasion arises' or 'as required'. This can be appropriate and is often used but it is important to provide clear instructions as to what event will trigger the use of the drug.

42. The 'analgesic ladder' is a phrase which will crop up in the course of this hearing. It describes the simple concept which you are entreated to apply at the sanction stage of a FTP case. In other words you should consider the lowest sanction first. The analgesic ladder provides, in a similar way, that drugs are classified into three groups depending on the severity of the pain that they are intended to meet. The starting point is non-opioid analgesics such as aspirin, paracetemol and Ibuprofen. Next there are more potent anti-inflammatory drugs such as Diclofenac and Codeine. Except in an emergency, which did not arise in any of the cases you will consider, it is only for patients for whom those first two stages have

proved ineffective to control their pain that Morphine and Diamorphine are recommended. The lowest starting dose should be used at the commencement of pain relief and increased if necessary by 50% on subsequent occasions.

43. You will hear reference to a document called the 'Wessex Protocol'. This is also known as the Palliative Care Handbook (File 1 Tab 4). This sets out guidance as to best practice when applying a palliative care regime. That means a medical regime to ensure that the patient is comfortable and pain free when their illness is no longer responsive to potentially curative treatment. In other words, when it is recognised that the patient is dying and can not or should not be saved by medical intervention.

44. One of the issues in the case is whether the nurses were in fact following the guidance given and whether in respect of certain patients the decision was taken inappropriately to treat patients under a palliative regime as opposed to a curative regime.

HB palliative care handbook.

NURSES

45. The GMC proposes to call a number of the nurses who cared for the patients and who administered doses of Diamorphine and Midazolam of which criticism is on occasion made. Many of the nurses who worked on the relevant wards can remember nothing beyond the notes that they made and it has not been thought necessary or relevant to parade those nurses before you. Some of the nurses do have recollection of the patients or the practices at the hospital and will be called by the GMC. Many are likely to

be highly supportive of Dr Barton with whom they worked over many years.

46. The Panel will have to be alert when listening to the evidence of those nurse witnesses to guard against biased or self serving evidence.

47. Lynne Barrett by way of example was a senior and experienced nurse who worked at GWMH from the late 1980s. She had no concerns about the use of syringe drivers nor the quantities of drugs that were being prescribed by Dr Barton. She takes the view that as a result of the issues raised at GWMH, patients will not now get the pain relief that they need. She feels that Dr Barton is being used as a scapegoat. You will need to assess that evidence, but it is called so as to provide you with as complete a picture as possible. Some nurses we are not calling if in the GMC's view they are so biased as to be not capable of belief. If the defence wish to call them then that is a matter for them.

48. Sister Hamblin was the clinical manager and Ward sister and it is clear from a substantial body of evidence that she was a formidable person who effectively ran the wards in Dr Barton's absence. She is too unwell to be called to give evidence and the GMC have taken the view that it would not be appropriate to rely upon her evidence in statement form.

49. Freda Shaw takes the simple line that 'syringe drivers were always used correctly and only when necessary'.

50. Other nurses have expressed concern about the extent to which both Diamorphine and syringe drivers were used on the wards. Some nurses speak about the use of Diamorphine without adopting the analgesic ladder

first. They speak of the considerable trust that Dr Barton appears to have placed in Gill Hamblin (see Carol Ball) and concerns appear to have been raised back in the early 1990s.

51. For a period Dr Barton had worked on the Redcliffe Annex prior to the transfer. Nurse Tubritt remembers that once she started the ward was better organised and syringe drivers were introduced at around that time. It was prior to the transfer to Dryad and Daedalus that nurse Tubritt remembers concerns being raised in the early 1990s about the use of Syringe Drivers and the quantity of Diamorphine being used.

52. Meetings were held between nurses and management and Dr Barton attended at least one of those meetings. Unfortunately although there were calls for a formal written policy on the use of Diamorphine and Syringe drivers no such policy appears ever to have been produced (See Exhibits to Turnbull's GMC statement in Bundle 1 Tab 6).

53. Nurse Turnbull was similarly concerned and certainly initially she was worried that the analgesic ladder was not being used appropriately. However her view once the ward was moved to become Dryad Ward, was that the culture did change and that syringe drivers were only used when needed.

54. Nurse Turnbull does however reflect in her evidence that the regime allowed the Nurse in Charge to increase the dosage of drugs at their discretion provided it was kept within the parameters set by Dr Barton. Those parameters were however set very wide indeed.

55. Meetings were held and fears apparently therefore were allayed. It will be a matter for the Panel to consider whether the concerns should in fact have continued and whether or not they had been addressed by a real change of culture.

56. Phillip Beed was the manager of Daedalus Ward from 1998. He describes how Dr Barton would attend the ward at 9 am every morning and carry out a review of the patients. He is very supportive of Dr Barton and had no concerns about her. It was a very busy ward according to Mr Beed.

57. Nurse Giffin remembers concerns about syringe drivers being raised in the early 1990s and there were meetings with Dr Barton and hospital management about their excessive use. Nurse Giffin appears eventually to have stopped complaining about what was going on and continued working with the others although in her view things did not in fact improve.

58. Ms Shirley Hallman was a senior nurse and only one grade lower than Gill Hamblin. She did not start work at the GWMH until 1998. She was new to palliative care and had a difficult working relationship with Ms Hamblin. She ran the ward when Nurse Hamblin was on leave or away. She describes Nurse Hamblin as an excellent nurse but 'her word was law'.

59. She did not feel that the analgesic ladder was appropriately adhered to. She describes how on Dryad it had become standard practice to double the dosage if it was deemed that the patient needed a higher dosage of opiates.

60. She was troubled by the fact that it appeared that Dr Barton would prescribe opiates and then hand the responsibility over to the nurses.

61. The GMC will call a number of nurses and you will have to analyse their evidence carefully. Some of the evidence may be founded on self protection or even upon a misguided loyalty. What may matter to your inquiry however is the evidence which actually supports the administration of opiates or in many cases, the lack of evidence as to why opiates were in fact administered or increased.

NOTE KEEPING

62. One of the allegations which is made in respect of every patient relates to the very poor quality of the notes kept by Dr Barton. In the cases you will be looking at there was a lack of a proper note of the first assessment by Dr Barton and a lack of reassessment notes or a proper diagnosis or treatment plan. The administration of Opiates was regularly increased with only a nurse's note to show it.

63. Dr Barton's explanation to the police was, in short, that she was too busy to make a note and that she had to decide whether to look after the patients or make notes about it.

64. She said this in one of her statements – "I was left with the choice of attending my patients and making notes as best I could or making more detailed notes about those I did see but potentially neglecting other patients" (see for example Dr Barton's generic statement and her statement re: Arthur Cunningham). The GMC does not accept that to be a

legitimate approach. Unless a proper note is made assessing the patient on admission and when there are significant changes in their state of health, then it is very likely that the treatment of that patient will be adversely effected.

65. There will be no baseline or benchmark from which to work. Other medical staff will not know what the finding and diagnosis was. The treating doctor may not remember what the state of health of the patient was when first assessed. Nursing staff will not be able to track the patient's progress nor will they know the appropriateness or not of administering analgesia. Nursing staff may not appreciate when a patient is opiate naïve nor might they understand the significance of that in setting the first dose.

66. Good notes are a critical element in the patient's care and in this case the notes were terribly inadequate and that may have led in some cases to failures in patient care.

BUNDLES AND PAPERS

67. Before turning to the individual patients let me introduce some of the paperwork you will be receiving. There are individual files for each of the twelve patients. We have put into each file only those documents which we think are immediately relevant to your consideration but we have all of the patient notes available should more documents become relevant. These are working files. We have retained the original pagination but at the front of each file you will find a chronology prepared by Mr Fitzgerald

which relates to the most important features of that patient's care and which follows the care afforded to each patient as shown in the notes. The original records are much larger and we have made efforts to restrict the amount of documentation that you need to see. If at any stage you feel the need to see more, or if either side wish to add to the material, then that can be done during the course of the hearing.

68. There are several further files. One is a file containing all of Professor Ford's reports. *[We are going to provide you with those in advance of his evidence and we would invite you to read his report in advance of hearing from the witnesses who we intend to call in relation to each patient. That will give you the context of the witnesses' evidence and highlight the issues which you may want to consider when you hear from the witnesses. It will mean that if anything occurs to you, to be of potential relevance during the course of the evidence of the witnesses themselves, you will be enabled to put the relevant question at the appropriate point in the evidence].*

to address separately. whether going before panel.

69. A further file contains miscellaneous material which is called Panel Bundle 1.

70. A final file contains the statements produced by Dr Barton when questioned by the police. There have been a number of investigations into what went on at this hospital. There was a substantial police investigation as well as an investigation by the CHI. When Dr Barton was interviewed by the police she made no answer to the many hours of questions which were put to her about what had happened within these two wards. Instead, Dr Barton chose to draft a series of statements which she provided to the police in advance of her interviews. Those statements are self serving in

the sense that they are drafted by Dr Barton or by her lawyers and they were never tested under questioning by a police officer. Nevertheless, it is proposed that you should receive those statements as her account at the time of her actions. They must be regarded as self serving statements and we will have to wait and see whether or not Dr Barton chooses to give evidence so that she can be tested upon her account.

71. Most recently there was a coroner's inquest which looked into the deaths of a number of the patients. There was a degree of publicity about that inquiry and again if you heard anything about that through the press or internet you no doubt well understand that you should ignore anything you have previously heard. All that matters so far as your consideration of these charges is concerned is the evidence you now hear put before you by both sides. The findings of those other hearings and inquiries are at this stage irrelevant to your considerations except in so far as you may hear witnesses being cross-examined upon the evidence that they may have given previously in the course of other enquiries.

Patient A – Leslie Pittock (January 1996)

72. The first patient with whom you are concerned is patient A (Leslie Pittock). He was 82 years old when he was admitted on **5th January 1996** to the GWMH to Dryad Ward. He had previously been admitted to Mulberry Ward on the **13th December 1995** which was a psychiatric ward within the GWMH where he was under the care of Dr Banks. He suffered from depression and mobility problems.

73. He was verbally aggressive and was not mobilising well. Following his admission he developed a chest infection.

74. On the **3rd and 4th January** he had been assessed first by Dr Banks and then by Dr Lord who recorded that he was completely dependent upon nursing case, he had a urinary catheter in place, an ulceration on his left buttock and hip and low protein in his blood. Dr Lord indicated that she would transfer him to the GWMH to a long stay bed. It was thought to be unlikely that he would return to a residential care home. He was noted to be very depressed.

75. His daughter Lynda Wiles commented that she felt he had lost the will to live.

76. He was transferred on Friday **5th January 1996** to the GWMH to Dryad Ward where Dr Barton made a short entry – p.196. "Transfer to Dryad Ward from Mulberry. Present problems immobility, depression, broken sacrum small superficial areas on right buttock. Ankle dry lesion, both heels suspect. Catheterised. Transfers with hoist. May need help to feed himself long standing depression on lithium and sertraline".

77. On Tueday **9th** January Dr Barton noted that the patient's right hand was painful and he had increased anxiety and agitation.

78. Dr Tandy made an entry on **10th January** that the patient was for 'TLC' Tender Loving Care. She appears to have seen the patient prior to the administration of prescription of Oramorph later that day. That was during a ward round with Dr Barton and Nurse Hamblin.

79. At p.200 the drug chart indicates that Dr Barton prescribed Oramorph 5 mgs 5 times a day on **10th January**. There is also an undated prescription for between 40-80 mgs Diamorphine to be given over a 24 hr period subcutaneously. It is likely that that prescription was written out on the **10th** January at the same time as the Oramorph prescription because it appears to have been superseded the following day on the **11th January** when Dr Barton wrote another prescription for Diamorphine, but this time for a variable dose between 80-120 mgs to be delivered Sub-Cutaneously (SC) together with Midazolam 40-80 mgs. Dr Barton describes her first prescription for opiates by syringe driver as a 'proactive' one.

80. Two doses of oral morphine appear to have been administered on the day they were prescribed ie: the **10th** , and that became the regular prescription for the next five days.

81. Of the higher prescription on the 11th January Dr Barton says this – " I would have been concerned that although it was not necessary to administer the medication at that stage, (the patient's) pain anxiety and distress might develop significantly and that appropriate medication should be available".

82. According to Professor Ford the prescription on the **11th January** for a variable dose of Diamorphine of 80-120 mgs was poor practice and potentially hazardous and the lowest dose was still inappropriately high because it amounted to a four-fold increase on the opiate dose she was already receiving orally. His view is effectively the same so far as the Midazolam is concerned. The prescriptions ran a high risk of producing respiratory depression and potentially coma.

83. No Diamorphine was in fact administered until Monday the **15th January** when it was started at a rate of 80 mgs over a 24 hour period. Midazolam at 60 mgs over a 24 hour period was started at the same time. The only note that appears to give any justification for that medication was a nursing note that the patient 'appeared agitated'. That was a four-fold increase as compared to the oral dose which he had been receiving. Dr Barton claims she would have seen the patient on that Monday but made no note about it. She says – "I believe, I may have been told that his condition had deteriorated considerably over the weekend". "I believe my assessment of his condition at this time was that he was in terminal decline".

84. There is a note in the nursing record (p.208) for the **15th January** which simply states – 'S/B Dr Barton, has commenced syringe driver at 08.25'.

85. The dose of Midazolam, both that prescribed by Dr Barton and that administered by the nurses was excessively high. An appropriate starting dose for a frail older man, if an SC dose was justified at all would have been in the region of 10 mgs over a 24 hour period rather than a range of 40-80 as prescribed and 60 mgs as administered particularly in light of the fact that Diamorphine was started at the same time.

86. The lowest dose of Diamorphine prescribed and administered (which was unnecessary in the first place) was also far too high given that the patient had, until that point, been on only 30 mgs morphine orally per 24 hours on the **14th January**. The equivalent dose, even if necessary, should have been one of around 15-20 mgs going up to 30 mgs if the patient was sill in pain. The Midazolam was also according to Professor Ford excessively high. There was no explanation for it in the notes and no assessment to justify it.

87. On the **16th** Dr Barton added Haloperidol to the mix. A nursing note (p.26) records that the patient was agitated but that may have been a reaction to the Morphine he was being administered. There should at least have been a reassessment.

88. Apparently on the 18th but it may have in fact been on the **17th** Dr Barton again increased the dose of Diamorphine to 120 mgs and Midazolam to 80 mgs. Those doses were given from the 17th onwards. Dr Barton says that the increases were made on the 17th because the patient was tense and agitated. The nursing record for the 17th indicates (p.210) "S/B Dr Barton, medication increased as patient remains tense and agitated… remains distressed on turning".

89. Although the <u>oral</u> morphine prescribed by Dr Barton may have been justified by reason of the pressure sores from which the patient was suffering, there is nothing else in the notes to reflect why such a dramatic increase in the use of opiates was thought to be necessary by Dr Barton. The patient was not noted to be in any particular pain although he was agitated at times.

90. No clinical assessment seems to have been conducted before the prescriptions for the use of major opiates were issued. The high point so far as an assessment is concerned is that the nursing notes on **17.1.96** (p.210) indicate – 's/b Dr Barton, Medication reviewed and altered.'

91. On the **18th** January there is noted by Dr Barton –'further deterioration, sc analgesia continues, difficulty controlling symptoms, try Nozinan'.

92. On the **18th January** Dr Barton prescribed a new drug – Nozinan at 50 mgs. Nozinan is a sedating drug used to control terminal restlessness and agitation. A note the previous day on the 17th made prior to administration of that drug recorded that the patient appeared to be 'more peaceful' (p.210) and it is difficult to see what the justification was for adding another sedative to the potent mix that the patient was already receiving.

93. On Saturday **20th January** there is a medical note (p.198) that Dr Briggs was consulted (presumably because Dr Barton was not available over the weekend) and that the Nozinan was to be increased from 50 mgs to 100 mgs and Haloperidol was to be stopped on the verbal order of Dr Briggs. He did not attend the patient and this appears to have been done over the telephone. His reason for doing so was that Staff Nurse Douglas expressed a suspicion that the Haloperidol may be causing a side effect and he was concerned about the interaction of the drugs which the patient had been prescribed.

94. Between the 17th and 23rd January the daily syringe driver was filled with 120 mgs Diamorphine and 80 mgs Midazolam.

95. These drugs in conjunction with one another and with Haloperidol which the patient was also prescribed by Dr Barton, carried a high risk of producing coma and respiratory depression.

96. The patient died four days after the 20th on the **24th January 1996.**

97. Dr Barton may well claim that she was performing regular assessments but if that is so then she made no note of them and it is difficult to see how she could assess the needs of the patient on subsequent occasions when she had no assessment baseline from which to work. An assessment with no notes is clinically fairly pointless for the purposes of the future management of the patient.

98. Professor Ford is very critical of the note keeping in relation to the drug charts as well. At one stage there were three active prescriptions for Diamorphine which was extremely hazardous and in addition there were two actively running prescriptions for Haloperidol which put the patient at risk of coma had they been administered.

99. The infusions of Diamorphine, Midazolam and Haloperidol and then Nozinan very likely led to respiratory depression and shortened Patient A's life although he was expected to die in the near future.

Patient B – Elsie Lavender (February 1996)

100. Patient B was born in Code A and was 83 years old when she was admitted to the Royal Hospital Haslar on **5th February 1996** following a fall at home where she lived alone. She was registered blind. She was X rayed and no bony injury was found but there was concern that she might have suffered a CVA (Cerebral Vascular Accident or stroke). She had pain in her left shoulder and abdominal pain.

101. According to her son Alan, she made very good progress at the Haslar and was, by the time she moved to the GWMH, talking coherently and understanding what was being said to her. She was also mobile with a stick.

102. Some weeks after her accident, on the **22nd February,** she was transferred to the GWMH Daedalus Ward for rehabilitation and hopefully for return to a rest home. She died two weeks later on the 6th March.

103. Upon transfer she was seen by Dr Barton (p.175) on the **22nd** who noted that the patient had leg ulcers, was incontinent of urine, and suffered from insulin dependent diabetes Mellitus. She prescribed Dihydrocodeine which is a powerful synthetic opioid pain-killer on the second level of the Analgesic ladder.

104. Professor Ford notes that there was no assessment of the patient's pain nor of her neurological function. There should have been a clinical review but there was not, or at least none that was properly noted. The patient's son Alan recalls Dr Barton telling him that his mother had come to the hospital to die. He was surprised as that had not been his understanding.

105. On the **24th** there is a nursing note that the patient's pain was not being controlled by DF118 (DHC) and she had a sacral sore. She was commenced by Dr Barton on Morphine 10 mgs twice daily (p.1021).

106. Two days later on the **26th** Dr Barton noted that the patient's bottom was very sore and needed a Pegasus mattress. 'Institute SC analgesia as necessary'. She wrote out prescriptions that day for Morphine MST (Morphine Sustained Release tablets) at 20 mgs twice daily, and Diamorphine at a variable dose as required of 80-160 mgs, 40 – 80 mgs Midazolam and 400-800 Mcgs Hyoscine. None of those medicines were in fact administered. In respect of those prescriptions however Professor Ford is very critical. He describes them as 'not justified, reckless and potentially highly dangerous' (para 11). Even the lowest dose of Diamorphine would have amounted to a four-fold increase in opiates.

107. Dr Barton's explanation in her police statement was that this was 'pro-active' prescribing for pain relief, in case the patient experienced uncontrolled pain. She claims that she would have seen the patient on the 28th, 29th February and 1st March but appears to have made no note about those assessments whatever. The 2nd and 3rd March was the weekend.

108. On Monday **4th March** the notes record that Dr Barton increased the MST prescription from 20 mgs twice daily to 30 mgs twice daily.

109. Dr Barton's next entry was on the **5th March** when she noted that the patient had deteriorated and was not eating or drinking (p.975). She noted that the patient was in 'some pain, therefore start SC analgesia'. A nursing note records that the patient's pain was uncontrolled and the patient was

distressed (p.1013, 1022). Nurse Couchman, whose note that was, explains that she would have been relying on the night staff in order to make that entry and the dose was authorised by Dr Barton.

- 5/3/96 .

110. The syringe driver was commenced by the nurses at 09:30 that day with Diamorphine at 100 mgs and Midazolam at 40 mgs over a 24 hour period (p.1022) which doses were allowed for by Dr Barton's prescription for Diamorphine of between 100-200 mgs over a 24 hour period. Her prescription of Midazolam was between 40-80 mgs over 24 hours. Dr Barton (police statement) says that that this was necessary to relieve the patient's pain and distress.

111. An equivalent dose to that which the patient was already receiving orally but to be given S/C would have been in the range of between 20-30 mgs per 24 hours. So, even though the nurses were in fact starting at the minimum dose prescribed by Dr Barton even that was over three times greater than her previous equivalent dose of opiates. If the intention was to control the patient's pain by increasing the dose then a 50% increase at most might have been appropriate. Professor Ford describes the prescribing by Dr Barton as 'reckless and dangerous' (para 13).

112. The following day **6th March** Dr Barton noted that the SC analgesia had commenced and the patient was now comfortable and peaceful, she also wrote: 'I am happy for nursing staff to confirm death'. A nursing note (p.1023) says that the patient was seen by Dr Barton that day and the medication other than through the Syringe Driver was discontinued as the patient was unrousable.

113. Professor Ford states that the description of the patient as being comfortable and peaceful was more likely to reflect the reality that the patient was by that stage in a drug induced coma (para 14).

114. At 9.28 pm that evening the patient died. In Professor Ford's view the administration of the sub-cut Diamorphine and Midazolam led to patient B's deterioration and contributed to her death.

115. In respect of each patient Dr Barton is charged with prescribing drugs in such a way as to create a situation whereby the patient could be administered drugs which were excessive to their needs and that such prescribing was inappropriate, potentially hazardous and not in the patient's best interests. It may be thought to be relevant specifically to those charges that there is evidence that in some of these cases excessive drugs were indeed administered and that the hazard did indeed arise.

116. Additionally in Professor Ford's view, when the patient's condition deteriorated there was a duty upon Dr Barton to consult with her consultant colleagues as to the best approach to future treatment.

Patient C – (Eva Page) (February 1998)

117. Patient C was 87 years old when she was admitted on **6th February 1998** to the Queen Alexandra hospital having experienced a general deterioration over a five day period and was complaining of nausea and a reduced appetite. A suspected malignant mass was seen in her chest and the notes recorded on 12th February that she should be managed with palliative care on Charles Ward to which she was transferred on the **19th February**.

118. On the 23rd February she was diagnosed as being depressed and suffering from possible carcinoma of the Bronchus, Ischeamic heart disease, and congestive heart failure. She was plainly not at all well but she does not appear to have been in any pain.

119. She was transferred to GWMH on 27th February 1998, according to Dr Barton's note 'for continuing care'. Her Barthel score was zero to 2 which meant she needed help with all of her basic bodily functions. The Barthel scoring system is a method of assessing a patients ability to cope with their daily living requirements (an example of which appears in Bundle 1 Tab). A Barthel score of 20 would indicate that the patient was fully competent in all daily living requirements, a score of 0 indicates that help is needed with all activities.

120. A note made by Dr Laing (the duty GP) on 28th February records that she was 'confused and felt lost' but was not in any pain. She was distressed however and she was given Thioridazine and a small dose of Oramorph (2.5mgs) to help her.

121. On 2nd March Dr Barton suggested the use of adequate Opioids to control fear and pain. A Fentanyl 25 microgram patch was started that day as well as a small amount of Diamorphine 5mgs given by injection. Fentanyl is a very powerful synthetic opioid which comes on a patch which can be applied to the skin. It is particularly useful in circumstances where it is difficult to inject the patient. By its nature its effect is less immediate but may be longer lasting and the effects remain long after the patch is removed.

122. That patch was the equivalent, according to Professor Ford, of a 90 mg oral dose. All of those drug prescriptions up to this point are approved of by Professor Ford who regards them to have been a reasonable response to the patient's anxiety despite the lack of pain although the Fentanyl patch is very likely to have caused the patient to become very drowsy.

123. On 3rd March a rapid deterioration in the patient's condition is recorded with her neck and both sides of her body rigid. That same day Dr Barton prescribed Diamorphine with a variable range from 20-200mgs daily and Midazolam at 20-80 mgs daily by syringe driver. There is no note that the Fentanyl patch was removed or directed to be removed at that time. That syringe driver was commenced at 10.50 hours with 20 mgs of each drug and 11 hours later at 9.30 pm she was pronounced dead.

124. Those prescriptions of Diamorphine and Midazolam were in Professor Ford's expert opinion not justified. Her deterioration on the 3rd could have been as a result either of a stroke or an adverse reaction to the Fentanyl patch. However there was no indication that the patient was at that stage in any pain. The drugs would be expected to result in depression of the

level of consciousness and respiratory depression. The prescriptions were not consistent with Good Medical Practice and the analgesic ladder was not followed.

Patient D - Alice Wilkie (August 1998)

125. Patient D was born in Code A and was 81 years old when she was admitted on **31st July 1998** from the Addenbrooke Rest Home to the Queen Alexandra Hospital Portsmouth Philip Ward which was within the department for elderly medicine. She had had a fall and was refusing fluids. She was severely dependent and had a 0 mental test score when she was transferred to GWMH Daedalus Ward on **6th August 1998**. The nursing notes reveal that she was for 'assessment and observation and then decide on placement'. A further note reveals – 'pain at times, unable to ascertain where'.

126. Dr Lord assessed the patient on **10th August 1998** – 'Barthel 2/20, eating and drinking better, confused and slow. Give up place at Addenbrookes. Review in one month. If no specialist medical or nursing problems discharge to a new home'. (Probably this would have meant a continuing care bed within the NHS).

127. An entry on **17th August** in the nursing notes records that there had been a deterioration over the weekend and the patient's daughter had agreed that active intervention was not appropriate'. 'To use syringe driver if patient is in pain'.

128. There is in the notes an undated prescription written by Dr Barton for a variable dose of between 20-200 mgs of Diamorphine and 20-80 mgs of Midazolam per 24 hours and by syringe driver. That prescription must have been written on or before the 20th when a syringe driver was started.

129. On **20th** the syringe driver was started with 30 mgs Diamorphine and 20 mgs of Midazolam. Prior to that point this patient had not been receiving any analgesic drugs but her daughter Marylyn Jackson who visited her that day did notice that she appeared to be in pain. In this case it is difficult to see how the analgesic ladder was being applied.

130. The next entry in the notes by a doctor is on the **21st August** by Dr Barton – 'marked deterioration over the last few days. SC analgesia commenced yesterday, Family aware and happy'. A nursing note of the same day records that the patient is 'comfortable and pain free'.

131. At 6.30 pm that day the patient's death was confirmed.

132. In Professor Ford's opinion there was nothing to justify the use of a syringe driver in this case, there being no record of specific pain. Even if there were such a record, milder analgesics could and should have been tried first. A medical assessment was required before prescribing those drugs when the deterioration was apparent.

133. The variable range prescribed by Dr Barton was poor practice, very hazardous and in Professor Ford's view unjustified.

134. So far as the notes are concerned in Professor Ford's view the only acceptable medical note was that made by Dr Lord on 10th August during the entirety of the patient's stay at the GWMH.

Patient E - Gladys Richards (August 1998)

135. Patient E was born in Code A and she was 91 years old when she was admitted as an emergency via the A&E department at Haslar Hospital on **29th July 1998**. She had fallen on her right hip which was then painful. She was found to have a fractured neck of femur. Surgery by way of hip replacement was performed on the **30th July**.

136. On 3rd August she was seen by Dr Reid. He found her to be confused but pleasant and cooperative. He took the view that despite her dementia she should be given the opportunity to be remobilised and with that in mind he organised her transfer to GWMH.

137. Between that assessment and transfer on the 11th she had an episode on the **8th August** when she was recorded as being agitated and she was calmed down with Haloperidol and Thioridazine.

138. Her daughter Lesley O'Brien remembers that she made a good recovery after the operation and was soon up on her feet and walking with the use of a Zimmer frame.

139. On **11th August** she was transferred to Daedalus Ward at the GWMH. By this stage she was fully weight bearing and walking with the assistance of two nurses and she was continent but needed total care with washing and dressing. The purpose of her admission appears to have been rehabilitation.

140. Dr Barton's note on admission was – 'Impression frail hemi-arthroplasty, not obviously in pain, please make comfortable. Transfers with hoist,

usually continent, needs help with ADL (Activities of Daily Living) Barthel 2, I am happy for nursing staff to confirm death'.

141. Professor Ford describes this note as revealing a much less proactive not to say pessimistic attitude towards this patient's rehabilitation. Dr Barton's failure to recognise the patient's rehabilitation needs may have led to subsequent sub-optimum care for this unfortunate patient. Philip Beed also says that she was, in his view, in pain from her hip but that was not recorded at the time and the notes on the 12th (p.50) specifically state that the patient did not seem to be in pain.

142. Dr Barton wrote a prescription that day (the **11th**), effectively upon the patient's admission for a variable dose of between 20-200 mgs of Diamorphine together with 20 – 80 mgs Midazolam to be administered via a syringe driver. Very fortunately none of that prescription was in fact administered at that time though the Midazolam was administered at a later stage when the patient was re-admitted to the hospital.

143. She also prescribed Oramorphine 10 mgs on the 11th which was administered on the morning of the patient's admission. That prescription Professor Ford regards as inappropriate in the circumstances and may in fact have precipitated what followed.

144. The following night on the **12th** the patient was very agitated possibly as a result of her new surroundings but potentially also as a result of the commencement of opiate analgesia and she had to be settled with a dose of haloperidol. Philip Beed describes the patient as agitated and he ascribes pain as being the cause of that agitation but he does not appear to have

made a note to that effect. The patient's daughter Lesley visited her mother on the day after her admission, ie: on the 12th and was very surprised to find that her mother was unrouseable. She remembered that up until her transfer to GWMH her mother had been enjoying three meals a day.

145. On the **13th** she was found on the floor having fallen from her chair. That fall may well have caused a dislocation of her repaired hip and it certainly appears to have caused the patient pain. Her daughter Lesley remembers this being obvious and that her mother was weeping and calling out. The staff at the GWMH at first instance seem to have thought that this was as a result of the patient's dementia.

146. The following day on the **14th** the patient was assessed by Dr Barton who noted that sedation and pain relief had been a problem and that the patient was very sensitive to Oramorph. The patient was referred to the surgeons at Haslar again having been given a small amount of Oramorph and a further operation was undertaken. Again she appears to have recovered well from that operation and to have been treated well at the Haslar (Lesley O'Brien).

147. On the **17th** August she returned to the GWMH and the transfer unfortunately appears to have been performed inappropriately. She was transferred without the use of a canvas sheet which once again may have put too much pressure on her hip causing it further damage. The decision appears to have been taken not to send her back to the Haslar Hospital again.

148. On that day Dr Barton wrote out a further prescription for a variable dose of 40-200 mgs of Diamorphine. The patient was then dosed with 40 mgs of Diamorphine but at that stage, given the patient's pain Professor Ford takes the view that although high, the dose was not unreasonable.

149. On the **18th** she was recorded by Dr Barton as being 'in great pain' and was put onto a syringe driver on the direction of Dr Barton. She was dosed with 40 mgs Diamorphine, 20 mgs Midazolam and 5 mgs Haloperidol. That dosage continued until her death.

150. The expert's view is that Midazolam which had in fact been prescribed 7 days earlier on the 11th should not have been added to the cocktail of drugs because the combination of drugs was likely to lead to respiratory depression and coma. Dr Barton's explanation in her police statement was that it was used as a muscle relaxant to assist her movement and to make her as comfortable as possible.

151. On the 21st she was recorded by Dr Barton as being 'I think more peaceful, needs Hyoscine for rattly chest' and she died later that day.

152. The focus of the charges in respect of this patient is upon the original prescription by Dr Barton back on the 11th August of Diamorphine and Midazolam before the patient had her second fall and dislocated her hip. That prescription was say the GMC unjustified and dangerous and allowed for the administration of Midazolam to the patient at the end of her life of which Professor Ford is also critical.

153. Professor Ford is most critical of that early prescription where there was little or no indication that the patient was in pain at all. In the last days of

her life there are certainly indications that the patient was in pain and did require pain relief by opiates but there is a total lack of any suggestion that the patient was in pain when she first arrived at the hospital.

154. Indeed Dr Barton, when she was interviewed by the police indicated that the patient did not appear to be in pain. Immediately prior to her arrival at GWMH the patient had not been on regular analgesics at all and had last taken two tablets of cocodamol.

155. The expert is of the opinion that it was simply inappropriate to start the patient on opiate medication before trying milder analgesics.

156. The decision immediately to prescribe subcutaneous Diamorphine, Haloperidol and Midazolam was inappropriate, reckless and placed the patient at serious risk of respiratory depression and coma if they had been administered. The administration of the Midazolam in the last days of the patient's life when added to the other drugs was unjustified and inappropriate. That administration would appear to have been upon Dr Barton's direction and it was her prescription.

Patient F - Ruby Lake (August 1998)

157. Patient F was born in Code A and was 84 when she was admitted to Royal Hospital Haslar on **5th August 1998** for treatment for a fractured neck of femur following a fall at home. She was operated upon the same day and was transferred to GWMH two weeks later on **18th August to Dryad Ward**. One of her daughters Pauline Robinson who saw her on the weekend of the **15th and 16th** describes her as being 'very lucid' and 'up-beat'. She was mobile with a Zimmer frame on transfer and could wash her top half independently but suffered from leg ulcers, angina and breathlessness. She died three days after her admission on the **21st**.

158. Her Barthel score (p.373) was 9 and so she was able to wash and feed herself but needed help getting dressed and some help with walking.

159. Dr Barton's note on admission (p.78) recorded the history of the fall and her Barthel score of 6. Her note then reads 'gentle rehabilitation. I am happy for nursing staff to confirm death'. Nurse Hallman for one was surprised when she saw that annotation in this patient's notes. The patient was started on Oramorph and 5 mgs was given to her just after lunch at 14.15. The nursing notes record that the patient had two sacral pressure sores and ulcerated legs (Barrett xp.375).

160. That night the patient became anxious and distressed and wanted someone to sit with her – she was given 10 mgs of Oramorph instead. The following day on the **19th** at 11.50 Nurse Shaw describes how she administered the patient with Oramorph oral solution 10mgs in 5 mls.

That drug is of course a pain killer. The patient was complaining of chest pains which were not radiating down her arm.

161. In Nurse Shaw's words she was just continuing the prescription which had been started the night before, she was unable to comment on the pain that the patient was suffering. That may be an indication of the regime to which nurses had become used and which therefore they pursued without much thought.

162. In her police statement Dr Barton claims that she reviewed the patient on the morning of the 19th but made no note about it. She says that she was concerned that the patient was going to die shortly and wanted to be sure she had appropriate pain relief for the pain from her fractured hip and her sores and also from her anxiety and distress.

163. Either on the **18th** or more probably on the following morning **19th** , the day after Patient F's admission, Dr Barton prescribed her a variable dose of Diamorphine at a range of 20-200 mgs and Midazolam 20-80 mgs over a 24 hour period. The prescription is undated but we know was administered on the **19th** at 16:00 by Syringe Driver at 20 mgs together with Midazolam at 20 mgs. Nurse Hallman made an entry in the notes that the patient's pain was only being relieved for short periods and she was very anxious (xp.394).

164. On the **20th** the Diamorphine was increased in the afternoon to 40 mgs. Nurse Turnbull notes that the patient was still suffering some distress when moved. Her daughter Dianne Mussell went to visit her on the 20th,

she had been a regular visitor up until that point. She noted a marked deterioration in her mother's response.

165. A day later on the **21st** those drugs were increased to 60 mgs each at 07:35. Although Dr Barton says that she may have been unaware of that increase she would in any event have approved it. The patients **death was recorded at 18.25**

166. Professor Ford is critical of all of Dr Barton's prescriptions. On the night of the 18th it is unfortunate that the response of the staff to the patient's agitation was to provide her with a dose of Morphine when she simply wanted someone to sit with her. In the alternative a dose of Temazepam would have calmed the patient.

167. The lack of clear instructions as to what the morphine was to be used for may explain why it was given for distress and anxiety when there was no indication of pain. It is not an appropriate first line treatment for stress or anxiety, indeed morphine can in fact promote or exacerbate exactly those symptoms.

168. There is no indication from Dr B why she thought it right to prescribe either the Diamorphine or the Midazolam and there appears to have been no adequate assessment of the patient. If there was an assessment there was no note made of it.

169. The patient deteriorated rapidly after the commencement of the syringe driver and there was no medical assessment as to why that was happening. It may well have been due to the sedative effects of the opiates that were

being automatically injected into her body. The reaction to the patient's deterioration was to increase the quantities of opiates she was receiving.

170. It is likely that this patient died as a result of the combined effect of the drugs in her system.

Patient G – Cunningham (September 1998)

171. Patient G was 79 years old when he was admitted to GWMH Dryad Ward on **21st September 1998** under the care of Dr Lord the Consultant to whom he was known.

172. He had been admitted to Mulberry Ward on 21st July 1998 when he was depressed and tearful, and since the 27th August he had been living in a local nursing home 'The Thalassa'.

173. He had been seen at the Dolphin Day Care Hospital by Nurse Pamela Gell where he was found to be very frail with a large necrotic sacral sore, he was depressed suffering from dementia and was diabetic. Dr Lord admitted him for treatment of his sacral ulcer, a high protein diet and Oramorph if he was in pain. Dr Lord notes that the nursing home was to keep his bed available for him to return for at least 3 weeks. His prognosis was described as being 'poor'.

174. Dr Barton saw him on the day of his admission on the **21st** and made the following note (p.647) – 'Transfer to Dryad Ward. Make comfortable, give adequate analgesia. I am happy for Nursing staff to confirm death'.

175. It appears that she prescribed Diamorphine at a variable dose of 40-200 mgs and Midazolam between 20-200 mgs on that very day. The prescription is undated (p.758) but it has to be presumed to be the 21st because he was, on the day of his admission, put onto a syringe driver delivering those opiates to him automatically. Dr Barton's explanation for her prescription (in her police statement dated 21.4.05) was that she was

concerned that the Oramorph might become inadequate in terms of pain relief.

176. The patient's step-son Charles Stewart-Farthing went to see him that day and found him to be cheerful but complaining that 'his behind was a bit sore'. He was started at a rate of 20 mgs Diamorphine and 20 mgs Midazolam on the **21st**, and according to Nurse Lloyd's notes (p.754) the other drugs he had been on Coproxamol and Senna were not given because the patient was being or about to be sedated. P.867 reveals the patient remained agitated until approximately 20.30. The notes reveal that the patient had been behaving pretty offensively However, the driver was not commenced until 23.10 that night when the patient is described as 'peaceful'. It is hard to glean therefore from the notes what caused the commencement of the syringe driver. Nurse Lloyd states that although the patient was peaceful, it was not certain that he would remain that way.

177. On the **23rd** that medication was increased to 20 mgs Diamorphine and 60 mgs Midazolam. A note (p.868) by Nurse Hallman records that he was seen by Dr Barton on the 23rd, he had been chesty overnight and so Hyoscine was added to the driver. His stepson was informed of a deterioration and asked if it was due to the commencement of the driver. He was informed that the patient was on a small dosage which he needed. Charles Stewart Farthing saw his step-father again that day and was shocked at the difference in his condition. He found his step-father to be unconscious. He was so concerned that he asked for the syringe driver to be stopped so that he could have a conversation with the patient but this was denied.

178. He insisted on a meeting with Dr Barton who informed him that the patient was dying due to his bedsores and that it was too late to interrupt the administration of the drugs. Dr Barton claims that she reassessed the patient on a daily basis but failed to make any notes about it. She refers to the doses the patient received as 'small and necessary'.

179. On the **24th** the Midazolam was increased to 80mgs and on the **25th** the Diamorphine was increased to 60 mgs. That followed a further prescription from Dr Barton dated the **25th** for a variable dose between 40-200 mgs Diamorphine and 20-200 mgs of Midazolam. On each occasion that the dose was increased Dr Barton claims in her police statement that she 'anticipates' (as she puts it) 'that the patient's agitation might have been increasing'.

180. The following day the **26th** , the Diamorphine was delivered to the patient's body at a rate of 80 mgs and the Midazolam at a rate of 100 mgs. The patient died that day at 23:15 of broncho-pneumonia.

181. The first prescriptions on the day of his admission by Dr Barton are described by Professor Ford as 'highly inappropriate' and 'reckless' particularly in light of Dr Lord's assessment that he should be prescribed intermittent Oramorphine if in pain (PRN). There is no doubt that the patient would have been in pain from his sacral sore but there was no indication that the patient would not be able to take any medication for his pain orally if he needed to.

182. The prescription written by Dr Barton which allowed the nurses to administer the Diamorphine and Midazolam was undated but must have

been written on the day of admission and was for a dose range of between 20-200 mgs Diamorphine, and 20-80 Midazolam. It was poor management to prescribe those drugs to an elderly frail underweight patient and it created the hazard that the combination of drugs could result in profound respiratory depression

183. The increases on the **23rd** and thereafter are described as inappropriate and dangerous by Professor Ford who also expresses the concern as to whether the nursing staff would have understood how long it takes for the opiates delivered through a syringe driver to take full effect which in this case would have been between 15 and 25 hours (para 3.11). The result of this would have been that they were increasing the doses before the earlier dose had a chance to be fully effective.

184. As his condition worsened, in all likelihood as a result of the drugs which were being administered to him, there was no reassessment to discover the cause.

185. The various dose increases without explanation is described as very poor practice. Even if that was being done independently by the nurses, Dr Barton had created the situation where that had become possible.

186. The administration of 100 mgs Midazolam and 80 mgs Diamorphine would produce respiratory depression and severe depression of the consciousness level.

187. In addition to all of this there is no note that the patient was provided with food or fluid during the period following his admission until his death five

days later and that is despite the note from Dr Lord that the patient was to be provided with a high protein diet.

188. The cause of death was bronchopneumonia which can occur as a secondary complication to opiate induced respiratory depression.

Patient H – Robert Wilson (October 1998)

189. Patient H was 75 years old when he was admitted to Queen Alexandra Hospital on **21st September 1998**. He had sustained a fracture of his humerus bone following a fall. Whilst at the QAH he was given relatively small doses of morphine for pain. On assessment his Barthel score was 5.

190. On **7th** October it was noted that he did not want to go into care but wanted to return home. He was seen by Dr Luznat who was a consultant in old age psychiatry and she noted that Code A during the previous 5 years. She thought he may have developed early dementia.

191. On **13th October** he was assessed by his consultant physician Dr Ravindrane who found that he needed both nursing and medical care and that a short spell in long-term NHS care would be appropriate. Dr Ravindrane felt that he would remain at risk of falling until fully mobilised and he thought that the patient's kidney function should be reviewed. He prescribed his patient Frusemide which is a diuretic and Paracetamol for pain relief. The patient could, according to the doctor, have stabilised or alternatively died quite quickly.

192. The patient was visited that day by his son Iain (Wilson) who remembers him on the **13th** , the day before his transfer to GWMH, sitting up in bed and having a joke.

193. On his discharge from the QAH he was taking Paracetamol and Codeine as required for pain but he had only required four doses of codeine over the five days prior to his transfer. He was a heavy man weighing 93 Kilos.

194. On the **14th October** he was transferred to Dryad Ward for continuing care and Dr Barton noted on his admission that he needed help with his daily living activities, his Barthel score was 7, and he lived normally with his wife. He was continent and the plan was for further mobilisation. She also noted that he had alcohol problems. He also had congestive cardiac failure.

195. Professor Ford has noted that there was no record of any symptomatic medical problem at that time (para 5.8 police report). His blood pressure was not taken nor was there any clinical examination. It is important to note that this patient was not admitted for palliative care but for rehabilitation.

196. His wife Gillian Kimbley saw him on the day of his transfer to GWMH and indeed travelled with him in a minibus which was used for the transfer. She remembers him being lucid that day and able to hold a conversation.

197. The nursing note at GWMH on the **14th** recorded that the patient had a long history of drinking and LVF (Left Ventrical failure) and chronic oedematous legs.

198. On the day of his admission into the GWMH **(14th)** Dr Barton prescribed him Oramorph 10 mgs in 5 mils, 2.5-5 mls 4 – hourly despite the fact that in the days leading up to his transfer he had only been on Codeine for pain relief.

199. That prescription for Oramorph was administered twice that day, once in the afternoon at 14.45 and again in the evening at 22.45.

200. The following day **15th** he was administered 10 mgs in 5mls every four hours. That was given according to the nursing notes because he was complaining of pain in his left arm. Up until the stage of his admission to GWMH his pain had been controlled by Codeine and Professor Ford regards that very first prescription of morphine to have been inappropriate. His son Iain saw him that day and describes how his father was in 'an almost paralysed state'.

201. On the **16th** he was seen by Dr Knapman who noted that the patient had deteriorated overnight and he was for active nursing care. His son Iain describes him as being almost in a coma and unable to speak.

202. Later on the **16th** it was noted by Nurse Hallman that his chest was very bubbly and a syringe driver was commenced with 20 mgs Diamorphine and 400 mcgs Hyoscine. That was on the basis of a prescription written by Dr Barton which may have been written, according to Dr Barton, on the day of admission for a variable dose of Diamorphine between 20 and 200 mgs over a 24 hour period by syringe driver. That was, according to her police statement, one of Dr Barton's 'proactive' prescriptions for pain relief.

203. There appears to have been no re-examination by Dr Barton prior to that prescription being administered by the nurses. Indeed from her police statement it appears that she was away that day. It is quite possible according to Professor Ford that the Morphine the patient had been receiving was the cause of his deterioration.

204. On the following day, the **17th**, his secretions had increased and so the Hyoscine was also increased (Florio). In the afternoon the dosage of Diamorphine was increased to 40 mgs and Midazolam was started at 20 mgs. The date of Dr Barton's prescription for Midazolam at a variable dose between 20-80 mgs is unclear but it must have been on or before the 17th being the date it was administered. Hyoscine which was the drug used to dry up secretions was also increased. There was no record made of the reason for starting the Midazolam and at the time the notes suggest that the patient was in fact comfortable. Professor Ford views the use of Midazolam in these circumstances to have been highly inappropriate (para 5.15).

205. No consideration appears to have been given by Dr Barton or by the nursing staff to the real possibility that the reason for the patient's deterioration may well have been the infusion of the cocktail of opiates which he was receiving automatically through a syringe driver. The prescription of continuous subcutaneous Diamorphine is not an appropriate treatment for a diagnosis of myocardial infarction and heart failure in a patient who is otherwise pain free.

206. A particular issue with this patient was his previous chronic alcoholism which had been noted by staff and appears to have been known to Dr Barton. The use of opioids in patients with liver disease as a result of alcoholism has to be very carefully monitored and preferably not used unless required to deal with severe pain. If he was in pain then a low dose of morphine would have been a more appropriate response.

207. On the night of the **17th and into the morning of the 18th** that dosage was continued but in the afternoon of the **18th** it was increased again from 40 to 60 mgs Diamorphine and from 20 to 40 mgs of Midazolam. During none of this period was there any note made by either nurses or doctors that the patient was in pain though there were many notes that the patient was deteriorating.

208. At 23:40 on the night of the **18th** the patient's death was recorded four days after he entered that ward at GWMH. It was recorded that he had died from congestive heart failure. Professor Ford is of the view that the cocktail of drugs is highly likely to have led to respiratory depression and or bronchopneumonia.

Patient I – Enid Spurgin (March 1999)

209. Patient I was 92 when she was admitted to the Royal Haslar on **19th March** 1999 following a fall in which she had broken her hip. Prior to her fall she had been living at home and caring for herself. According to her medical notes she had been active and in good health. The fracture is described by an Orthopaedic surgeon Daniel Redfearn who has examined her notes, and was instructed by the police as an expert in her case, as a 'relatively complicated one'.

210. At the Haslar she had initially been given 3 doses of 5 mgs Morphine over the 20th and 21st March which had resulted in Hallucinations and so a note was made by the anaesthetist – nil further opiates. She was operated upon on the **20th** a right dynamic hip screw inserted. The only other analgesic prescribed for her was paracetamol (Redfearn).

211. She appears to have had post operative complications by way of bleeding, a haematoma developed and she had a painful hip.

212. Dr Reid reviewed her on the 23rd March and noted that she was still in a lot of pain and that was proving a barrier to mobilisation.

213. She was transferred that day **26th March** to GWMH Dryad Ward. Prior to transfer she was mobile and walking short distances with a Zimmer Frame and two nurses. She was continent during the day but not at night and her only analgesia was paracetamol. [Her nephew Carl Jewell who visited her at the Haslar fully expected his Aunt to be discharged from the GWMH and returned to her home].

214. Dr Barton made a note on admission (p.27) of her transfer to Dryad Ward '...PMH nil of significance, Barthel, not weight bearing, tissue paper skin, not continent, plan sort out analgesia'.

215. Dr Barton prescribed her Oramorph on the day of her admission 10mgs in 5 mls 2.5 mgs 4 times a day. A note (p.106 and see Tubbritt) asserts that the patient had complained a lot of pain. Oral morphine was administered on the **26th, 27th and 28th March** and then discontinued because the patient was vomiting it. She was given codydromol as an alternative (Barrett and Lloyd).

216. On the 27th, although it was a Saturday, Dr Barton believes she reassessed the patient although if she did she made no note, and she increased the prescription for Oramorph to 10 mls 4 times a day with 20 mls at night.

217. The care plan records that the patient was experiencing pain on movement (p.84).

218. If pain was uncontrolled by less powerful analgesics then those prescriptions were appropriate, according to Professor Ford. However, there is no note from Dr Barton recording her assessment or her reasons for prescribing as she did. The patient should not have been in severe pain unless something had gone wrong with the hip repair which would have required re-assessment.

219. The fact that Dr Barton has recorded that the patient was not weight bearing is not consistent with the notes made at the Royal Haslar and is either inaccurate or indicates that there had been a change in the patient's mobility. That should have triggered a re-assessment which does not

appear to have taken place. A nursing note (p86) reveals that on the 4th April the wound was oozing serous fluid and blood and the wound was redressed.

220. On the 31st March Dr Barton has prescribed 10mgs of Morphine Sulphate to be given twice a day. There is no note of any review by her.

221. [The patient's nephew Carl remembers visiting her on about the 1st April when she was still talking about leaving the hospital. His impression was that she was very rarely seeing a doctor].

222. On the **6th April** Dr Reid suggested that there may have been a problem with the hip screw and requested that an X-ray be arranged. Unfortunately that was never actioned. That day, Dr Barton increased the dose of Morphine by slow release tablets to 20 mgs twice daily. In her police statement she reveals that she would have seen the patient that morning but made no note about it.

223. A note by Nurse Shaw (p.106?) of that consultation with Dr Barton reveals that Enid has been incontinent a few times but was insistent about not going into a care home. There was in that note no mention of pain. Those doses were administered until the **11th** April.

224. By the **11th** April the patient was very drowsy but still in pain if moved.

225. On the **12th** April Dr Barton prescribed Diamorphine by syringe driver at a variable dose between 20-200 mgs over a 24 hour period as well as 20-80 mgs of Midazolam. There is no note of any further assessment by Dr Barton on the 12th.

226. Those prescriptions are described by Professor Ford as 'reckless and inappropriate'. The patient was already described as 'very drowsy' and any dose over about 30 mgs sub-cut would be highly likely to produce coma and respiratory depression.

227. In fact the dose administered by Nurse Shaw, apparently either on her own calculation or under Dr Barton's direction on **12th April,** was 80 mgs Diamorphine together with 30 mgs Midazolam. Those doses were well within the variable dose that Dr Barton had prescribed but in fact were much higher than the dose of Morphine that the patient was already receiving and extremely dangerous. Nurse Lynne Barrett could not explain why the patient was prescribed such a large dose and she in fact thought that the dose was only 60 mgs.

228. When Dr Reid noticed that the patient was receiving 80 mgs of Diamorphine he reduced it down to 40 mgs (p.108 and Barrett) however the patient died the following day. In Professor Ford's view the drugs she was being administered were a direct contributor to the patient's death.

229. Mr Redfearn the orthopaedic expert raises concerns in relation to the lack of response to the patient's pain which should have prompted the doctors to look for a possible orthopaedic explanation for her symptoms. This was never done.

230. The charges reflect on this occasion specifically the lack of assessment by Dr Barton given the patient's condition on entry onto the ward. Criticism is also made of the prescriptions written by Dr Barton on the 12th and the direction to administer such a high dose on the same day.

Patient J – Geoffrey Packman (August 1999)

231. Patient J was born in Code A and he was 67 years old when admitted to Dryad Ward on 23rd August 1999. He was suffering from bi-lateral leg oedema (swelling) and venous hypertension. He was very obese, suffered from atrial fibrillation and had poor mobility. He had a poor Barthel score. He was not a well man.

232. Some weeks earlier he had suffered an accident in his bathroom at home. He was admitted to A&E on the **6th** August to Anne Ward at the Queen Alexandra Hospital. On the 8th August it was noted that he had very severe sores on his sacral area. The annotation was made in his notes on two occasions – "not for 555" meaning that he was not to be given resuscitation in the event of a life threatening event.

233. Eventually, according to his wife Betty, he made a good recovery and looked better than he had for years.

234. He was, on the **23rd August, transferred to Dryad Ward** for recuperation and rehabilitation.

235. When he was assessed on Dryad Ward by Dr Ravindrane on the **23rd** the problems recorded were: obesity, arthritis in both knees, pressure sores. His mental test score was however good there being no significant cognitive impairment. His Barthel score had by now improved to 6. Nurse Hallman however remembers this patient as having the worst pressure sores she had ever seen.

236. Dr Barton believes, according to her police statement about this patient, that she must have reviewed him on the morning of the **24th** but made no

note about it. On the **24th** August a drug called Clexane was prescribed which he received to reduce the risk of a DVT as well as Temazepam

237. On the **25th** August he was vomiting and passing fresh blood. Again there is no note of any review by Dr Barton though she thinks she performed one. The notes reveal that when it was noted that the patient was passing fresh blood through his rectum Dr Beasley was contacted and directed that Clexane which was an anti-clotting agent should be stopped.

238. His wife Betty recalls visiting him with friends on around the 25th or 26th and meeting Dr Barton for the first time. Dr Barton took her into a room and told her bluntly that her husband was going to die and she should look after herself now. Betty was very shocked and surprised.

239. On **26th** August Dr Barton made this note – 'called to see. Pale clammy unwell. Suggests ?MI (Myocardial Infarction) treat stat Diamorph, and Oramorph overnight. Alternative possibility GI (gastrointestinal) bleed but no haematemesis (vomiting of blood). Not well enough to transfer to an acute unit, keep comfortable. I am happy for nursing staff to confirm death.'

240. No note of pulse, blood pressure or any other indications of a clinical examination are present.

241. However on that day (Thursday **26th)** Dr Barton appears to have given a verbal order to give Diamorphine intra muscularly which was injected that day. She also prescribed Oramorph 10 mgs in 5 mls 4 times a day which was administered daily thereafter from the 27th August until the syringe driver was commenced on the 30th August. There is also an undated

prescription written by Dr Barton for a variable dose of Diamorphine of between 40-200 mgs and Midazolam of 20-80 mgs. Dr Barton says in her police statement that she wrote that prescription out on the **26th** and that may well be right. Dr Barton says however that she had no intention that it should be administered at that time.

242. The following day, on Friday **27th** , the patient is noted to be in discomfort particularly when his dressings were changed. Dr Barton claims she would have reviewed him but made no note of it.

243. The syringe driver was commenced on Monday the **30th** August which was a Bank Holiday, with Diamorphine at a rate of 40mgs and Midazolam at 20 mgs. There is no note from Dr Barton about that and she is not sure if she would have gone in on a bank Holiday. It seems therefore that the syringe driver was started at the discretion of the nurses as was the amount of opiate to be administered within the range set by Dr Barton and at the lowest dose. Dr Barton believes the nurses would have spoken to her but there is no note of that recorded.

244. Those same doses were administered on the **31st August** when it was also noted that he had passed a large amount of black faeces which was an indication of a significant gastro-intestinal bleed.

245. On the **1st September** the Diamorphine was increased to 60 mgs and the Midazolam to 40 and then 60 mgs on the same day and then the following day they were increased again.

246. On the 1st Betty visited him and he did not wake up throughout the visit. His daughter Victoria remembers that her Dad deteriorated once he was in

the GWMH and that he appeared to be 'spaced out'. She describes the change as 'dramatic'.

247. On the 2nd **September** the Diamorphine was increased to 90 mgs and the Midazolam was increased to 80 mgs in a 24 hour period. Jeanette Florio (nurse) says that she could not imagine such an increase taking place without the authority of a doctor. Dr Barton says that she would have reviewed the patient but made no note of it. She says this – "I anticipate again that (the patient) would have been experiencing pain and distress". If that is so it is very surprising that no note has been made about it.

248. The patient's daughter Victoria sat with him throughout the 2nd. He was unconscious throughout the day.

249. The patient **died on the 3rd September** at 13.50.

250. In Professor Ford's opinion the patient's death from a massive gastrointestinal bleed was contributed to by the Clexane he was prescribed on the 24th August although it was stopped the following day, and possibly by the opiate induced respiratory depression. He was not dying nor expected to die prior to his deterioration on Dryad Ward on the 26th August. He had pressure sores but those were treatable. He had been transferred for recuperation and rehabilitation. Before deciding that the patient should not be transferred to an acute unit, which Dr Barton did on the 26th, she should have had further discussion with a senior consultant colleague.

251. Her assessment of the patient was inadequate and her verbal order to administer Diamorphine was inappropriate.

252. There is no proper explanation for the doses of subcutaneous Diamorphine or Midazolam that she prescribed and no explanation for the dramatic increase in quantities of those drugs being administered.

253. The dose ranges were inappropriate and hazardous and unjustified by an assessment of the patient's condition.

Patient K – Elsie Devine (October 1999)

254. Patient K was an 88 year old lady when she was admitted on 9th October 1999 to the Queen Alexandra hospital with an episode of acute confusion. Her problems are summarised by the letter at xp.29 and 30 by Dr Taylor a clinical assistant in old age psychiatry.

255. She was confused, disorientated and sometimes aggressive. She had a medical history of treated hypothyroidism and chronic renal failure. She was independent and able to wash but tended to get herself lost.

256. She was transferred to GWMH on the **21st October 1999**. The referral letter (p.21) written by Dr Jay a consultant geriatrician who saw her on the 19th stated – that she was alert and could stand but was unsteady on walking. She was increasingly confused and had been aggressive until she got to know the staff.

257. Dr Barton's note on admission on the **21st** stated that she was for continuing care. That she needed help with all her daily living needs and she had a Barthel score of 8. 'Plan get to know. Assess rehab potential probably for rest home in due course'.

258. On the **25th October** and **1st November** there are entries by Dr Reid indicating that the patient was continent but mildly confused and wandering during the day, she was suffering from renal failure, but was physically independent although she needed help with bathing.

259. Two weeks later on Monday the **15th** November there is a note that she had been aggressive at times and needed Thioridazine to calm her down. Lynne Barrett was one of the nurses who helped to look after her and she

recalls a specific aggressive incident when the patient grabbed a nurse and would not let go and kicked out at Ms Barrett.

260. Dr Reid saw her on his ward round that day but that was the last time he saw her. He noted that there was not a single entry on her clinical notes since the last time he had seen her two weeks before. He made a full examination of her. Her heart, chest, bowels and liver were all normal. Her legs were however badly swollen. He wanted the patient to be seen by Dr Luznat the psychiatrist and made a note to that effect.

261. On the **18th** the patient was seen by Dr Taylor one of Dr Luznat's team (Consultant Old age Psychiatry) and arrangements were being made to transfer her to an old age psychiatry ward for assessment and management.

262. However, that same day she was confused and aggressive (18th) and Dr Barton prescribed a Fentanyl patch for the patient. Fentanyl is an opiate which is applied to the skin on a patch. There was no indication in the notes as to why Dr Barton thought it appropriate to start the patient on opiates and there is no reference anywhere in the notes to this patient being in pain. Dr Barton in her statement to the police about this patient stated that the patch was 'an attempt to calm her, to make her more comfortable and to enable nursing care'. The patch was applied at 09:15 on the 18th and can take up to 24 hours before it becomes fully effective (Reid) and remains in the system for between 12 and 24 hours after the patch itself is removed (Reid).

263. A note made by Dr Barton on the **19th** indicates that there had been a marked deterioration overnight.

264. Dr Barton wrote on the **19th** – 'today further deterioration in general condition. Needs SC analgesia with Midazolam. Son aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death'. Dr Barton prescribed that day Diamorphine 40-80 mgs and Midazolam 40-80 mgs.

265. In addition at 08:30 the patient was given an injection of Chlorpromazine 50 mgs prescribed by Dr Barton following an incident in which the patient is suggested to have been aggressive with nurses. This is a tranquiliser and 50 mgs is according to Dr Reid at the upper end of the normal range of dosage. An hour later a syringe driver was started by the nurses that day (**19th**) at 09:25 containing 40 mgs of Diamorphine and 40 mgs of Midazolam. The Fentanyl patch was not removed until 3 hours later at 12:30 according to the notes. There is no record anywhere in the notes that the patient was at any time in pain. At this stage therefore on this Friday morning this patient had in her system, Fentanyl, Chlorpromazine, Diamorphine and Midazolam.

266. It is very difficult to understand why anyone would have thought it appropriate to start this patient on anything less that the minimum dose of 20 mgs Midazolam even if the patient was complaining of pain, which she wasn't.

267. The syringe driver was kept replenished for the next two days at those dosages. Dr Barton wrote in her police statement – 'this medication (Diamorphine and Midazolam) was prescribed at 09.25 and was administered with the sole intention of relieving (the patient's) significant distress, anxiety and agitation which were clearly very upsetting for her'.

268. Dr Barton again says that she had been making daily weekday reviews of this patient but accepts that she failed to make a note of any of them and that she 'relied greatly on daily reports from the nurse in charge and their nursing note entries'.

269. The patient **died** two days later on the **21st November.**

270. Dealing with the Diamorphine and Midazolam prescription on the 19th Professor Ford can not see the justification for it. Even if the patient had been in pain, for which there is no evidence, the starting doses were excessively high. An appropriate starting dose might have been 10 or 20 mgs if the patient was in pain but not double that and not when coupled with Midazolam.

271. Neither in Professor Ford's view was the Fentanyl justified. This regime of opiate medication has every appearance of being given to keep the patient quiet which would not be an appropriate use of opiates in this setting.

272. The drugs administered are very likely to have led to respiratory depression and coma.

Patient L – Jean Stevens (May 1999)

273. Patient L was 73 years old when admitted to Royal Haslar Hospital on 26th April 1999 after experiencing chest pains and collapsing.

274. She was found to have suffered a stroke as a result of a cerebral infarction in the right parietal lobe. She was looked after for several weeks and made a substantial recovery. [She was seen on the 19th May by her daughter June Bailey and was in good spirits, laughing and joking].

275. On 20th May she was transferred to Daedalus Ward but she was according to records in a very poorly condition and died two days later.

276. The criticism by the GMC of Dr Barton's care of this patient hinges around her immediate prescription upon entry onto the ward on the **20th** of Oramorphine, Diamorphine, and Midazolam in the usual very large variable ranges. This is not a case where this unfortunate patient was likely to recover or leave the hospital.

277. The only note by Dr Barton was on (Vol 3, p.20). The 2nd note was by nurse Tubritt recording death on the 22nd. According to her husband (Mr Stevens), Dr Barton did not in fact see her at all during her short stay at GWMH.

278. A nursing note on the **21st** recorded a conversation with her husband indicating that he was anxious that medications should not be given which might shorten her life.

279. The syringe driver was started on **21st** with 20 mgs Diamorphine and 20 mgs Midazolam.

280. Dr Barton's entry makes no mention of the patient being in any pain and contains no record of any physical examination of the patient. In Professor Ford's expert opinion there is no evidence that Dr Barton undertook a clinical assessment of this patient. Although the patient had previously complained of chronic abdominal pain, treatment with opiates would not have been appropriate.

281. In addition the dose ranges were far too wide and the dose of Midazolam excessively high.

CONCLUSION

282. As already indicated, Professor Ford is very critical of the quality of Dr Barton's note making. She failed to note assessments of the patients' condition if she was making them, she failed to make notes about important decisions relating to treatment and prescribing. She made few if any notes about why she regularly increased the dosages of her prescriptions.

283. Failing to make appropriate notes in relation to assessments in admission to the hospital is particularly serious because it leaves other treating medical personnel in the dark about what the baseline condition of the patient was upon admission and it left her with no notes that she could rely upon to assess properly whether the patient's condition had improved or worsened.

284. In view of the complete lack of note making it has to be inferred that no assessments were being performed properly before opiates were prescribed. The prescription of very large doses of opiates appears to have become a matter of course in the GWMH and the patient's best interests were not served as a result.

285. The prescribing by Dr Barton was, on occasion, dangerous and inappropriate and left far too much to the discretion of the nurses.

286. Patients were overdosed with opiates so much so as to become unresponsive.

BURDEN AND STANDARD OF PROOF

287. The burden of proving the charges is upon the GMC and the standard of proof in this case which is heard under the old rules is the criminal standard. In other words, before finding any of the heads of charge which have not been admitted, proved, the Panel would have to be sure that Dr Barton had acted in the way alleged.

A) WITNESS SCHEDULE AND EXPLANATION

B) PATIENT NOTES AND CHONOLOGIES

C) PROFESSOR FORD'S REPORTS

Tom Kark

QEB Hollis Whiteman Chambers

Temple, London EC4Y 9BS 4th June 2009

Draft Final 6.5.09

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 ***5mg 5 times daily***, 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,

b) In relation to your prescriptions described in paragraphs 2a (ii) and 2a (iii):

i) ***the lowest doses prescribed of Diamorphine and Midazolam were too high;***

ii) the dose range was too wide,

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

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

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

e) Your actions in prescribing the drugs as described in paragraphs 2a) ii), iii), iv), v), and vi) ~~and/or vii)~~ were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient A.

Patient B (Elsie Lavender)

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

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

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

iv) On 5 March you prescribed Diamorphine with a dose range of 100 - 200 mg and Midazolam with a dose range of 40 mg – 80 mg over a twenty-four hour period to be administered SC and a syringe driver was commenced containing Diamorphine 100 mg and Midazolam 40 mg.

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

i) ***the lowest commencing doses prescribed on 26 February and 5 March of Diamorphine and Midazolam were too high;***

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

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

c) Your actions in prescribing the drugs described in paragraphs 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 ***colleague*** when Patient B's condition deteriorated.

e) Your actions and omissions in relation to your management of patient B were:

i) inadequate,

ii) not in the best interests of Patient B.

Patient C (Eva Page)

4. a) i) On 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care,

ii) On 3 March 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20-80mg to be administered SC over a twenty-four hour period on a continuing daily basis.

b) In relation to your prescription for drugs described in paragraph 4a) ii):

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

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

c) Your actions in prescribing the drugs described in paragraph 4a) ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of your patient,

Patient D (Alice Wilkie)

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

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

b) In relation to your prescription for drugs as described in paragraph 5a (ii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs as described in paragraph 5a (ii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient D.

Patient E (Gladys Richards)

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

ii) On 11 August you prescribed 10 mg Oramorphine 'prn' (as required),

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

b) In relation to your prescription for drugs described in paragraph 6a) (iii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraph 6a) ii) and/or (iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient ***E***.

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

b) In relation to your prescription for drugs described in paragraph 7a) (iii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraphs 7a) ii) and/or iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient F.

Patient G (Arthur Cunningham)

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

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

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

b) In relation to your prescriptions for drugs described in paragraphs 8a) (ii) and/or (iii):

i) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraphs 8a) (ii) and/or (iii) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient G.

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

Patient H (Robert Wilson)

9. a) i) Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease [Code A] and other medical conditions,

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

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

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

~~b) You did not properly assess Patient H upon admission. This was:~~

~~i) inadequate,~~

~~ii) not in the best interests of Patient H.~~

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

i) inappropriate,

ii) potentially hazardous,

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

iv) not in the best interests of Patient H.

d) In relation to your prescription described in paragraph 9a) iii):

i) the dose range was too wide,

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

e) Your actions in prescribing the drugs described in paragraphs 9***a)*** ii), iii) and/or iv) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient H.

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

Patient I (Enid Spurgin)

10 a) i) Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital,

ii) On 12 April you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twenty-four hour period on a continuing daily basis,

iii) On 12 April a syringe driver with 80 mgs Diamorphine and 20 mgs Midazolam over twenty-four hours was started under

your direction but later the dose was reduced to 40 mgs by Dr Reid.

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

   i) inadequate,

   ii) not in the best interests of Patient I.

c) In relation to your prescription for drugs described in paragraph 10a) ii):

   i) the dose range was too wide,

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

d) Your actions in prescribing the drugs described in paragraph 10a) ii) were:

   i) inappropriate,

   ii) potentially hazardous,

   iii) not in the best interests of Patient I.

e) The dosage you authorised/directed described in paragraph 10a) iii) was excessive to Patient I's needs. This was:

   i) inappropriate,

   ii) potentially hazardous,

   iii) not in the best interests of Patient I.

Patient J (Geoffrey Packman)

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

ii) On 26 August 1999 you gave verbal permission for 10 mg of Diamorphine to be administered to Patient J,

iii) You saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death',

iv) You did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition,

v) On 26 August you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis,

vi) On 26 August you also prescribed Oramorphine 20 mg at night.

b) In relation to your prescription for drugs described in paragraph 11a) v):

i) ***the lowest doses of Diamorphine and Midazolam prescribed were too high;***

ii) the dose range was too wide,

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

c) Your actions in prescribing the drugs described in paragraphs 11a) ii) and/or v) were:

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient J.

d) Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11a) iv) was:

i) inappropriate,

ii) not in the best interests of Patient J.

Patient K (Elsie Devine)

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

ii) On admission you prescribed Morphine solution 10mg in 5 ml as required,

iii) On 18 and 19 November there was a deterioration in the Patient K's condition and on 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.

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 lowest doses of Diamorphine and Midazolam prescribed were too high;***

ii) the dose range was too wide,

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

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

i) inappropriate,

ii) potentially hazardous,

iii) not in the best interests of Patient K.

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

Patient L (Jean Stevens)

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

ii) On 20 May 1999 you prescribed:

a) Oramorphine 10 mgs in 5 mls 2.5-5mls;

b) Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis;

c) Midazolam with a dose range of 20 to 80 mgs to be administered SC;

iii) You further prescribed Oramorphine 10 mgs in 5 mls 4 times a day ***and 20 mgs nocte (at night)*** as a regular prescription to start on 21 May 1999;

iv) Doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient in 21 and 22 May 1999.

~~b) 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 13 a) ii) and/or iii):

i) There was insufficient clinical justification for such prescriptions;

ii) The dose range of Diamorphine ***and Midazolam*** was too wide;

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

iv) Your actions in prescribing the drugs described in paragraph 13 a) ii) and or iii) were:

a. Inappropriate;

b. potentially hazardous;

c. Not in the best interests of patient L.

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

Records

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

    i) the findings upon each examination,

    ii) an assessment of the patient's condition,

    iii) the decisions made as a result of examination,

    iv) the drug regime,

    v) the reason for the drug regime prescribed by you,

    vi) the reason for the changes in the drug regime prescribed and/or directed by you,

    b) Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were:

    i) inappropriate,

    ii) not in the best interests of your patients.

Assessment

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

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

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

The GMC

and

Dr Jane Barton

Opening

INTRODUCTION

1. This case concerns the treatment provided to twelve patients at the Gosport War Memorial Hospital all of whom were in-patients there between 1996 and 1999. Dr Barton was employed during the period as a clinical assistant which meant that she had day-to-day care of the patients on the two relevant wards which were Daedalus and Dryad.

2. The Hampshire Primary Care Trust boasted four hospitals at the relevant time in the Portsmouth Area. The Queen Alexandra Hospital which has a number of sites clustered around the top of Portsmouth; St Mary's Hospital which is in Portsmouth itself; the Royal Haslar Hospital which was once the Royal Naval Hospital, the first version of which was built in the middle of the 18th Century; and finally the Gosport War Memorial Hospital (GWMH).

3. The GWMH was opened in 1923. Since then it has occasionally been extended. At the relevant time that you will be asked to consider, the

GWMH was effectively a cottage hospital which would receive patients who required longer term or rehabilitative care. Prior to the period we are considering the GWMH had been spread around a number of sites, but by the relevant time period it was centred in a single building.

4. It was a community hospital and did not have an acute ward nor any emergency facilities. Originally palliative care patients or those terminally ill were cared for in part of the Gosport War Memorial Hospital (GWMH) called the Redcliffe Annex which was some miles from the main hospital. That was a geriatric ward for patients who could not cope on their own, it was closed in 1995 and all of their patients were sent to Dryad Ward which was one of three wards at the GWMH. The other two elderly care wards being called Daedalus and Sultan Ward.

5. Emergencies arising on the wards of the Gosport War Memorial Hospital would have to be transferred by ambulance to one of the local hospitals where emergency treatment could be provided. The Royal Haslar was a few minutes away.

6. Dr Barton was a local GP practising in Gosport in Hampshire. She qualified at Oxford University in 1972 as a Bachelor of Medicine and a Bachelor of Chemistry. She became a GP, initially as an assistant and then as a partner. In 1980 she was appointed to the General Practitioner medical staff at the GWMH (see - Samuel) and in 1988 she applied for and was appointed to the post of Clinical Assistant at the Gosport War Memorial Hospital. The period of her employment there, upon which this case will focus, was between 1996 and 1999.

7. During her period at the hospital she continued in her full time post as a GP doing morning surgeries at her GP practice every day and evening surgeries on a rota basis with her other GP partners. She was also doing one night a fortnight on call and one weekend on call in four (police statement of Dr Barton re: Gladys Richards).

8. Dr Barton had not specialised in either Geriatric or Palliative medicine and had no specific training other than some ½ day sessions in 1989 B1, T2 p.4 ~~of which we are aware~~ other than her experience over the years. Dr Barton's main job was as a GP in a local Gosport practice. She would conduct ward rounds at GWMH as a general rule between 7.30 and 8 a.m. Monday to Friday on a daily basis (Barrett). She would also, according to the witness Philip Beed and according to the statement Dr Barton made subsequently to the police, attend at midday to clerk any new admissions. She would be fairly reliant on nursing staff to flag up any problems and would not necessarily see every patient every day (Beed, Interview 7/25).

9. There are two wards at the GWMH to which all of the twelve patients upon whom we are focussing were admitted.

10. Dryad Ward which was an elderly care ward consisted of approximately 20 beds.

11. Daedalus Ward was a 24 bed ward. 8 of those beds were for slow stream stroke patients and the remaining beds were for the continuing care of elderly patients. Many of the patients admitted to these wards were expected to be rehabilitated sufficiently so that they could either return home or to care homes. This was not a hospice although of course some patients were very ill and inevitably were not going to leave hospital.

12. Additionally GWMH had an old age psychiatric ward by the name of Mulberry.

13. Dr Barton appears to have developed a practice on the two wards Dryad and Daedalus, of prescribing large quantities of opiates on an 'in-case' or, as she called it, an 'anticipatory' basis. 'In case' the patient found themselves to be in pain or 'in case' the patient's pain was uncontrolled by the opiates already given, or 'in case' Dr Barton was away or it was a weekend. Many of the patients you are going to hear about were opiate naïve, in other words, until they set foot inside the GWMH, they had never been given opiates as a form of pain relief and had not apparently required them. In the view of the GMC's expert Professor Ford, none of the patients, about whom you are going to hear, were properly and appropriately prescribed opiates by Dr Barton.

14. There was we say a series of failures which led to patients being over medicated and unnecessarily anaesthetised. The failures included a lack of proper assessment before opiates were prescribed and a wholly irresponsible method of prescribing opiates. There was an almost universal failure by Dr Barton to make proper notes either of assessment of the patients if such assessments were taking place or to justify her actions in prescribing opiates. Frequently opiate medication was increased with no explanation noted. even though these were drugs which were capable of ending life.

15. The favoured method of prescribing to these patients was to provide for a variable dose of the drugs Diamorphine and Midazolam which were to be administered by way of syringe driver. The dose range prescribed by Dr Barton was, in each case that you are going to consider, far too wide and breached acceptable medical practice.

16. Prior to the syringe driver being administered many of the patients were unnecessarily prescribed oral morphine in the form of liquid morphine called 'Oramorph' or slow release Morphine tablets (MSTs).

17. Philip Beed one of the nurses and Clinical Manager of Daedalus Ward puts it in this way (police interview p.28/37) – "it's the nursing staff who really have the full picture of how a patient has been and then we would discuss and talk about how we would do it with the medical staff making decisions about care. We would call a doctor if we needed to, but we would have discussed the patient's ongoing care and prognosis on each occasion we saw the doctor so we are empowered to initiate a syringe driver. The syringe driver would be written up and the instruction would be 'if this patient's condition worsens you can utilise the syringe driver to keep that patient pain free'". There appears therefore to have been considerable discretion left with the nursing staff as to commencement of the syringe drivers and the quantity of opiate to administer. Some nurses will say they always consulted the Doctor 1st. It seems that some did not.

18. When ~~the~~ patients became agitated, they were then administered increasing quantities of Diamorphine and Midazolam by the nurses under Dr Barton's prescriptions, until they were agitated no more. On occasion the agitation may have been the result of the effect of Oramorph in the 1st place. Many of the patients who are described in the nursing notes as 'calm and peaceful' were, in fact, according to Professor Ford, in 'drug induced comas'.

19. Professor Ford, is the Professor of Pharmacology of old Age at the University of Newcastle upon Tyne and practices as a consultant Physician in clinical Pharmacology at the Freeman Hospital. He is the co-editor of Drugs and the Older Population published in July 2000.

20. He has examined each of the cases which we have placed before you and he is highly critical of Dr Barton's practice in terms of her prescribing, her lack of assessment of patients and her failure to make relevant and necessary notes.

21. Dr Barton may claim, that she was entitled to rely on the experience of the nurses when prescribing the ~~huge~~ Large quantities of Diamorphine and Midazolam which she did. She may say that she was entitled to rely on the nurses, not to provide the medication which she was prescribing unless it was necessary. However, there was a lack of a proper system to ensure that patients were not overmedicated and in the view of Professor Ford, over-medication was a frequent and recurring problem. Dr Barton effectively, delegated responsibility for her patients, in relation to the administration of opiates, to the care of the nurses, and there were frequent occasions when the nurses went on to use those prescriptions inappropriately.

22. As ~~she~~ Dr Barton said in her police statement – "on a day to day basis mine was the only medical input". That was true & her responsibility was therefore a high one.

CONSULTANTS

23. There were three consultants who had duties in relation to these two wards. The wards were visited on a weekly basis by one consultant or the other. However in general they were reliant upon what they were told about the patient by Dr Barton.

24. The consultants were Dr Tandy, Dr Reid and Dr Lord. None of them saw the patients more than once a week on the wards and often it appears to have been less than that and the day to day control was left to Dr Barton and her nursing staff. Dr Tandy was away on maternity leave from April 1998 until February 1999 and her post was not filled by a locum.

25. **Dr Jane Tandy** was a Consultant Geriatrician at the Queen Alexandra Hospital Portsmouth who was ostensibly responsible for Dryad Ward at GWMH as consultant from 1994. She was away on sick leave for a month from 11 July to 12 August 1996 and again from 16 September to 22 November. From the 23 November 1996 to 1 September 1997 she went on maternity leave. When she was there she carried out a ward round once every two weeks on Wednesdays. She was only there during the period when patients A and B (Leslie Pittock + Elsie Lavender) were on the ward and would have left by the time patient C arrived.

26. She describes Dr Barton as more experienced than her in long term and palliative care.

27. **Dr Reid** was based at the Queen Alexandra Hospital in Portsmouth. He was a consultant Geriatrician. He carried out one session a week at the Dolphin Day Hospital and from February 1999 was the consultant in

Enid Spurgin, Geoffrey Packman, Elsie Devine, G + L ?? Jean Stevens.

charge of Dryad Ward. He was in post at the times that Patient I, J and K were admitted to Dryad Ward.

28. He would carry out a ward round on Monday afternoon. On alternate weeks Dr Barton would accompany him. He would therefore only see her once a fortnight. He was not aware that Dr Barton was writing up prescriptions for patients with a variable dose in advance of them complaining of pain. He spoke to her on one occasion about a variable dose he saw and appears to have accepted her explanation.

29. He was aware that Dr Barton was working very hard and believed that without her GWMH would not have been able to function.

30. **Dr Lord** would carry out a consultant ward-round once a week alternating between Dryad and Daedalus (Beed).

31. She is in New Zealand and careful consideration has been given as to whether she should be called as a witness. A review of the notes of the twelve patients with whom you are specifically concerned reveals that although she provided medical services to a number of them prior to their transfer to the GWMH her input post transfer was very limited indeed. She had no role in the prescribing treatment at GWMH for Patients A, B, E, F, H, I, J, K or L.

Eva Page, Alice Wilkie, Arthur Cunningham

32. Her role in relation to patients C, D, G was very limited as you will hear and is in any event revealed by the notes. In the circumstances it has been decided that she will not be called by the GMC.

33. Dr Barton may say she was overworked and under pressure and, if that is shown to be true, that may be some mitigation for what occurred, but it

does not provide a defence for some of the practices which built up and which were directly contrary to Good Medical Practice.

34. In due course Dr Barton did resign after these events, apparently because of the pressures of work but there was unfortunately quite clearly a period of time under her management when her patients were receiving very substandard care.

THE DRUGS + PROTOCOLS

35. Of the drugs that you will be hearing about there are ~~four~~ five which are central to this case: Oramorph, Diamorphine, Midazolam and Hyoscine. + Haloperidol.

36. Oramorph is an oral solution of Morphine. It is suitable to be given as an opiate where the patient is able to swallow. It has the effect of depressing respiration and causing hypotension. It should be avoided for acute alcoholics.

37. Diamorphine, as you will know, is what drugs users call 'Heroin'. It is a powerful opioid analgesic and is given via syringe. Apart from removing the sensation of pain it has a depressive effect on the vital functions and frequently causes nausea and vomiting. Its use should be avoided in the case of acute alcoholism. Great care has to be taken when exchanging oral morphine for subcutaneously delivered Diamorphine. The dosage delivered subcutaneously should, according to the BNF, be one third to one half of the oral dose of Morphine. So an oral dose of 30 mgs Morphine over 24 hours should be replaced by a dose of no more than 10-15 mgs as a subcutaneous infusion over 24 hours (Ford). If the same level of analgesia is required.

* Haloperidol is an anti-psychotic drug used to relieve anxiety + tension.
It can also provide relief from nausea + vomiting.
It will increase drowsiness

38. Midazolam is a sedative and anti-epileptic and said to be suitable for the very restless patient. It can be mixed in a syringe driver with Diamorphine. Midazolam can cause respiratory and cardiovascular depression, hypotension and ultimately death.

39. Hyoscine has the effect of reducing salivary and respiratory excretions. In the elderly particularly it can cause drowsiness.

40. Specific advice is given in the BNF (File 1 Tab 3 page 7) that dosages for elderly patients should generally be substantially lower than for younger patients. Doses should generally start with 50% less than the normal adult dose.

41. Drugs may be prescribed 'PRN' (pro re nata) or 'as the occasion arises' or 'as required'. This can be appropriate and is often used but it is important to provide clear instructions as to what event will trigger the use of the drug.

42. The 'analgesic ladder' is a phrase which will crop up in the course of this hearing. It describes the simple concept which you are entreated to apply at the sanction stage of a FTP case. In other words you should consider the lowest sanction first. The analgesic ladder provides, in a similar way, that drugs are classified into three groups depending on the severity of the pain that they are intended to meet. The starting point is non-opioid analgesics such as aspirin, paracetemol and Ibuprofen. Next there are more potent anti-inflammatory drugs such as Diclofenac and Codeine. Except in an emergency, which did not arise in any of the cases you will consider, it is only for patients for whom those first two stages have

proved ineffective to control their pain that Morphine and Diamorphine are recommended. The lowest starting dose should be used at the commencement of pain relief and increased if necessary by 50% on subsequent occasions.

43. You will hear reference to a document called the 'Wessex Protocol'. This is also known as the Palliative Care Handbook (File 1 Tab 4). This sets out guidance as to best practice when applying a palliative care regime. That means a medical regime to ensure that the patient is comfortable and pain free when their illness is no longer responsive to potentially curative treatment. In other words, when it is recognised that the patient is dying and can not or should not be saved by medical intervention.

44. One of the issues in the case is whether the nurses were in fact following the guidance given and whether in respect of certain patients the decision was taken inappropriately to treat patients under a palliative regime as opposed to a curative regime.

NURSES

45. The GMC proposes to call a number of the nurses who cared for the patients and who administered doses of Diamorphine and Midazolam of which criticism is on occasion made. Many of the nurses who worked on the relevant wards can remember nothing beyond the notes that they made and it has not been thought necessary or relevant to parade those nurses before you. Some of the nurses do have recollection of the patients or the practices at the hospital and will be called by the GMC. Many are likely to

be highly supportive of Dr Barton with whom they worked over many years.

46. The Panel will have to be alert when listening to the evidence of those nurse witnesses to guard against biased or self serving evidence.

47. Lynne Barrett by way of example was a senior and experienced nurse who worked at GWMH from the late 1980s. She had no concerns about the use of syringe drivers nor the quantities of drugs that were being prescribed by Dr Barton. She takes the view that as a result of the issues raised at GWMH, patients will not now get the pain relief that they need. She feels that Dr Barton is being used as a scapegoat. You will need to assess that evidence, but it is called so as to provide you with as complete a picture as possible. Some nurses we are not calling if in the GMC's view they are so biased as to be not capable of belief. If the defence wish to call them then that is a matter for them.

48. Sister Hamblin was the clinical manager and Ward sister and it is clear from a substantial body of evidence that she was a formidable person who effectively ran the wards in Dr Barton's absence. She is too unwell to be called to give evidence and the GMC have taken the view that it would not be appropriate to rely upon her evidence in statement form.

49. Freda Shaw takes the simple line that 'syringe drivers were always used correctly and only when necessary'.

50. Other nurses have expressed concern about the extent to which both Diamorphine and syringe drivers were used on the wards. Some nurses speak about the use of Diamorphine without adopting the analgesic ladder

first. They speak of the considerable trust that Dr Barton appears to have placed in Gill Hamblin (see Carol Ball) and concerns appear to have been raised back in the early 1990s.

51. For a period Dr Barton had worked on the Redcliffe Annex prior to the transfer. Nurse Tubritt remembers that once she started, the ward was better organised and syringe drivers were introduced at around that time. It was prior to the transfer to Dryad and Daedalus that nurse Tubritt remembers concerns being raised in the early 1990s about the use of Syringe Drivers and the quantity of Diamorphine being used.

52. Meetings were held between nurses and management and Dr Barton attended at least one of those meetings. Unfortunately, although there were calls for a formal written policy on the use of Diamorphine and Syringe drivers no such policy appears ever to have been produced (See Exhibits to Turnbull's GMC statement in Bundle 1 Tab 6).

53. Nurse Turnbull was similarly concerned and certainly initially she was worried that the analgesic ladder was not being used appropriately. However her view once the ward was moved to become Dryad Ward, was that the culture did change and that syringe drivers were only used when needed. We will have to look carefully at whether there was in fact a change of culture or whether in fact became used to an inappropriate regime + practices.

54. Nurse Turnbull does however reflect in her evidence that the regime allowed the Nurse in Charge to increase the dosage of drugs at their discretion provided it was kept within the parameters set by Dr Barton. Those parameters were however set very wide indeed.

55. Meetings were held and fears apparently therefore were allayed. It will be a matter for the Panel to consider whether the concerns should in fact have continued and whether or not they had been addressed by a real change of culture.

56. Phillip Beed was the manager of Daedalus Ward from 1998. He describes how Dr Barton would attend the ward at 9 am every morning and carry out a review of the patients. He is very supportive of Dr Barton and had no concerns about her. It was a very busy ward according to Mr Beed.

57. Nurse Giffin remembers concerns about syringe drivers being raised in the early 1990s and there were meetings with Dr Barton and hospital management about their excessive use. Nurse Giffin appears eventually to have stopped complaining about what was going on and continued working with the others although in her view things did not in fact improve.

58. Ms Shirley Hallman was a senior nurse and only one grade lower than Gill Hamblin. She did not start work at the GWMH until 1998. She was new to palliative care and had a difficult working relationship with Ms Hamblin. She ran the ward when Nurse Hamblin was on leave or away. She describes Nurse Hamblin as an excellent nurse but 'her word was law'.

59. She did not feel that the analgesic ladder was appropriately adhered to. She describes how on Dryad it had become standard practice to double the dosage if it was deemed that the patient needed a higher dosage of opiates.

60. She was troubled by the fact that it appeared that Dr Barton would prescribe opiates and then hand the responsibility over to the nurses.

61. The GMC will call a number of nurses and you will have to analyse their evidence carefully. Some of the evidence may be founded on self protection or even upon a misguided loyalty. What may matter to your inquiry however is ~~the~~ to look at whether there evidence which actually supports the administration of opiates or in many cases, the lack of evidence as to why opiates were in fact administered or increased.

NOTE KEEPING

62. One of the allegations which is made in respect of every patient relates to the very poor quality of the notes kept by Dr Barton. In the cases you will be looking at there was a lack of a proper note of the first assessment by Dr Barton and a lack of reassessment notes or a proper diagnosis or treatment plan. The administration of Opiates was regularly increased with only a nurse's note to show it.

63. Dr Barton's explanation to the police was, in short, that she was too busy to make a note and that she had to decide whether to look after the patients or make notes about it.

64. She said this in one of her statements – "I was left with the choice of attending my patients and making notes as best I could or making more detailed notes about those I did see but potentially neglecting other patients" (see for example Dr Barton's generic statement and her statement re: Arthur Cunningham). The GMC does not accept that to be a

legitimate approach. Unless a proper note is made assessing the patient on admission and when there are significant changes in their state of health, then it is very likely that the treatment of that patient will be adversely effected.

With no proper notes

65. There will be no baseline or benchmark from which to work. Other medical staff will not know what the finding and diagnosis was. The treating doctor may not remember what the state of health of the patient was when first assessed. Nursing staff will not be able to track the patient's progress nor will they know the appropriateness or not of administering analgesia. Nursing staff may not appreciate when a patient is opiate naïve nor might they understand the significance of that in setting the first dose.

66. Good notes are a critical element in the patient's care and in this case the notes were terribly inadequate and that may have led in some cases to serious failures in patient care.

BUNDLES AND PAPERS

67. Before turning to the individual patients let me introduce some of the paperwork you will be receiving. There are individual files for each of the twelve patients. We have put into each file only those documents which we think are immediately relevant to your consideration but we have all of the patient notes available should more documents become relevant. These are working files. We have retained the original pagination but at the front of each file you will find a chronology prepared by Mr Fitzgerald

which relates to the most important features of that patient's care and which follows the care afforded to each patient as shown in the notes. The original records are much larger and we have made efforts to restrict the amount of documentation that you need to see. If at any stage you feel the need to see more, or if either side wish to add to the material, then that can be done during the course of the hearing.

68. There are several further files. One is a file containing all of Professor Ford's reports. *[We are going to provide you with those in advance of his evidence and we would invite you to read his report in advance of hearing from the witnesses who we intend to call in relation to each patient. That will give you the context of the witnesses' evidence and highlight the issues which you may want to consider when you hear from the witnesses. It will mean that if anything occurs to you, to be of potential relevance during the course of the evidence of the witnesses themselves, you will be enabled to put the relevant question at the appropriate point in the evidence]*.

69. A further file contains miscellaneous material which is called Panel Bundle 1. That contains the relevant BNFs, the Wessex Protocol, + a no. of helpful documents.

70. A final file contains the statements produced by Dr Barton when questioned by the police. There have been a number of investigations into what went on at this hospital. There was a substantial police investigation as well as an investigation by the CHI (Commission for Health Care Improvement). When Dr Barton was interviewed by the police she made no answer to the many hours of questions which were put to her about what had happened within these two wards. Instead, Dr Barton chose to draft ~~with her lawyers no doubt~~ a series of statements which she provided to the police in advance of her interviews. Those statements are self serving in

the sense that they are drafted by Dr Barton or by her lawyers and they were never tested under questioning by a police officer. Nevertheless, it is proposed that you should receive those statements as her account at the time of her actions. They must be regarded as self serving statements and we will have to wait and see whether or not Dr Barton chooses to give evidence so that she can be tested upon her account.

71. Most recently there was a coroner's inquest which looked into the deaths of a number of the patients. There was a degree of publicity about that inquiry and again if you heard anything about that through the press or internet you no doubt well understand that you should ignore anything you have previously heard. All that matters so far as your consideration of these charges is concerned is the evidence you now hear put before you by both sides. The findings of those other hearings and inquiries are, at this stage irrelevant to your considerations, except in so far as you may hear witnesses being cross-examined upon the evidence that they may have given previously in the course of other enquiries.

Patient A – Leslie Pittock (January 1996)

72. The first patient with whom you are concerned is patient A (Leslie Pittock). He was 82 years old when he was admitted on **5th January 1996** to the GWMH to Dryad Ward. He had previously been admitted to Mulberry Ward on the **13th December 1995** which was a psychiatric ward within the GWMH where he was under the care of Dr Banks. He suffered from [Long Term] depression and mobility problems.

73. He was verbally aggressive and was not mobilising well. Following his admission he developed a chest infection.

74. On the **3rd and 4th January** he had been assessed first by Dr Banks and then by Dr Lord who recorded that he was completely dependent upon nursing case, he had a urinary catheter in place, an ulceration on his left buttock and hip and low protein in his blood. Dr Lord indicated that she would transfer him to the GWMH to a long stay bed. It was thought to be unlikely that he would return to a residential care home. He was noted to be very depressed.

75. His daughter Lynda Wiles commented that she felt he had lost the will to live.

76. He was transferred on Friday **5th January 1996** to the GWMH to Dryad Ward where Dr Barton made a short entry – p.196. "Transfer to Dryad Ward from Mulberry. Present problems immobility, depression, broken sacrum small superficial areas on right buttock. Ankle dry lesion, both heels suspect. Catheterised. Transfers with hoist. May need help to feed himself long standing depression on lithium and sertraline". His only physical problem ∴ appears to have been a sore at the bottom of his back

Healing broken skin around the sacral area at the bottom of his back.

77. On Tueday **9th** January Dr Barton noted that the patient's right hand was painful and he had increased anxiety and agitation.

78. Dr Tandy made an entry on **10th January** that the patient was for 'TLC' Tender Loving Care. She appears to have seen the patient prior to the administration of prescription of Oramorph later that day. That was during a ward round with Dr Barton and Nurse Hamblin.

79. At p.200 the drug chart indicates that Dr Barton prescribed Oramorph 5 mgs 5 times a day on **10th January**. There is also an undated prescription for between 40-80 mgs Diamorphine to be given over a 24 hr period subcutaneously. It is likely that that prescription was written out on the **10th** January at the same time as the Oramorph prescription because it appears to have been superseded the following day on the **11th January** when Dr Barton wrote another prescription for Diamorphine, but this time for a variable dose between 80-120 mgs to be delivered Sub-Cutaneously (SC) together with Midazolam 40-80 mgs. Dr Barton describes her first prescription for opiates by syringe driver as a 'proactive' one.

80. Two doses of oral morphine appear to have been administered on the day they were prescribed ie: the **10th** , and that became the regular prescription for the next five days.

81. Of the higher prescription on the 11th January Dr Barton says this – " I would have been concerned that although it was not necessary to administer the medication at that stage, (the patient's) pain anxiety and distress might develop significantly and that appropriate medication should be available".

82. According to Professor Ford the prescription on the **11th January** for a variable dose of Diamorphine of 80-120 mgs was poor practice and potentially hazardous and the lowest dose was still inappropriately high because it amounted to a four-fold increase on the opiate dose she was already receiving orally. His view is effectively the same so far as the Midazolam is concerned. The prescriptions ran a high risk of producing respiratory depression and potentially coma.

83. No Diamorphine was in fact administered until Monday the **15th January** when it was started at a rate of 80 mgs over a 24 hour period. Midazolam at 60 mgs over a 24 hour period was started at the same time. The only note that appears to give any justification for that medication was a nursing note that the patient 'appeared agitated'. That was a four-fold increase as compared to the oral dose which he had been receiving. Dr Barton claims she would have seen the patient on that Monday but made no note about it. She says – "I believe, I may have been told that his condition had deteriorated considerably over the weekend". "I believe my assessment of his condition at this time was that he was in terminal decline".

84. There is a note in the nursing record (p.208) for the **15th January** which simply states – 'S/B Dr Barton, has commenced syringe driver at 08.25'.

85. The dose of Midazolam, both that prescribed by Dr Barton and that administered by the nurses was excessively high. An appropriate starting dose for a frail older man, if an SC dose was justified at all would have been in the region of 10 mgs over a 24 hour period rather than a range of 40-80 as prescribed and 60 mgs as administered particularly in light of the fact that Diamorphine was started at the same time.

86. The lowest dose of Diamorphine prescribed and administered (which was unnecessary in the first place) was also far too high given that the patient had, until that point, been on only 30 mgs morphine orally per 24 hours on the **14th January**. The equivalent dose, even if necessary, should have been one of around 15 ~~20~~ mgs ~~going up to 30 mgs~~ increasing only if the patient was sill in pain. The Midazolam was also, according to Professor Ford, excessively high. There was no explanation for it in the notes and no assessment to justify it.

87. On the **16th** Dr Barton added Haloperidol to the mix. A nursing note (p.26) records that the patient was agitated but that may have been a reaction to the Morphine he was being administered. There should at least have been a reassessment.

p. 190

88. ~~Apparently on the 18th but it may have in fact been~~ On the **17th** Dr Barton again increased the dose of Diamorphine to 120 mgs and Midazolam to 80 mgs. Those doses were given from the 17th onwards. Dr Barton says that the increases were made on the 17th because the patient was tense and agitated. The nursing record for the 17th indicates (p.210) "S/B Dr Barton, medication increased as patient remains tense and agitated… remains distressed on turning".

89. Although the <u>oral</u> morphine prescribed by Dr Barton may have been justified by reason of the pressure sores from which the patient was suffering, there is nothing else in the notes to reflect why such a dramatic increase in the use of opiates was thought to be necessary by Dr Barton. The patient was not noted to be in any particular pain although he was agitated at times.

90. No clinical assessment seems to have been conducted before the prescriptions for the use of major opiates were issued. The high point so far as an assessment is concerned is that the nursing notes on **17.1.96** at 14.30 (p.210) indicate – 's/b Dr Barton, Medication reviewed and altered.'

91. On the **18th** January there is noted by Dr Barton –'further deterioration, sc analgesia continues, difficulty controlling symptoms, try Nozinan'. (p.198)

92. On the **18th January** Dr Barton prescribed a new drug – Nozinan at 50 mgs. Nozinan is a sedating drug used to control terminal restlessness and agitation. A note the previous day on the 17th made prior to administration of that drug recorded that the patient appeared to be 'more peaceful' (Night) (p.210) and it is difficult to see what the justification was for adding another sedative to the potent mix that the patient was already receiving.

93. On Saturday **20th January** there is a medical note (p.198) that Dr Briggs was consulted (presumably because Dr Barton was not available over the weekend) and that the Nozinan was to be increased from 50 mgs to 100 mgs and Haloperidol was to be stopped on the verbal order of Dr Briggs. He did not attend the patient and this appears to have been done over the telephone. His reason for doing so was that Staff Nurse Douglas expressed a suspicion that the Haloperidol may be causing a side effect and he was concerned about the interaction of the drugs which the patient had been prescribed. He appears to have been simply pursuing the regime instituted by Dr. Barton w/o reviewing what was happening.

94. Between the 17th and 23rd January the daily syringe driver was filled with 120 mgs Diamorphine and 80 mgs Midazolam.

95. These drugs in conjunction with one another and with Haloperidol which the patient was also prescribed by Dr Barton, carried a high risk of producing coma and respiratory depression.

96. The patient died four days after the 20th on the **24th January 1996**.

97. Dr Barton may well claim that she was performing regular assessments but if that is so then she made no note of them and it is difficult to see how she could assess the needs of the patient on subsequent occasions when she had no assessment baseline from which to work. An assessment with no notes is clinically fairly pointless for the purposes of the future management of the patient.

98. Professor Ford is very critical of the note keeping in relation to the drug charts as well. At one stage there were three active prescriptions for Diamorphine which was extremely hazardous and in addition there were two actively running prescriptions for Haloperidol which put the patient at risk of coma had they been administered.

99. The infusions of Diamorphine, Midazolam and Haloperidol and then Nozinan very likely led to respiratory depression and shortened Patient A's life although he was expected to die in the near future.

The death Certificate recorded Bronco ~~Rt~~ Pneumonia as the cause of death which is the 1st time that illness is mentioned in the notes.

Patient B – Elsie Lavender (February 1996)

100. Patient B was born in Code A and was 83 years old when she was admitted to the Royal Hospital Haslar on **5th February 1996** following a fall at home where she lived alone. She was registered blind. She was X rayed and no bony injury was found but there was concern that she might have suffered a CVA (Cerebral Vascular Accident or stroke). She had pain in her left shoulder and abdominal pain.

101. According to her son Alan, she made very good progress at the Haslar and was, by the time she moved to the GWMH, talking coherently and understanding what was being said to her. She was also mobile with a stick.

102. Some weeks after her accident, on the **22nd February,** she was transferred to the GWMH Daedalus Ward for rehabilitation and hopefully for return to a rest home. She died two weeks later on the 6th March.

to GWMH

103. Upon transfer she was seen by Dr Barton (p.175) on the **22nd** who noted that the patient had leg ulcers, was incontinent of urine, and suffered from insulin dependent diabetes Mellitus. She prescribed Dihydrocodeine which is a powerful synthetic opioid pain-killer on the second level of the Analgesic ladder.

104. Professor Ford notes that there was no assessment of the patient's pain nor of her neurological function. There should have been a clinical review but there was not, or at least none that was properly noted. The patient's son Alan recalls Dr Barton telling him that his mother had come to the hospital to die. He was surprised as that had not been his understanding.

105. On the **24th** there is a nursing note that the patient's pain was not being controlled by DF118 (DHC) and she had a sacral sore. She was commenced by Dr Barton on Morphine 10 mgs twice daily (p.1021).

106. Two days later on the **26th** Dr Barton noted that the patient's bottom was very sore and needed a Pegasus mattress. 'Institute SC analgesia as necessary'. She wrote out prescriptions that day for Morphine MST (Morphine Sustained Release tablets) at 20 mgs twice daily, and Diamorphine at a variable dose as required of 80-160 mgs, 40 – 80 mgs Midazolam and 400-800 Mcgs Hyoscine. None of those medicines were in fact administered. In respect of those prescriptions however Professor Ford is very critical. He describes them as 'not justified, reckless and potentially highly dangerous' (para 11). Even the lowest dose of Diamorphine would have amounted to a four-fold increase in opiates.

Doubling the dose

a normal conversion dose would have started at 10 mgs Diamorphine not 80 if she had been receiving 20 mgs a day up to that point

107. Dr Barton's explanation in her police statement was that this was 'pro-active' prescribing for pain relief, in case the patient experienced uncontrolled pain. She claims that she would have seen the patient on the 28th, 29th February and 1st March but appears to have made no note about those assessments whatever. The 2nd and 3rd March was the weekend.

108. On Monday **4th March** the notes record that Dr Barton increased the MST prescription from 20 mgs twice daily to 30 mgs twice daily.

109. Dr Barton's next entry was on the **5th March** when she noted that the patient had deteriorated and was not eating or drinking (p.975). She noted that the patient was in 'some pain, therefore start SC analgesia'. A nursing note records that the patient's pain was uncontrolled and the patient was

distressed (p.1013, 1022). Nurse Couchman, whose note that was, explains that she would have been relying on the night staff in order to make that entry and the dose was authorised by Dr Barton.

110. The syringe driver was commenced by the nurses at 09:30 that day with Diamorphine at 100 mgs and Midazolam at 40 mgs over a 24 hour period (p.1022) which doses were allowed for by Dr Barton's prescription for Diamorphine of between 100-200 mgs over a 24 hour period. Her prescription of Midazolam was between 40-80 mgs over 24 hours. Dr Barton (police statement) says that that this was necessary to relieve the patient's pain and distress.

111. An equivalent dose to that which the patient was already receiving orally but to be given S/C would have been in the range of between 20-30 mgs per 24 hours. So, even though the nurses were in fact starting at the <u>minimum</u> dose prescribed by Dr Barton even that was over three times greater than her previous equivalent dose of opiates. If the intention was to control the patient's pain by increasing the dose then a 50% increase at most might have been appropriate. Professor Ford describes the prescribing by Dr Barton as 'reckless and dangerous' (para 13).

up to 45 mgs

112. The following day **6th March** Dr Barton noted that the SC analgesia had commenced and the patient was now comfortable and peaceful, she also wrote: 'I am happy for nursing staff to confirm death'. A nursing note (p.1023) says that the patient was seen by Dr Barton that day and the medication other than through the Syringe Driver was discontinued as the patient was unrousable. Given the dose of Diamorphine to which she was so subjected that is perhaps not surprising.

113. Professor Ford states that the description of the patient as being comfortable and peaceful was more likely to reflect the reality that the patient was by that stage in "a drug induced coma" (para 14).

114. At 9.28 pm that evening the patient died. In Professor Ford's view the administration of the sub-cut Diamorphine and Midazolam led to patient B's deterioration and contributed to her death.

115. In respect of each patient Dr Barton is charged with prescribing drugs in such a way as to create a situation whereby the patient could be administered drugs which were excessive to their needs and that such prescribing was inappropriate, potentially hazardous and not in the patient's best interests. It may be thought to be relevant specifically to those charges that there is evidence that in some of these cases excessive drugs were indeed administered and that the hazard did indeed arise.

116. Additionally in Professor Ford's view, when the patient's condition deteriorated there was a duty upon Dr Barton to consult with her consultant colleagues as to the best approach to future treatment. For that reason there are specific charges at 3(d)(e) to reflect that specific criticism.

Patient C – (Eva Page) (February 1998)

117. Patient C was 87 years old when she was admitted on **6th February 1998** to the Queen Alexandra Hospital having experienced a general deterioration over a five day period and was complaining of nausea and a reduced appetite. A suspected malignant mass was seen in her chest and the notes recorded on 12th February that she should be managed with palliative care on Charles Ward to which she was transferred on the **19th February**.

118. On the 23rd February she was diagnosed as being depressed and suffering from possible carcinoma of the Bronchus, Ischeamic heart disease, and congestive heart failure. She was plainly not at all well but she does not appear to have been in any pain.

119. She was transferred to GWMH on 27th February 1998, according to Dr Barton's note 'for continuing care'. Her Barthel score was zero to 2 which meant she needed help with all of her basic bodily functions. The Barthel scoring system is a method of assessing a patient's ability to cope with their daily living requirements (an example of which appears in Bundle 1 Tab). A Barthel score of 20 would indicate that the patient was fully competent in all daily living requirements, a score of 0 indicates that help is needed with all activities.

120. A note made by Dr Laing (the duty GP) on 28th February records that she was 'confused and felt lost' but was not in any pain. She was distressed however and she was given Thioridazine and a small dose of Oramorph (2.5mgs) to help her.

121. On 2nd March Dr Barton suggested the use of adequate Opioids to control fear and pain. A Fentanyl 25 microgram patch was started that day as well as a small amount of Diamorphine 5mgs given by injection. Fentanyl is a very powerful synthetic opioid which comes on a patch which can be applied to the skin. It is particularly useful in circumstances where it is difficult to inject the patient. By its nature its effect is less immediate but may be longer lasting and the effects remain long after the patch is removed.

122. That patch was the equivalent, according to Professor Ford, of a 90 mg oral dose. All of those drug prescriptions up to including this point are approved of by Professor Ford who regards them to have been a reasonable response to the patient's anxiety despite the lack of pain although the Fentanyl patch is very likely to have caused the patient to become very drowsy.

123. The following day On 3rd March a rapid deterioration in the patient's condition is recorded with her neck and both sides of her body rigid. That same day Dr Barton prescribed Diamorphine with a variable range from 20-200mgs daily and Midazolam at 20-80 mgs daily by syringe driver. There is no note that the Fentanyl patch was removed or directed to be removed at that time. That syringe driver was commenced at 10.50 hours with 20 mgs of each drug and 11 hours later at 9.30 pm she was pronounced dead.

124. Those prescriptions of Diamorphine and Midazolam were in Professor Ford's expert opinion not justified. Her deterioration on the 3rd could have been as a result either of a stroke or an adverse reaction to the Fentanyl patch. However, there was no indication that the patient was at that stage in any pain. The drugs would be expected to result in depression of the

level of consciousness and respiratory depression. The prescriptions were not consistent with Good Medical Practice and the analgesic ladder was not followed.

Patient D - Alice Wilkie (August 1998)

125. Patient D was born in Code A and was 81 years old when she was admitted on **31st July 1998** from the Addenbrooke Rest Home to the Queen Alexandra Hospital Portsmouth Philip Ward which was within the department for elderly medicine. She had had a fall and was refusing fluids. She was severely dependent and had a 0 mental test score when she was transferred to GWMH Daedalus Ward on **6th August 1998**. The nursing notes reveal that she was for 'assessment and observation and then decide on placement'. A further note reveals – 'pain at times, unable to ascertain where'.

126. Dr Lord assessed the patient on **10th August 1998** – 'Barthel 2/20, eating and drinking better, confused and slow. Give up place at Addenbrookes. Review in one month. If no specialist medical or nursing problems discharge to a new home'. (Probably this would have meant a continuing care bed within the NHS).

127. An entry on **17th August** in the nursing notes records that there had been a deterioration over the weekend and the patient's daughter had agreed that active intervention was not appropriate'. 'To use syringe driver if patient is in pain'.

128. There is, in the notes, an undated prescription written by Dr Barton for a variable dose of between 20-200 mgs of Diamorphine and 20-80 mgs of Midazolam per 24 hours and by syringe driver. That prescription must have been written on or before the 20th when a syringe driver was started. page?

129. On **20th** the syringe driver was started with 30 mgs Diamorphine and 20 mgs of Midazolam. Prior to that point this patient had not been receiving any analgesic drugs but her daughter Marylyn Jackson who visited her that day did notice that she appeared to be in pain. In this case it is difficult to see how the analgesic ladder was being applied. because the 1st drugs used were opiates at a relatively high level for an opiate naive patient.

130. The next entry in the notes by a doctor is on the **21st August** by Dr Barton – 'marked deterioration over the last few days. SC analgesia commenced yesterday, Family aware and happy'. A nursing note of the same day records that the patient is 'comfortable and pain free'. On that day the pt's daughter recalls Dr. Barton looking at the patient & saying 'Any time now'.

131. At 6.30 pm that day the patient's death was confirmed. So within ~~2da~~ a day of the Syringe Driver being instigated the pt. was dead

132. In Professor Ford's opinion there was nothing to justify the use of a syringe driver in this case, ~~there being no record of specific pain. Even if there were such a record~~, milder analgesics could and should have been tried first. A medical assessment was required before prescribing those drugs when the deterioration was apparent.

133. The variable range prescribed by Dr Barton was poor practice, very hazardous and in Professor Ford's view unjustified.

134. So far as the notes are concerned in Professor Ford's view the only acceptable medical note was that made by Dr Lord on 10th August during the entirety of the patient's stay at the GWMH.

Patient E - Gladys Richards (August 1998)

135. Patient E was born in Code A and she was 91 years old when she was admitted as an emergency via the A&E department at Haslar Hospital on **29th July 1998**. She had fallen on her right hip which was then painful. She was found to have a fractured neck of femur. Surgery by way of hip replacement was performed on the **30th July**.

136. On 3rd August she was seen by Dr Reid. He found her to be confused but pleasant and cooperative. He took the view that despite her dementia she should be given the opportunity to be remobilised and with that in mind he organised her transfer to GWMH.

137. Between that assessment and transfer on the 11th she had an episode on the **8th August** when she was recorded as being agitated and she was calmed down with Haloperidol and Thioridazine.

138. Her daughter Lesley O'Brien remembers that she made a good recovery after the operation and was soon up on her feet and walking with the use of a Zimmer frame.

139. On Tuesday **11th August** she was transferred to Daedalus Ward at the GWMH. By this stage she was fully weight bearing and walking with the assistance of two nurses and she was continent but needed total care with washing and dressing. The purpose of her admission appears to have been rehabilitation.

140. Dr Barton's note on admission was – 'Impression frail hemi-arthroplasty, not obviously in pain, please make comfortable. Transfers with hoist,

usually continent, needs help with ADL (Activities of Daily Living) Barthel 2, I am happy for nursing staff to confirm death'.

141. Professor Ford describes this note as revealing a much less proactive not to say pessimistic attitude towards this patient's rehabilitation. Dr Barton's failure to recognise the patient's rehabilitation needs may have led to subsequent sub-optimum care for this unfortunate patient. Philip Beed also says that she was, in his view, in pain from her hip but that was not recorded at the time and the notes on the 12th (p.50) specifically state that the patient did not seem to be in pain.

142. Dr Barton wrote a prescription that day (the **11th**), effectively upon the patient's admission for a variable dose of between 20-200 mgs of Diamorphine together with 20 – 80 mgs Midazolam to be administered via a syringe driver. Very fortunately none of that prescription was in fact administered at that time though the Midazolam was administered at a later stage when the patient was re-admitted to the hospital.

143. She also prescribed Oramorphine 10 mgs on the 11th which was administered on the morning of the patient's admission. That prescription Professor Ford regards as inappropriate in the circumstances and may in fact have precipitated what followed.

144. The following night on the Wed **12th** the patient was very agitated possibly as a result of her new surroundings but potentially also as a result of the commencement of opiate analgesia and she had to be settled with a dose of haloperidol. Philip Beed describes the patient as agitated and he ascribes pain as being the cause of that agitation but he does not appear to have

made a note to that effect. The patient's daughter Lesley visited her mother on the day after her admission, ie: on the 12th and was very surprised to find that her mother was unrouseable. She remembered that up until her transfer to GWMH her mother had been enjoying three meals a day.

Thurs August

145. On the **13th** she was found on the floor having fallen from her chair. That fall may well have caused a dislocation of her repaired hip and it certainly appears to have caused the patient pain. Her daughter Lesley remembers this being obvious and that her mother was weeping and calling out. The staff at the GWMH at first instance seem to have thought wrongly that this was as a result of the patient's dementia.

Friday

146. The following day on the **14th** the patient was assessed by Dr Barton who noted that sedation and pain relief had been a problem and that the patient was very sensitive to Oramorph. The patient was referred to the surgeons at Haslar again having been given a small amount of Oramorph and a further operation was undertaken. Again she appears to have recovered well from that operation and to have been treated well at the Haslar (Lesley O'Brien).

Monday

147. On the **17th** August she returned to the GWMH and the transfer unfortunately appears to have been performed inappropriately. She was transferred without the use of a canvas sheet which once again may have put too much pressure on her hip causing it further damage + pain. The decision appears to have been taken not to send her back to the Haslar Hospital again.

148. On that day Dr Barton wrote out a further prescription for a variable dose of 40-200 mgs of Diamorphine. The patient was then dosed with 40 mgs of Diamorphine but at that stage, given the patient's pain Professor Ford takes the view that although high, the dose was not unreasonable.

149. On the Tuesday **18th** she was recorded by Dr Barton as being 'in great pain' and was put onto a syringe driver on the direction of Dr Barton. She was dosed with 40 mgs Diamorphine, 20 mgs Midazolam and 5 mgs Haloperidol. That dosage continued until her death.

150. The expert's view is that Midazolam which had in fact been prescribed 7 days earlier on the 11th should not have been added to the cocktail of drugs because the combination of drugs was likely to lead to respiratory depression and coma. Dr Barton's explanation in her police statement was that it was used as a muscle relaxant to assist her movement and to make her as comfortable as possible.

151. On the 21st she was recorded by Dr Barton as being 'I think more peaceful, needs Hyoscine for rattly chest' and she died later that day.

152. The focus of the charges in respect of this patient is upon the original prescription by Dr Barton back on the 11th August of Diamorphine and Midazolam before the patient had her second fall and dislocated her hip. That prescription, was say the GMC, unjustified and dangerous and allowed for the administration of Midazolam to the patient at the end of her life of which Professor Ford is also critical.

153. Professor Ford is most critical of that early prescription where there was little or no indication that the patient was in pain at all. In the last days of

her life there are certainly indications that the patient was in pain and did require pain relief by opiates but there is a total lack of any suggestion that the patient was in pain when she first arrived at the hospital.

154. Indeed Dr Barton, when she was interviewed by the police, indicated that the patient did not appear to be in pain. Immediately prior to her arrival at GWMH the patient had not been on regular analgesics at all and had last taken two tablets of cocodamol.

155. The expert is of the opinion that it was simply inappropriate to start the patient on opiate medication before trying milder analgesics.

156. The decision immediately to prescribe subcutaneous Diamorphine, Haloperidol and Midazolam was inappropriate, reckless and placed the patient at serious risk of respiratory depression and coma if they had been administered. The administration of the Midazolam in the last days of the patient's life when added to the other drugs was unjustified and inappropriate. That administration would appear to have been upon Dr Barton's direction and it was her prescription.

Patient F - Ruby Lake (August 1998)

157. Patient F was born in [Code A] and was 84 when she was admitted to Royal Hospital Haslar on **5th August 1998** for treatment for a fractured neck of femur following a fall at home. She was operated upon the same day and was transferred to GWMH two weeks later on **18th August to Dryad Ward**. One of her daughters Pauline Robinson who saw her on the weekend of the **15th and 16th** describes her as being 'very lucid' and 'up-beat'. She was mobile with a Zimmer frame on transfer and could wash her top half independently but suffered from leg ulcers, angina and breathlessness. She died three days after her admission on the **21st**.

Tuesday

The same day that pt. E was put onto a Syringe Driver.

* One of the last notes made by Surgeon Commander Coltman at the Royal Haslar was - on 18-8-98 "Well, comfortable + happy - to GWMH today"

158. Her Barthel score (p.373) was 9 and so she was able to wash and feed herself but needed help getting dressed and some help with walking.

159. Dr Barton's note on admission (p.78) recorded the history of the fall and her Barthel score of 6. Her note then reads 'gentle rehabilitation. I am happy for nursing staff to confirm death'. Nurse Hallman, for one, was surprised when she saw that annotation in this patient's notes. The patient was started on Oramorph and 5 mgs was given to her just after lunch at 14.15. The nursing notes record that the patient had two sacral pressure sores and ulcerated legs (Barrett xp.375).

160. That night the patient became anxious and distressed and wanted someone to sit with her – she was given 10 mgs of Oramorph instead. The following day on the Wed 19th at 11.50 Nurse Shaw describes how she administered the patient with Oramorph oral solution 10mgs in 5 mls.

That drug is of course a pain killer. The patient was complaining of chest pains which were not radiating down her arm.

161. In Nurse Shaw's words she was just continuing the prescription which had been started the night before, she was unable to comment on the pain that the patient was suffering. That may be an indication of the regime to which nurses had become used and which therefore they pursued without much thought.

162. In her police statement Dr Barton claims that she reviewed the patient on the morning (Wed) of the 19th but made no note about it. She says that she was concerned that the patient was going to die shortly and wanted to be sure she had appropriate pain relief for the pain from her fractured hip and her sores and also from her anxiety and distress.

163. Either on the **18th** or more probably on the following morning **19th** , the day after Patient F's admission, Dr Barton prescribed her a variable dose of Diamorphine at a range of 20-200 mgs and Midazolam 20-80 mgs over a 24 hour period. The prescription is undated but we know was administered on the **19th** at 16:00 by Syringe Driver at 20 mgs together with Midazolam at 20 mgs. Nurse Hallman made an entry in the notes that the patient's pain was only being relieved for short periods and she was very anxious (xp.394).

164. On the **20th** (Thurs) the Diamorphine was increased in the afternoon to 40 mgs. Nurse Turnbull notes that the patient was still suffering some distress when moved. Her daughter ~~Dianne Mussell~~ Pauline went to visit her on the 20th,

she had been a regular visitor up until that point. She noted a ~~marked~~ stat + dramatic decline ~~deterioration~~ in her mother's response.

165. A day later on the **21st** those drugs were increased to 60 mgs each at 07:35. Although Dr Barton says that she may have been unaware of that increase she would in any event have approved it. The patients **death was recorded at 18.25** that evening.

166. Professor Ford is critical of all of Dr Barton's prescriptions. On the night of the 18th it is unfortunate that the response of the staff to the patient's agitation was to provide her with a dose of Morphine when she simply wanted someone to sit with her. In the alternative a dose of Temazepam would have calmed the patient.

167. The lack of clear instructions as to what the morphine was to be used for may explain why it was given for distress and anxiety when there was no indication of pain. It is not an appropriate first line treatment for stress or anxiety, indeed morphine can in fact promote or exacerbate exactly those symptoms.

168. There is no indication from Dr B why she thought it right to prescribe either the Diamorphine or the Midazolam and there appears to have been no adequate assessment of the patient. If there was an assessment there was no note made of it.

169. The patient deteriorated rapidly after the commencement of the syringe driver and there was no medical assessment as to why that was happening. It may well have been due to the sedative effects of the opiates that were

being automatically injected into her body. The reaction to the patient's deterioration was to increase the quantities of opiates she was receiving.

170. It is likely that this patient died not from any illness but as a result of the combined effect of the drugs in her system. Her daughter Pauline did not have any concerns about the manner of her mother's death at the time.

Patient G – Cunningham (September 1998)

171. Patient G was 79 years old when he was admitted to GWMH Dryad Ward Monday on **21st September 1998** under the care of Dr Lord the Consultant to whom he was known.

172. He had been admitted to Mulberry Ward on 21st July 1998 when he was depressed and tearful, and since the 27th August he had been living in a local nursing home 'The Thalassa'.

173. He had been seen at the Dolphin Day Care Hospital by Nurse Pamela Gell where he was found to be very frail with a large necrotic sacral sore, he was depressed suffering from dementia and was diabetic. Dr Lord admitted him to Dryad for treatment of his sacral ulcer, a high protein diet and Oramorph if he was in pain. Dr Lord notes that the nursing home was to keep his bed available for him to return for at least 3 weeks. His prognosis was described as being 'poor'. Note p. 644

174. Dr Barton saw him on the day of his admission on the **21st** September and made the following note (p.647) – 'Transfer to Dryad Ward. Make comfortable, give adequate analgesia. I am happy for Nursing staff to confirm death'. ORAMORPH

(or by Lord?)

175. It appears that she prescribed ORAMORPH 2.5 - 10 mgs PRN Diamorphine at a variable dose of 20-200 mgs and Midazolam between 20-200 mgs on that very day. The prescription is undated (p.758) but it has to be presumed to be the 21st because he was, on the day of his admission, put onto a syringe driver at 23.10 delivering those opiates to him automatically. Dr Barton's explanation for her prescription (in her police statement dated 21.4.05) was that she was

He was given oramorph 5 mgs at 14.15 and 10 mgs at 20.15 p.m.

concerned that the Oramorph might become inadequate in terms of pain relief.

176. The patient's step-son Charles Stewart-Farthing went to see him that day - The Monday of his admission and found him to be cheerful but complaining that 'his behind was a bit sore'. THe PT was started at a rate of 20 mgs Diamorphine and 20 mgs Midazolam on the **21**st, and according to Nurse Lloyd's notes (p.754) the other drugs he had been on Coproxamol and Senna were not given because the patient was being or about to be sedated. P.867 reveals the patient remained agitated until approximately 20.30. 15 mins after Oramorph was given The notes reveal that the patient had been behaving pretty offensively However, the driver was not commenced until 23.10 that night when the patient is described as 'peaceful'. It is hard to glean therefore from the notes what caused the commencement of the syringe driver. Nurse Lloyd states that although the patient was peaceful, it was not certain that he would remain that way.

177. On Wed the **23**rd that medication was increased to 20 mgs Diamorphine and 60 mgs Midazolam. A note (p.868) by Nurse Hallman records that he was seen by Dr Barton on the 23rd, he had been chesty overnight and so Hyoscine was added to the driver. His stepson was informed of a deterioration and asked if it was due to the commencement of the driver. He was informed that the patient was on a small dosage which he needed. Charles Stewart Farthing saw his step-father again that day and was shocked at the difference in his condition. He found his step-father to be unconscious. He was so concerned that he asked for the syringe driver to be stopped so that he could have a conversation with the patient but this was denied.

178. He insisted on a meeting with Dr Barton who informed him that the patient was dying due to his bedsores and that it was too late to interrupt the administration of the drugs. Dr Barton claims that she reassessed the patient on a daily basis but failed to make any notes about it. She refers to the doses the patient received as 'small and necessary'.

179. On the Thursday **24th** the Midazolam was increased to 80mgs and on the **25th** the Diamorphine was increased to 60 mgs. That followed a further prescription from Dr Barton dated the Friday **25th** for a variable dose between 40-200 mgs Diamorphine and 20-200 mgs of Midazolam. On each occasion that the dose was increased Dr Barton claims in her police statement that she 'anticipates' (as she puts it) 'that the patient's agitation might have been increasing'.

180. The following day the Saturday **26th** , the Diamorphine was delivered to the patient's body at a rate of 80 mgs and the Midazolam at a rate of 100 mgs. The patient died that day at 23:15 according to the death certificate of broncho-pneumonia.

181. The first prescriptions on the day of his admission by Dr Barton are described by Professor Ford as 'highly inappropriate' and 'reckless' particularly in light of Dr Lord's assessment that he should be prescribed intermittent Oramorphine if in pain (PRN). There is no doubt that the patient would have been in pain from his sacral sore but there was no indication that the patient would not be able to take any medication for his pain orally if he needed to.

182. The prescription written by Dr Barton which allowed the nurses to administer the Diamorphine and Midazolam was undated but must have

been written on the day of admission and was for a dose range of between 20-200 mgs Diamorphine, and 20-80 Midazolam. It was poor management to prescribe those drugs to an elderly frail underweight patient and it created the hazard that the combination of drugs could result in profound respiratory depression

183. The increases on the **23rd** and thereafter are described as inappropriate and dangerous by Professor Ford who also expresses the concern as to whether the nursing staff would have understood how long it takes for the opiates delivered through a syringe driver to take full effect which in this case would have been between 15 and 25 hours (para 3.11). The result of this would have been that they were increasing the doses before the earlier dose had a chance to be fully effective.

184. As his condition worsened, in all likelihood as a result of the drugs which were being administered to him, there was no reassessment to discover the cause. + Dr Barton did not seek advice from a Consultant as she did have done.

185. The various dose increases without explanation is described as very poor practice. Even if that was being done independently by the nurses, Dr Barton had created the situation where that had become possible.

186. The administration of 100 mgs Midazolam and 80 mgs Diamorphine would produce respiratory depression and severe depression of the consciousness level.

187. In addition to all of this there is no note that the patient was provided with food or fluid during the period following his admission until his death five

days later and that is despite the note from Dr Lord that the patient was to be provided with a high protein diet. The v. opposite seems to have occurred.

188. The cause of death was given as bronchopneumonia which can occur as a secondary complication to opiate induced respiratory depression.

Patient H – Robert Wilson (October 1998)

189. Patient H was 75 years old when he was admitted to Queen Alexandra Hospital on **21st September 1998**. He had sustained a fracture of his humerus bone following a fall. Whilst at the QAH he was given relatively small doses of morphine for pain. On assessment his Barthel score was 5.

190. On **7th** October it was noted that he did not want to go into care but wanted to return home. He was seen by Dr Luznat who was a consultant in old age psychiatry and she noted that Code A during the previous 5 years. She thought he may have developed early dementia.

Tuesday

191. On **13th October** he was assessed by his consultant physician Dr Ravindrane who found that he needed both nursing and medical care and that a short spell in long-term NHS care would be appropriate. Dr Ravindrane felt that he would remain at risk of falling until fully mobilised and he thought that the patient's kidney function should be reviewed. He prescribed his patient Frusemide which is a diuretic and Paracetamol for pain relief. The patient could, according to the doctor, have stabilised or alternatively died quite quickly.

192. The patient was visited that day by his son Iain (Wilson) who remembers him on the **13th**, the day before his transfer to GWMH, sitting up in bed and having a joke.

193. On his discharge from the QAH he was taking Paracetamol and Codeine as required for pain but he had only required four doses of codeine over the five days prior to his transfer. He was a heavy man weighing 93 Kilos.

Wad

194. On the **14th October** he was transferred to Dryad Ward for continuing care and Dr Barton noted on his admission that he needed help with his daily living activities, his Barthel score was 7, and he lived normally with his wife. He was continent and the plan was for further mobilisation. She also noted that he had alcohol problems. He also had congestive cardiac failure.

195. Professor Ford has noted that there was no record of any symptomatic medical problem at that time (para 5.8 police report). His blood pressure was not taken nor was there any clinical examination. It is important to note that this patient was not admitted for palliative care but for rehabilitation.

196. His wife Gillian Kimbley saw him on the day of his transfer to GWMH and indeed travelled with him in a minibus which was used for the transfer. She remembers him being lucid that day and able to hold a conversation.

197. The nursing note at GWMH on the **14th** recorded that the patient had a long history of drinking and LVF (Left Ventrical failure) and chronic oedematous legs.

198. On the day of his admission into the GWMH (**14th**) Dr Barton prescribed him Oramorph 10 mgs in 5 mils, 2.5-5 mls 4 – hourly despite the fact that in the days leading up to his transfer he had only been on Codeine for pain relief.

10 mgs 4X daily

199. That prescription for Oramorph was administered twice that day, once in the afternoon at 14.45 and again in the evening at 22.45.

Thurs. ~~Thursday prescribed by Dr. B 10 mgs~~ 4x daily and

200. The following day **15th** he was administered 10 mgs in 5mls every four hours. That was given according to the nursing notes because he was complaining of pain in his left arm. Up until the stage of his admission to GWMH his pain had been controlled by Codeine and Professor Ford regards that ~~very first~~ prescription of morphine to have been inappropriate. His son Iain saw him that day and describes how his father was in 'an almost paralysed state'.

Friday

201. On the **16th** he was seen by Dr Knapman who noted that the patient had deteriorated overnight and he was for active nursing care. His son Iain describes him as being almost in a coma and unable to speak.

202. Later on the **16th** it was noted by Nurse Hallman that his chest was very bubbly and a syringe driver was commenced with 20 mgs Diamorphine and 400 mcgs Hyoscine. That was on the basis of a prescription written by Dr Barton which may have been written, according to Dr Barton, on the day of admission for a variable dose of Diamorphine between 20 and 200 mgs over a 24 hour period by syringe driver. That was, according to her police statement, one of Dr Barton's 'proactive' prescriptions for pain relief.

203. There appears to have been no re-examination by Dr Barton prior to that prescription being administered by the nurses. Indeed from her police statement it appears that ~~she~~ Dr. B was away that day. It is quite possible according to Professor Ford that the Morphine the patient had been receiving was the cause of his deterioration.

Saturday

204. On the following day, the **17th**, his secretions had increased and so the Hyoscine was also increased (Florio). In the afternoon the dosage of Diamorphine was increased to 40 mgs and Midazolam was started at 20 mgs. The date of Dr Barton's prescription for Midazolam at a variable dose between 20-80 mgs is unclear but it must have been on or before the 17th being the date it was administered. Hyoscine which was the drug used to dry up secretions was also increased. There was no record made of the reason for starting the Midazolam and at the time the notes suggest that the patient was in fact comfortable. Professor Ford views the use of Midazolam in these circumstances to have been highly inappropriate (para 5.15).

205. No consideration appears to have been given by Dr Barton or by the nursing staff to the real possibility that the reason for the patient's deterioration may well have been the infusion of the cocktail of opiates which he was receiving automatically through a syringe driver. The prescription of continuous subcutaneous Diamorphine is not an appropriate treatment for a diagnosis of myocardial infarction and heart failure in a patient who is otherwise pain free.

206. A particular issue with this patient was his previous chronic alcoholism which had been noted by staff and appears to have been known to Dr Barton. The use of opioids in patients with liver disease as a result of alcoholism has to be very carefully monitored and preferably not used unless required to deal with severe pain. If he was in pain then a low dose of morphine would have been a more appropriate response.

Sat   Sunday

207. On the night of the **17th and into the morning of the 18th** that dosage was continued but in the afternoon of the **18th** it was increased again from 40 to 60 mgs Diamorphine and from 20 to 40 mgs of Midazolam. During none of this period was there any note made by either nurses or doctors that the patient was in pain though there were many notes that the patient was deteriorating.

Sunday   √ stat

208. At 23:40 on the night of the **18th** the patient's death was recorded ~~four~~ days after he entered that ward at GWMH. It was recorded that he had died from congestive heart failure. Professor Ford is of the view that the cocktail of drugs is highly likely to have led to respiratory depression and/ or bronchopneumonia.

Patient I – Enid Spurgin (March 1999)

209. Patient I was 92 when she was admitted to the Royal Haslar on **19th March** 1999 following a fall in which she had broken her hip. Prior to her fall she had been living at home and caring for herself. According to her medical notes she had been active and in good health. The fracture is described by an Orthopaedic surgeon Daniel Redfearn who has examined her notes, and was instructed by the police as an expert in her case, as a 'relatively complicated one'.

210. At the Haslar she had initially been given 3 doses of 5 mgs Morphine over the 20th and 21st March which had resulted in Hallucinations and so a note was made by the anaesthetist – nil further opiates. She was operated upon on the **20th** a right dynamic hip screw inserted. The only other analgesic prescribed for her was paracetamol (Redfearn).

211. She appears to have had post operative complications by way of bleeding, a haematoma developed and she had a painful hip.

212. Dr Reid reviewed her on the 23rd March and noted that she was still in a lot of pain and that was proving a barrier to mobilisation.

213. She was transferred ~~that day~~ on Friday **26th March** to GWMH Dryad Ward. Prior to transfer she was mobile and walking short distances with a Zimmer Frame and two nurses. She was continent during the day but not at night and her only analgesia was paracetamol. [~~Her nephew Carl Jewell who visited her at the Haslar fully expected his Aunt to be discharged from the GWMH and returned to her home~~].

214. Dr Barton made a note on admission (p.27) of her transfer to Dryad Ward

Past Med History

'...PMH nil of significance, Barthel, not weight bearing, tissue paper skin, not continent, plan sort out analgesia'.

215. Dr Barton prescribed her Oramorph on the day of her admission 10mgs in 5 mls 2.5 mgs 4 times a day. A note (p.106 and see Tubbritt) asserts that the patient had complained a lot of pain. Oral morphine was administered on the **26th, 27th and 28th March** and then discontinued because the patient was vomiting it. She was given codydromol as an alternative (Barrett and Lloyd). which was consistent with her reaction at the Royal Haslar.

216. On the 27th, although it was a Saturday, Dr Barton believes she reassessed the patient although if she did she made no note, and she increased the prescription for Oramorph to 10 mls 4 times a day with 20 mls at night.

217. The care plan records that the patient was experiencing pain on movement (p.84).

218. If pain was uncontrolled by less powerful analgesics then those prescriptions were appropriate, according to Professor Ford. However, there is no note from Dr Barton recording her assessment or her reasons for prescribing as she did. The patient should not have been in severe pain unless something had gone wrong with the hip repair which would have required re-assessment.

219. The fact that Dr Barton has recorded that the patient was not weight bearing is not consistent with the notes made at the Royal Haslar and is either inaccurate or indicates that there had been a change in the patient's mobility. That should have triggered a re-assessment which does not

appear to have taken place. A nursing note (p86) reveals that on the 4th April the wound was oozing serous fluid and blood and the wound was redressed.

220. On the 31st March Dr Barton has prescribed 10mgs of Morphine Sulphate to be given twice a day. There is no note of any review by her.

221. [The patient's nephew Carl remembers visiting her on about the 1st April when she was still talking about leaving the hospital. His impression was that she was very rarely seeing a doctor].

222. On the **6th April** Dr Reid suggested that there may have been a problem with the hip screw and requested that an X-ray be arranged. Unfortunately that was never actioned. That day, Dr Barton increased the dose of Morphine by slow release tablets to 20 mgs twice daily. In her police statement she reveals that she would have seen the patient that morning but made no note about it.

223. A note by Nurse Shaw (p.106?) of that consultation with Dr Barton reveals that Enid has been incontinent a few times but was insistent about not going into a care home. There was in that note no mention of pain. Those doses were administered until the **11th** April.

224. By the **11th** April the patient was very drowsy but still in pain if moved.

225. On the **12th** April Dr Barton prescribed Diamorphine by syringe driver at a variable dose between 20-200 mgs over a 24 hour period as well as 20-80 mgs of Midazolam. There is no note of any further assessment by Dr Barton on the 12th.

226. Those prescriptions are described by Professor Ford as 'reckless and inappropriate'. The patient was already described as 'very drowsy' and any dose over about 30 mgs sub-cut would be highly likely to produce coma and respiratory depression.

227. In fact the dose administered by Nurse Shaw, apparently either on her own calculation or under Dr Barton's direction on **12th April,** was 80 mgs Diamorphine together with 30 mgs Midazolam. Those doses were well within the variable dose that Dr Barton had prescribed but in fact were much higher than the dose of Morphine that the patient was already receiving and extremely dangerous.* Nurse Lynne Barrett could not explain why the patient was prescribed such a large dose and she in fact thought that the dose was only 60 mgs.

*The equivalent sub cut dose wld have been 20 mgs. w/o Midazolam

228. When Dr Reid noticed that the patient was receiving 80 mgs of Diamorphine he reduced it down to 40 mgs (p.108 and Barrett) however the patient died the following day. In Professor Ford's view the drugs she was being administered were a direct contributor to the patient's death.

229. Mr Redfearn the orthopaedic expert raises concerns in relation to the lack of response to the patient's pain which should have prompted the doctors to look for a possible orthopaedic explanation for her symptoms. This was never done.

230. The charges reflect on this occasion specifically the lack of assessment by Dr Barton given the patient's condition on entry onto the ward. Criticism is also made of the prescriptions written by Dr Barton on the 12th and the direction to administer such a high dose on the same day.

Patient J – Geoffrey Packman (August 1999)

231. Patient J was born in Code A and he was 67 years old when admitted to Monday Dryad Ward on 23rd August 1999. He was suffering from bi-lateral leg oedema (swelling) and venous hypertension. He was very obese, suffered from atrial fibrillation and had poor mobility. He had a poor Barthel score. He was not a well man.

232. Some weeks earlier he had suffered an accident in his bathroom at home. It had taken 2 ambulance crews to get him out of his bathroom. He was admitted to A&E on the **6th** August to Anne Ward at the Queen Alexandra Hospital. On the 8th August it was noted that he had very severe sores on his sacral area. The annotation was made in his notes on two occasions – "not for 555" meaning that he was not to be given resuscitation in the event of a life threatening event.

233. Eventually, according to his wife Betty, he made a good recovery in hospital and looked better than he had for years.

234. He was, on Monday the **23rd August, transferred to Dryad Ward** for recuperation and rehabilitation.

235. When he was assessed on Dryad Ward by Dr Ravindrane on the **23rd** the problems recorded were: obesity, arthritis in both knees, pressure sores. His mental test score was however good there being no significant cognitive impairment. His Barthel score had by now improved to 6. Nurse Hallman however remembers this patient as having the worst pressure sores she had ever seen.

236. Dr Barton believes, according to her police statement about this patient, that she must have reviewed him on the morning of Tues the **24th** but made no

note about it. On the **24th** August a drug called Clexane was prescribed which he received to reduce the risk of a DVT as well as Temazepam That may have caused a GI bleed from which the pt. was later to suffer.

237. On the **25th** August he was vomiting and passing fresh blood. Again there is no note of any review by Dr Barton though she thinks she performed one. The notes reveal that when it was noted that the patient was passing fresh blood through his rectum Dr Beasley was contacted and directed that Clexane which was an anti-clotting agent should be stopped.

238. His wife Betty recalls visiting him with friends on around the 25th (Wed) or 26th (Thurs) and meeting Dr Barton for the first time. Dr Barton took her into a room and told her bluntly that her husband was going to die and she should look after herself now. Betty was very shocked and surprised.

239. On **26th** August Dr Barton made this note – 'called to see. Pale clammy unwell. Suggests ?MI (Myocardial Infarction) treat stat Diamorph, and Oramorph overnight. Alternative possibility GI (gastrointestinal) bleed but no haematemesis (vomiting of blood). Not well enough to transfer to an acute unit, keep comfortable. I am happy for nursing staff to confirm death.'

240. No note of pulse, blood pressure or any other indications of a clinical examination are present.

241. However on that day (Thursday **26th)** Dr Barton appears to have given a verbal order to give Diamorphine intra muscularly which was injected that day. She also prescribed Oramorph 10 mgs in 5 mls 4 times a day which was administered daily thereafter from the 27th August until the syringe driver was commenced on the 30th August. There is also an undated

prescription written by Dr Barton for a variable dose of Diamorphine of between 40-200 mgs and Midazolam of 20-80 mgs. Dr Barton says in her police statement that she wrote that prescription out on the **26th** and that may well be right. Dr Barton says however that she had no intention that it should be administered at that time.

242. The following day, on Friday **27th** , the patient is noted to be in discomfort particularly when his dressings were changed. Dr Barton claims she would have reviewed him but made no note of it.

243. The syringe driver was commenced on Monday the **30th** August which was a Bank Holiday, with Diamorphine at a rate of 40mgs and Midazolam at 20 mgs. There is no note from Dr Barton about that and she is not sure if she would have gone in on a bank Holiday. It seems therefore that the syringe driver was started at the discretion of the nurses as was the amount of opiate to be administered within the range set by Dr Barton and at the lowest dose. Dr Barton believes the nurses would have spoken to her but there is no note of that recorded.

244. Those same doses were administered on the **31st August** when it was also noted that he had passed a large amount of black faeces which was an indication of a significant gastro-intestinal bleed.

245. On the **1st September** the Diamorphine was increased to 60 mgs and the Midazolam to 40 and then 60 mgs on the same day and then the following day they were increased again.

246. On the 1st Betty visited him and he did not wake up throughout the visit. His daughter Victoria remembers that her Dad deteriorated once he was in

the GWMH and that he appeared to be 'spaced out'. She describes the change as 'dramatic'.

Thurs.

247. On the **2nd September** the Diamorphine was increased to 90 mgs and the Midazolam was increased to 80 mgs in a 24 hour period. Jeanette Florio (nurse) says that she could not imagine such an increase taking place without the authority of a doctor. Dr Barton says that she would have reviewed the patient but made no note of it. She says this – "I anticipate again that (the patient) would have been experiencing pain and distress". If that is so, it is very surprising that no note has been made about it.

248. The patient's daughter Victoria sat with him throughout the 2nd. He was unconscious throughout the day.

Friday

249. The patient **died on the 3rd September** at 13.50. 11 days after his admission

250. In Professor Ford's opinion the patient's death from a massive gastrointestinal bleed was contributed to by the Clexane he was prescribed on the 24th August although it was stopped the following day, and possibly by the opiate induced respiratory depression. He was not dying nor expected to die prior to his deterioration on Dryad Ward on the 26th August. He had pressure sores but those were treatable. He had been transferred for recuperation and rehabilitation. Before deciding that the patient should not be transferred to an acute unit, which Dr Barton did on the 26th, she should have had further discussion with a senior consultant colleague. Reflected by charge 11 (a)(iv)

251. Her assessment of the patient was inadequate and her verbal order to administer Diamorphine was inappropriate.

252. There is no proper explanation for the doses of subcutaneous Diamorphine or Midazolam that she prescribed and no explanation for the dramatic increase in quantities of those drugs being administered.

253. The dose ranges were inappropriate and hazardous and unjustified by an assessment of the patient's condition.

Patient K – Elsie Devine (October 1999)

254. Patient K was an 88 year old lady when she was admitted on 9th October 1999 to the Queen Alexandra hospital with an episode of acute confusion. Her problems are summarised by the letter at xp.29 and 30 by Dr Taylor a clinical assistant in old age psychiatry.

255. She was confused, disorientated and sometimes aggressive. She had a medical history of treated hypothyroidism and chronic renal failure. She was independent and able to wash but tended to get herself lost.

256. She was transferred to GWMH on [Thursday] the **21st October 1999**. The referral letter (p.21) written by Dr Jay a consultant geriatrician who saw her on the 19th stated – that she was alert and could stand but was unsteady on walking. She was increasingly confused and had been aggressive until she got to know the staff.

257. Dr Barton's note on admission on [Thurs] the **21st** stated that she was for continuing care. That she needed help with all her daily living needs and she had a Barthel score of 8. 'Plan get to know. Assess rehab potential probably for rest home in due course'.

258. On the **25th October** and **1st November** there are entries by Dr Reid indicating that the patient was continent but mildly confused and wandering during the day, she was suffering from renal failure, but was physically independent although she needed help with bathing.

259. Two weeks later on Monday the **15th** November there is a note that she had been aggressive at times and needed Thioridazine to calm her down. Lynne Barrett was one of the nurses who helped to look after her and she

recalls a specific aggressive incident when the patient grabbed a nurse and would not let go and kicked out at Ms Barrett.

260. Dr Reid saw her on his ward round that day but that was the last time he saw her. He noted that there was not a single entry on her clinical notes since the last time he had seen her two weeks before. He made a full examination of her. Her heart, chest, bowels and liver were all normal. Her legs were however badly swollen. He wanted the patient to be seen by Dr Luznat the psychiatrist and made a note to that effect.

261. On Thurs the **18th** Nov the patient was seen by Dr Taylor one of Dr Luznat's team (Consultant Old age Psychiatry) and arrangements were being made to transfer her to an old age psychiatry ward for assessment and management.

262. However, that same day she was confused and aggressive (18th) and Dr Barton prescribed a Fentanyl patch for the patient. Fentanyl is an opiate which is applied to the skin on a patch. There was no indication in the notes as to why Dr Barton thought it appropriate to start the patient on opiates and there is no reference anywhere in the notes to this patient being in pain. Dr Barton in her statement to the police about this patient stated that the patch was 'an attempt to calm her, to make her more comfortable and to enable nursing care'. The patch was applied at 09:15 on the 18th and can take up to 24 hours before it becomes fully effective (Reid) and remains in the system for between 12 and 24 hours after the patch itself is removed (Reid).

263. A note made by Dr Barton on Friday the **19th** indicates that there had been a marked deterioration overnight. ie: Since the Fentanyl was applied the morning before.

264. Dr Barton wrote on the **19th** – 'today further deterioration in general condition. Needs SC analgesia with Midazolam. Son aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death'. Dr Barton prescribed that day Diamorphine 40-80 mgs and Midazolam 40-80 mgs.

265. In addition at 08:30 on the 19TH the patient was given an injection of Chlorpromazine (Not on chrono) 50 mgs prescribed by Dr Barton following an incident in which the patient is suggested to have been aggressive with nurses. This is a tranquiliser and 50 mgs is according to Dr Reid at the upper end of the normal range of dosage. An hour later a syringe driver was started by the nurses that day Friday (**19th**) at 09:25 containing 40 mgs of Diamorphine and 40 mgs of Midazolam. The Fentanyl patch was not removed until 3 hours later at 12:30 according to the notes. There is no record anywhere in the notes that the patient was at any time in pain. At this stage therefore on this Friday morning this patient had in her system, Fentanyl, Chlorpromazine, Diamorphine and Midazolam.

266. It is very difficult to understand why anyone would have thought it appropriate to start this patient on anything less that the minimum dose of 20 mgs Midazolam even if the patient was complaining of pain, which she wasn't.

267. The syringe driver was kept replenished for the next two days at those dosages. Dr Barton wrote in her police statement – 'this medication (Diamorphine and Midazolam) was prescribed at 09.25 and was administered with the sole intention of relieving (the patient's) significant distress, anxiety and agitation which were clearly very upsetting for her'.

268. Dr Barton again says that she had been making daily weekday reviews of this patient but accepts that she failed to make a note of any of them and that she 'relied greatly on daily reports from the nurse in charge and their nursing note entries'.

269. The patient **died** two days later on Sunday the **21st November.**

270. Dealing with the Diamorphine and Midazolam prescription on the 19th Professor Ford can not see the justification for it. Even if the patient had been in pain, for which there is no evidence, the starting doses were excessively high. An appropriate starting dose might have been 10 or 20 mgs if the patient was in pain but not double that and not when coupled with Midazolam.

271. Neither in Professor Ford's view was the Fentanyl justified. This regime of opiate medication has every appearance of being given to keep the patient quiet which would not be an appropriate use of opiates in this setting.

272. The drugs administered are very likely to have led to respiratory depression and coma.

Patient L – Jean Stevens (May 1999)

273. Patient L was 73 years old when admitted to Royal Haslar Hospital on 26th April 1999 after experiencing chest pains and collapsing.

274. She was found to have suffered a stroke as a result of a cerebral infarction in the right parietal lobe. She was looked after for several weeks and made a substantial recovery. [~~She was seen on the 19th May by her daughter June Bailey and was in good spirits, laughing and joking~~].

275. On Thursday 20th May she was transferred to Daedalus Ward but she was according to records in a very poorly condition and died two days later.

276. The criticism by the GMC of Dr Barton's care of this patient hinges around her immediate prescription upon entry onto the ward on the **20th** of Oramorphine, Diamorphine, and Midazolam in the usual very large variable ranges. This is not a case where this unfortunate patient was likely to recover or leave the hospital.

277. The only note by Dr Barton was on 20TH (Vol 3, p.20). The 2nd note was by nurse Tubritt recording death on the 22nd. ~~According to her husband (Mr Stevens), Dr Barton did not in fact see her at all during her short stay at GWMH.~~

278. A nursing note on the **21st** recorded a conversation with her husband indicating that he was anxious that medications should not be given which might shorten her life.

279. The syringe driver prescribed by Dr B was started on **21st** with 20 mgs Diamorphine and 20 mgs Midazolam.

280. Dr Barton's entry makes no mention of the patient being in any pain and contains no record of any physical examination of the patient. In Professor Ford's expert opinion there is no evidence that Dr Barton undertook a clinical assessment of this patient. Although the patient had previously complained of chronic abdominal pain, treatment with opiates would not have been appropriate.

281. In addition the dose ranges were far too wide and the dose of Midazolam excessively high.

CONCLUSION

282. As already indicated, Professor Ford is very critical of the quality of Dr Barton's note making. She failed to note assessments of the patients' condition if she was making them, she failed to make notes about important decisions relating to treatment and prescribing. She made few if any notes about why she regularly increased the dosages of her prescriptions.

283. Failing to make appropriate notes in relation to assessments in admission to the hospital is particularly serious because it leaves other treating medical personnel in the dark about what the baseline condition of the patient was upon admission and it left her with no notes that she could rely upon to assess properly whether the patient's condition had improved or worsened.

284. In view of the complete lack of note making it has to be inferred that no assessments were being performed properly before opiates were prescribed. The prescription of very large doses of opiates appears to have become a matter of course in the GWMH and the patient's best interests were not served as a result.

285. The prescribing by Dr Barton was, on occasion, dangerous and inappropriate and left far too much to the discretion of the nurses.

286. Patients were overdosed with opiates so much so as to become unresponsive.

BURDEN AND STANDARD OF PROOF

287. The burden of proving the charges is upon the GMC and the standard of proof in this case which is heard under the old rules is the criminal standard. In other words, before finding any of the heads of charge which have not been admitted, proved, the Panel would have to be sure that Dr Barton had acted in the way alleged.

A) WITNESS SCHEDULE AND EXPLANATION

B) PATIENT NOTES AND CHONOLOGIES

C) PROFESSOR FORD'S REPORTS

Tom Kark

QEB Hollis Whiteman Chambers

Temple, London EC4Y 9BS 4th June 2009

Expert Review

Copy B

Edna Purnell

No. BJC/37

Date of Birth: Code A

Date of Death: 3 December 1998

Mrs Purnell lived at Addenbroke Residential Home at the time of her admission to the Royal Haslar Hospital to undergo surgery for a fractured neck of femur.

Following the operation on 26 October 1998 and the insertion of a dynamic hip screw, she was admitted to Gosport War Memorial Hospital for rehabilitation on 11 November 1998.

At Gosport War Memorial Hospital *Dr Naismith noted there was a readiness to move quickly from a single dose of Co-codamol to Oramorph in doses of 5 to 10mgs which was given twice most days. Mrs Purnell became very drowsy on Oramorph and from that point her renal functions seem to have diminished.

The syringe driver was started with 20mgs of Diamorphine which was three times the dose Mrs Purnell was receiving orally. At this point she appeared comfortable although semi conscious.

The experts have considered this case to be a natural death albeit that the treatment was sub optimal and that the dose of opioids was markedly escalated in her final few days.

*Dr Lawson notes that in his opinion Mrs Purnell would have died in any event without opiates being used. The medical records make note of the concerns expressed by Mrs Purnell's son as to the treatment that was being provided to his mother.

Copy C

Hampshire Constabulary
Police Headquarters
West Hill
WINCHESTER
Hampshire
SO22 5DB

Tel: 01962 841500

Fax: 01962 871189
Telex: 47361 HANPOL

I R Readhead LL.B
Deputy Chief Constable

Your ref:

Our ref:
IR/DCC/hjs

18 SEP 2002

PRIVATE AND CONFIDENTIAL

Dear Mr Wilson,

Questions for Deputy Chief Constable, I. Readhead at a meeting arranged with Miss Emily Yeats and other Families, at Fareham Police Station on Wednesday, 11th September, 2002.

In furtherance to the above meeting, I promised that I would write to you concerning the questions that you put to me. Under the circumstances, I also feel it is prudent for me to send a copy of this letter to all other relatives.

Q. I. *In the evidential test used by Crown Prosecutors it states that, 'Crown Prosecutors must be satisfied that there is enough evidence to provide a realistic prospect of a conviction'.*

So how do you justify your proposed course of action when:

(i) *No families have been interviewed. As an example, Mr. Mike Wilson received letters from four different officers over a period of 15 months advising him that an officer would come to interview him. Nobody ever came.*

(ii) *No staff from the hospital have been interviewed.*

(iii) *And with the exception of expert medical opinions on only four cases, no other investigation appears to have taken place?*

A.1.

(i) We have now interviewed all families or obtained evidence form members of staff who may have been involved with the treatment of those who died at

Ryder, Robert

From: Ryder, Robert
Sent: 12 March 2007 16:03
To: 'Paul Hylton Code A
Subject: RE: Dr Barton

Paul
Thanks for your e mail. I have now considered the documents sent to me by the police relating the classification and re-classification of this patient's case. Unfortunately, the documents are incomplete, and the extracts which have been provided are not clear. Therefore I have written to the police to seek clarification. I will be in touch as soon as I receive a response.
regards
Rob

From: Paul Hylton Code A
Sent: 06 March 2007 12:21
To: Ryder, Robert
Subject: RE: Dr Barton

Rob
I think that we should at least look into the reasons underlying the reclassification of the case. It may help us in the long run if we can have the confidence of all the families, even those whose cases do not end up going to Panel. There is a community-type relationship down there and we need to try as best we can to regain the confidence of all of them.
If the investigation is getting too time or resource intensive then get back to me.
Paul

> -----Original Message-----
> **From:** Ryder, Robert Code A
> **Sent:** 05 Mar 2007 17:24
> **To:** Paul Hylton Code A
> **Subject:** Dr Barton
>
> *** *Before acting on this email or opening any attachment you are advised to read the Eversheds disclaimer at the end of this email.* ***
>
> Dear Paul
>
> I refer to my recent email concerning a call which I received from a Mr Stevens, concerning his wife, Jean, one of Dr Barton's former patients.
>
> This is a case which the police, in their investigation, initially categorised at level three. Subsequently they downgraded the case to category one.
>
> When you and I discussed the matter on the telephone, it was agreed that I would contact the police and seek confirmation regarding the classification of the case. I attach a letter dated 21 July 2005, which the police sent to Mr Stevens. The letter is self-explanatory and it appears that the reason for the reclassification is due to the fact that when the key clinical team first considered the matter they did not have the benefit of the patient's medical records before she was transferred to the Gosport Hospital. As part of the police investigation, the patient's records prior to her admission to the Gosport Hospital were obtained - from the Haslar Hospital. The key clinical team then reconsidered the case and came to the conclusion that the patient had received appropriate treatment at Gosport.
>
> I have spoken to Mr Stevens again about this. He cannot understand why the experts

decided to re-categorise. I have explained to him that currently I am only looking at category three cases and I have explained to him that I will need permission from you to investigate the reasons underlying the reclassification of the case. In an effort to manage his expectations, I have also indicated to him that it is doubtful that the GMC will include this case in the fitness to practise proceedings. I have explained that it is simply not possible to refer all the cases which the police investigated, and that in practical terms only a selection of the strongest cases are likely to proceed. He understands the position, but nevertheless asked me to speak to you about the possibility of investigating the case relating to his wife.

I look forward to hearing from you.

Regards.

Rob

Robert Ryder
Associate

Direct Dial: Code A
Internationa
www.eversheds.com

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Ryder, Robert

From: Ryder, Robert
Sent: 05 March 2007 17:24
To: 'Paul Hylton Code A
Subject: Dr Barton
Attachments: CAR_LIB1-#1798115-v1-Letter_from_Hampshire_Police.PDF

Dear Paul

I refer to my recent email concerning a call which I received from a Mr Stevens, concerning his wife, Jean, one of Dr Barton's former patients.

This is a case which the police, in their investigation, initially categorised at level three. Subsequently they downgraded the case to category one.

When you and I discussed the matter on the telephone, it was agreed that I would contact the police and seek confirmation regarding the classification of the case. I attach a letter dated 21 July 2005, which the police sent to Mr Stevens. The letter is self-explanatory and it appears that the reason for the reclassification is due to the fact that when the key clinical team first considered the matter they did not have the benefit of the patient's medical records before she was transferred to the Gosport Hospital. As part of the police investigation, the patient's records prior to her admission to the Gosport Hospital were obtained - from the Haslar Hospital. The key clinical team then reconsidered the case and came to the conclusion that the patient had received appropriate treatment at Gosport.

I have spoken to Mr Stevens again about this. He cannot understand why the experts decided to re-categorise. I have explained to him that currently I am only looking at category three cases and I have explained to him that I will need permission from you to investigate the reasons underlying the reclassification of the case. In an effort to manage his expectations, I have also indicated to him that it is doubtful that the GMC will include this case in the fitness to practise proceedings. I have explained that it is simply not possible to refer all the cases which the police investigated, and that in practical terms only a selection of the strongest cases are likely to proceed. He understands the position, but nevertheless asked me to speak to you about the possibility of investigating the case relating to his wife.

I look forward to hearing from you.

Regards.

Rob

Robert Ryder
Associate

Direct Dial: Code A
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HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable

Fareham Police Station
Quay Street
Fareham
Hampshire
P016 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

DR BARTON

Background

1. Gosport War Memorial Hospital (GWMH) is a 113 bed community hospital managed previously by the Fareham and Gosport Primary Care Trust. The hospital came under the control of the Portsmouth Health Care (NHS) Trust from April 1994 until April 2002.

2. The hospital operates on a day-to-day basis with nursing and support staff employed by the PCT. At the relevant time clinical expertise was provided by way of visiting general practitioners and clinical assistants subject to the supervision of consultants.

3. Elderly patients were generally admitted to GWMH by referrals from local hospitals or general practitioners for palliative, rehabilitative or respite care.

4. Doctor Jane BARTON ("Dr BARTON") is a registered Medical Practitioner who in 1988 took up a part-time position in GWMH as Clinical Assistant in Elderly Medicine. During the period that she worked at GWMH, Dr BARTON also worked on a part-time basis as a partner in general practice.

Police Investigations

5. Hampshire Police conducted a number of investigations, referred to below, into the deaths of elderly patients at GWMH, following allegations that patients admitted since 1989 for rehabilitative or respite care were inappropriately administered Diamorphine and other opiate drugs at dosages or in circumstances that hastened or caused death. The investigations also looked at further concerns raised by families of the deceased which indicated that the general standard of care afforded to patients was below an acceptable standard and potentially negligent.

6. Most of the allegations involved Dr BARTON.

7. Two allegations (in respect of patients, SPURGIN and PACKMAN, referred to in more detail below) were investigated by the Police in respect of a consultant Dr Richard REID. Part of Dr REID's responsibilities involved the supervision of Dr BARTON.

8. Of 945 death certificates issues in respect of patient deaths at GWMH between 1995 and 2000, 456 were certified by Dr. BARTON.

9. The allegations were subject of three extensive investigations by Hampshire Police between 1998 and 2006 during which the circumstances surrounding the deaths of 92 patients were examined. At every stage experts were commissioned to provide evidence of the standard of care applied to the cases under review.

10. The Crown Prosecution Service reviewed the evidence at the conclusion of each of the three investigation phases and on every occasion concluded that the prosecution test was not satisfied and that there was insufficient evidence to sanction a criminal prosecution of healthcare staff, in particular Dr BARTON.

<u>The First Police Investigation</u>

11. Hampshire Police investigations commenced in 1998 following the death of Gladys RICHARDS aged 91.

12. Mrs Richards died at the GWMH on Friday 21 August 1998 whilst recovering from a surgical operation carried out at the nearby Royal Haslar Hospital to address a broken neck of femur on her right side (hip replacement).

13. Following the death of Mrs Richards two of her daughters, Mrs MACKENZIE and Mrs LACK complained to the Hampshire Police about the treatment that had been given to their mother at the GWMH. Mrs MACKENZIE contacted Gosport Police on 27 September 1998 and alleged that her mother had been unlawfully killed.

14. Local officers (Gosport CID) carried out an investigation submitting papers to the Crown Prosecution Service in March 1999.

15. The Reviewing CPS Lawyer determined that on the evidence available a criminal prosecution could not be justified.

16. Mrs MACKENZIE then expressed her dissatisfaction with the quality of the police investigation and made a formal complaint against the officers involved.

17. The complaint made by Mrs MACKENZIE was upheld and a review of the police investigation was carried out.

<u>Second Police Investigation</u>

18. Hampshire Police commenced a re-investigation into the death of Gladys RICHARDS on Monday 17 April 2000.

19. Professor Brian LIVESLEY an elected member of the academy of experts provided a medical opinion in a report dated 9 November 2000 and came to the following conclusions:

- "Doctor Jane BARTON prescribed the drugs Diamorphine, Haloperidol, Midazolam and Hyoscine for Mrs Gladys RICHARDS in a manner as to cause her death."

- "Mr Philip James BEED, Ms Margaret COUCHMAN and Ms Christine JOICE were also knowingly responsible for the administration of these drugs."

- "As a result of being given these drugs, Mrs RICHARDS was unlawfully killed."

20. A meeting took place on 19 June 2001 between senior police officers, the CPS caseworker Paul CLOSE, Treasury Counsel and Professor LIVESLEY.

21. Treasury Counsel took the view that Professor LIVESLEY's report on the medical aspects of the case, and his assertions that Mrs RICHARDS had been unlawfully killed were flawed with regard to his understanding of the law.

22. Professor LIVESLEY provided a second report dated 10 July 2001 where he concluded, as follows:

- "It is my opinion that as a result of being given these drugs Mrs RICHARDS death occurred earlier than it would have done from natural causes."

23. In August 2001 the Crown Prosecution Service nevertheless advised that there was insufficient evidence to sustain a realistic prospect of a conviction.

24. Local media coverage of the case of Gladys RICHARDS resulted in other families raising concerns about the circumstances of their relatives' deaths at the GWMH and as a result four more cases were randomly selected for review - Arthur CUNNINGHAM, Alice WILKIE, Robert WILSON and Eva PAGE.

25. Expert opinions were sought from a further two medical experts, professors FORD and MUNDY who were each provided with copies of the medical records of the four patients in addition to the medical records of Gladys RICHARDS.

26. The reports from Professor FORD and Professor MUNDY were reviewed by the Police and a decision was taken not to forward them to the CPS as the conclusions were similar to the RICHARDS case and that there was insufficient evidence to provide a realistic prospect of conviction. The Police then decided that there would be no further investigations at that time.

27. Copies of the expert witness reports of Professor FORD and Professor MUNDY were forwarded to the General Medical Council, the Nursing and Midwifery Council and the Commission for Health Improvement, for appropriate action.

Intervening Developments between Second and Third Investigations

28. On 22 October 2001 the Commission for Health Improvement (CHI) launched an investigation into the quality of health care at GWMH, interviewing 59 staff in the process.

29. A report of the CHI investigation findings was published in May 2002, concluding that a number of factors contributed to a failure of the Trust systems to ensure good quality of patient care.

30. The CHI further reported that the Trust, post investigation, had adequate policies and guidelines in place that were being adhered to, governing the prescription and administration of pain relieving medicines to older patients.

31. Following the CHI Report, the Chief Medical Officer Sir Liam DONALDSON commissioned Professor Richard BAKER to conduct a statistical analysis of the mortality rates at GWMH, including an audit/review of the use of opiate drugs.

32. On Monday 16 September 2002 staff at GWMH were assembled to be informed of the intended audit at the hospital by Professor BAKER. Immediately following the meeting nurse Anita TUBBRITT (who had been employed at GWMH since the late 1980s) handed to hospital management a bundle of documents.

33. The documents were copies of memos, letters and minutes relating to the concerns of nursing staff raised at a series of meetings held in 1991 and early 1992 including:-

- The increased mortality rate of elderly patients at the hospital.
- The sudden introduction of syringe drivers and their use by untrained staff.
- The use of Diamorphine unnecessarily or without consideration of the sliding scale of analgesia (as per the Wessex Protocol).
- Particular concerns regarding the conduct of Dr BARTON in respect of prescription and administration of Diamorphine.

34. Nurse TUBBRITT'S disclosure was reported to the police by local health authorities and a meeting of senior police and NHS staff was held on 19 September 2002. The following decisions were made:-

- To examine the new documentation and investigate the events of 1991.

- To review existing evidence and new material in order to identify any additional viable lines of enquiry.

- To submit the new material to experts and subsequently to the CPS.

- To examine possible individual and corporate liability.

35. A telephone number for concerned relatives to contact police was issued via a local media release.

Third Police Investigation

36. On 23 September 2002 Hampshire Police commenced enquiries. Initially relatives of 62 elderly patients who had died at Gosport War Memorial Hospital contacted police voicing standard of care concerns.

37. In addition, Professor Richard BAKER, during his statistical review of mortality rates at GWMH, identified 16 cases which were of concern to him in terms of pain management.

38. 14 further cases were identified for investigation through ongoing complaints by family members between 2002 and 2006.

39. A total of 92 cases were investigated by police during the third phase of the investigation.

40. A team of medical experts (the key clinical team) were appointed to review the 92 cases, and completed this work between September 2003 and August 2006.

41. The multi-disciplinary team reported upon Toxicology, General Medicine, Palliative Care, Geriatrics and Nursing.

42. The terms of reference for the team were to examine patient notes (initially independently) and to assess the quality of care provided to each patient according to the expert's professional discipline.

43. The Clinical Team were not confined to looking at the specific issue of syringe drivers or Diamorphine, but to include issues relating to the wider standard and duty of care with a view to screening each case through a scoring matrix into predetermined categories:-

Category 1 - Optimal care.
Category 2 - Sub optimal care.
Category 3 - Negligent care.

44. The cases were screened in batches of twenty and following this process the experts met to discuss findings and reach a consensus.

45. Each expert was instructed to retain and preserve their notes and findings for possible disclosure to interested parties.

46. All cases in categories 1 and 2 were quality assured by a medical/legal expert, Matthew LOHN to confirm the key clinical Team's findings.

47. Of the 92 cases reviewed 78 failed to meet the threshold of negligence required to conduct a full criminal investigation and accordingly these cases were referred by the police to the General Medical Council and Nursing and Midwifery Council for their information and attention.

48. The fourteen Category 3 cases were referred to the police for further investigation. These included two cases which the police considered as part of their second investigation - WILSON and CUNNINGHAM. Of the fourteen cases, four were potentially negligent in terms of standard of care, but the cause of death was assessed as entirely natural. In the circumstances, the essential element of causation in these four cases was not capable of being proved.

49. Accordingly the following four cases were released from police investigation in June 2006:-

- Clifford HOUGHTON.
- Thomas JARMAN.
- Edwin CARTER.
- Norma WINDSOR.

50. The final ten cases (referred to below) were subject to a full criminal investigation on the basis that they had been assessed by the key clinical team as being 'negligent care that is today outside the bounds of acceptable clinical practice and where the cause of death is unclear'.

51. The investigation included taking statements from all relevant healthcare staff involved in care of the patients and family members. Medical experts were engaged to provide opinions in terms of causation and standard of care. The police took statements from over 300 witnesses.

52. The expert witnesses, principally Dr Andrew WILCOCK (Palliative care) and Dr David BLACK (Geriatrics) were instructed with guidance from the Crown Prosecution Service to ensure that their reports addressed the relevant legal issues in the context of a criminal investigation.

53. The experts completed their reports following a review of each patient's medical records, all witness statements and transcripts of police interviews with Dr Reid and Dr Barton. They were also provided with the relevant documents required to put the circumstances of care into 'time context'. The reviews were conducted by the experts independently.

54. Supplementary expert medical evidence was obtained where necessary to clarify particular medical conditions beyond the immediate sphere of knowledge of Dr's BLACK and WILCOCK.

55. A common denominator in respect of the ten cases was that the clinical assistant in each case was Dr BARTON. She was responsible for the initial and continuing care of the patients, including the prescription and administration of opiates and other drugs using syringe drivers.

56. Dr BARTON was interviewed under caution in respect of the allegations.

57. The interviews were conducted in two phases. The initial phase was designed to obtain an account from Dr BARTON in respect of care delivered to individual patients. Dr BARTON responded during these interviews by submitting prepared statements and exercised her right of silence in respect of questions asked.

58. During a second interview phase (following provision of expert witness reports to the police investigation team) Dr BARTON again exercised her right of silence and refused to answer any questions.

59. Dr REID was interviewed in respect of 2 cases (PACKMAN and SPURGIN) following concerns raised by the expert witnesses. Dr REID answered all questions put to him.

60. Full files of evidence were submitted to the Crown Prosecution Service between December 2004 and September 2006 in the following format:-

- Senior Investigating Officer summary and general case summary.
- Expert reports.
- Suspect interview records.
- Witness list.
- Family member statements.
- Healthcare staff statements.
- Police officer statements.
- Copy medical records.
- Documentary exhibits file.

61. Additional evidence was forwarded to the CPS including general healthcare concerns raised by staff in terms of working practices and the conduct of particular staff.

62. The ten category three cases were:-

1. Elsie DEVINE 88 yrs. Admitted to GWMH 21 October 1999, diagnosed multi-infarct dementia, moderate/chronic renal failure. Died 21 November 1999, 32 days after admission. Cause of death recorded as Bronchopneumonia and Glomerulonephritis.

2. Elsie LAVENDER 83 yrs. Admitted to GWMH 22 February 1996 with head injury/ brain stem stroke. She had continued pain around the shoulders and arms for which the cause was never found. Died 6 March 1996, 14 days after admission. Cause of death recorded as Cerebrovascular accident (stroke).

3. Sheila GREGORY 91 yrs. Admitted to GWMH 3 September 1999 with fractured neck of the femur, hypothyroidism, asthma and cardiac failure. Died 22 November 1999, 81 days after admission. Cause of death Bronchopnuemonia.

4. Robert WILSON 74 yrs. Admitted to GWMH 14 October 1998 with fractured left humerus and Code A hepatitis. Died 18 October 1998 4 days after admission. Cause of death recorded as congestive cardiac failure and renal/liver failure.

5. Enid SPURGIN 92 yrs. Admitted to GWMH 26 March 1999 with a fractured neck of the femur. Died 13 April 1999 18 days after admission. Cause of death recorded as cerebrovascular accident.

6. Ruby LAKE 84 yrs. Admitted to GWMH 18 August 1998 with a fractured neck of the femur, atrial fibrillation, ischemic heart disease dehydrated and leg/buttock ulcers. Died 21 August 1998 3 days after admission. Cause of death recorded as bronchopneumonia.

7. Leslie PITTOCK 82 yrs. Admitted to GWMH 5 January 1996 with Parkinsons disease. He was physically and mentally frail; immobile, suffering depression. Died 24 January 1996 15 days after admission cause of death recorded as bronchopneumonia.

8. Helena SERVICE 99 yrs. Admitted to GWMH 3 June 1997 with multiple medical problems, diabetes, congestive cardiac failure, confusion and sore skin. Died 5 June 1997 2 days after admission. Cause of death recorded as congestive cardiac failure.

9. Geoffrey PACKMAN 66 yrs. Admitted to GWMH 23 August 1999 with morbid obesity cellulitis arthritis immobility and pressure sores. Died 3 September 1999 13 days after admission. Cause of death recorded as myocardial infarction.

10. Arthur CUNNINGHAM 79 yrs. Admitted to GWMH 21 September 1998 with Parkinson's disease and dementia. Died 26 September 1998 5 days after admission. Cause of death recorded as bronchopneumonia.

63. Dr David WILCOCK provided extensive evidence in respect of patient care and identified particular themes of concern in respect of the final 10 category ten cases including:-

- *'Failure to keep clear, accurate, and contemporaneous patients records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed'.*

- *'Lack of adequate assessment of the patient's condition, based on the history and clinical signs and, if necessary, an appropriate examination'*

- *'Failure to prescribe only the treatment, drugs, or appliances that serve patients' needs'*

- *'Failure to consult colleagues including:-*

Enid Spurgin - orthopaedic surgeon, microbiologist
Geoffrey Packman - general physician, gastroenterologist
Helena Service - general physician, cardiologist
Elsie Lavender - haematologist
Sheila Gregory - psychogeriatrician
Leslie Pittock - general physician/palliative care physician
Arthur Cunningham - palliative care physician

64. Many of the concerns raised by Dr WILCOCK were reflected by expert Geriatrician Dr David BLACK, and by other experts who were commissioned to review other aspects of the medical care. Full details are contained within their reports.

65. There was however little consensus between the two principal experts Drs BLACK and WILCOCK as to whether the category 3 patients were in irreversible/terminal

decline, and little consensus as to whether negligence more than minimally contributed towards the death of patients.

66. As a consequence Treasury Counsel and the Crown Prosecution Service concluded in December 2006 that having regard to the overall expert evidence it could not be proved that Dr BARTON was negligent to the required criminal standard.

67. Whilst the medical evidence obtained by police was detailed and complex it did not prove that the medication contributed substantially towards death. There is some expert evidence which suggests that in the case of some patients the opiates prescribed and/or administered where excessive to the patient's needs and may have hastened the patient's death by a matter of hours or days.

68. In the view of the CPS there was not sufficient evidence to prove that the doctors were criminally culpable and the CPS concluded that there was no realistic prospect of conviction.

69. Family group members of the deceased and stakeholders were informed of the decision in December 2006. The police investigation was closed.

IOC Proceedings and Referrals

70. The IOC considered Dr Barton's case on three occasions; on 21 June 2001 (during the second police investigation); on 21 March 2002 and on 19 September 2002 (a few days prior to the police starting the third investigation).

71. On each occasion the IOC made no Order. On 13 February 2002, approximately one month before the second IOC Hearing, it appears that Dr Barton came to the following agreement with the Isle of Wight, Portsmouth and South East Hampshire Health Authority :

- To cease to provide medical care for adult patients at GWMH
- To stop prescribing opiats and benzodiazepines with immediate effect.

72. On 13 February 2002 it appears that Dr Barton reached a separate agreement with the Portsmouth Health Care NHS Trust, which effectively meant that Dr Barton would no longer work at GWMH.

73. On 29 August 2002, shortly before the second IOC Hearing and one month before the police commenced their third investigation, the Preliminary Proceedings Committee decided to refer to the Professional Conduct Committee the cases referred to in paragraph 24 above, i.e. RICHARDS, CUNNINGHAM, WILKIE, WILSON and PAGE.

74. The allegations which were referred relate to the period between February and October 1998 and include the following :-

Inappropriate/unprofessional prescribing of opiate and sedative drugs; and prescribing in dosages and combinations which were excessive and potentially hazardous to the condition of the patients.

The cases have been "on hold" pending the conclusion of the Police investigations.

Work carried out by Eversheds to date

75. We have obtained a large volume of documents from the Hampshire Police and are in the process of reading and analysing the papers. We have focused on the ten Category 3 cases referred to in paragraph 62 above. We are waiting to receive from the Police, further papers relating to Mrs RICHARDS, Mrs WILKIE and Mrs PAGE, i.e. the three cases which have already been referred to the Professional Conduct Committee, but which are not included in the list of ten Category 3 cases.

76. We have prepared and forwarded to Paul Hylton a summary of each of the ten Category 3 cases. We have also given an indication of the relative strengths and weaknesses of each case. On the basis of what we have read so far, there are three reasonably strong cases - WILSON, SPURGIN and PACKMAN. There are a further two cases which are worthy of more detailed consideration - PITTOCK, and LAVENDER. The remaining five cases are relatively weak in view of the conclusions reached by the experts.

77. It is difficult, at this stage, to gauge how many cases are likely to go forward via the case examiner to the Professional Conduct Committee. We need to discuss the selection of cases further with you as part of a Strategy Review. For present purposes, we suggest that it would be prudent to work on the basis that a maximum of ten cases will go forward to the FTP Panel. However, we consider it likely that the number of cases will be reduced with the benefit of further analysis and investigation.

78. We have reported to Paul Hylton that on average the Police have taken between 20 and 50 statements from witnesses in each case. In each case there are also between two and six experts. On the basis of our reading so far, it is likely that we will need to re-interview a significant proportion of the witnesses of fact. More detailed work will be needed to refine the expert evidence and tailor it, where necessary, for use in the FTP proceedings.

79. We estimate that we will need at least six months to gather evidence and a further two months for the experts to consider the additional evidence before

draft charges are formulated. The Defence will probably need a similar amount of time to prepare their case.

80. With regard to the duration of the hearing, our best estimate at the moment is that the case in respect of each individual patient will take approximately two weeks, including an estimate for the Panel's determination on the factual evidence, impairment and sanction. This equates to an estimate for the whole hearing of approximately 20 weeks, assuming that a total of ten individual cases are referred.

81. Most of the evidence obtained by the Police concerns Doctor BARTON's role. However, the experts are critical of various Consultants who worked with Doctor BARTON during the course of her employment as a clinical assistant - in particular Dr REID. Therefore, there is a possibility that cases involving other Practitioners will also need to be referred to the FTP Panel in due course. This is something we need to consider with you in more detail in determining an overall strategy in this case.

4013

attendance

Client	General Medical Council (4/PWJ/RRR/4013)	Date	14 February 2007
Matter	Barton	F/E	Robert Ryder
Attendees			

On 14 February, Paul Hylton telephoned on receipt of my e-mail sent during the afternoon.

Paul recalls speaking to Mr. Stephens. However, Paul was under the impression that his wife's case was on the Category 3 cases. I confirmed that Mr. Stephens told me that whilst the case had been classified initially by the police as Class 3, it had subsequently been downgraded.

Paul asked if I could contact the police to find out whether the case had, in fact, been downgraded and if so, the reasons and whether those reasons had been communicated to Mr. Stephens. When we have this information, we can review whether or not Mrs. Stephens' cases should be added to the 13 cases which I am already looking at.

In passing, I mentioned to Paul that I am forming some initial views on how long it will take to prepare this case for hearing and how long the hearing might take. I explained that the police have interviewed between 20 and 50 witnesses in each case and used between 2 and 6 experts in each case.

Of the 13 cases I have looked at, at least 3 are unlikely to proceed on the basis of the expert evidence. The GMC will have to consider, in due course, whether to go with the remaining cases or a lower number. However, assuming that 10 cases go forward, my initial view is that each case will take about 2 weeks, factoring into this estimate a time which the Panel will need to reach a determination on facts and to reach a decision on impairment and sanction. This would give an estimated overall hearing time of 20 weeks.

I also estimate that it will take us at least six months to collate the evidence and a further two months for the experts to review any extra evidence which has been collated. The other side will need at least as much time to prepare their defence. Therefore, we are looking at a hearing date in the summer of next year.

I also mentioned to Paul a possible complicating factor - the involvement of the Supervising Consultant. He has been criticised in the various expert reports. Although the criticisms are lacking in specific detail.

We agreed that in the next few weeks, we should have a strategy meeting.

Following my call to Paul, I spoke to D.S. Stephenson. He said that he would dig out Mrs. Stephens' files and he would call me back tomorrow. He thinks, from memory, that the case was downgraded from a Category 3 to a Category 2 case. He thinks this was because the initial classification was based only on the Hospital records at Gosport. When the key clinical team obtained the records from the Queen Alexandra/Haslar Hospitals, the case against Dr. Barton was not quite so strong.

attendance

I then telephoned Mr. Stephens. I explained that following our call this morning, I checked to see what documents we have. I confirmed that we have the medical records. We do not have the witness statements. I also explained that I had spoken to Paul Hylton and I have been asked by him to contact the police to find out the reasons why his wife's case was re-classified. I said I had contacted the police and they had agreed to do this promptly.

I said that I would contact him again as soon as I had heard from the police. In the meantime, he said that he has copies of the police witness statements and can send these to me if necessary. He thinks he already sent copies to Paul Hylton. I asked him not to send me copies for the moment. I said I would review the matter after I had spoken to the police.

Ryder, Robert

From: Ryder, Robert
Sent: 14 February 2007 16:58
To: 'Paul Hylton Code A
Subject: Dr Barton

Dear Paul
I spoke to a Mr. Earnest Stephens today, the husband of one of Dr Barton's patients. He mentioned that he had been in touch with you and that you, in turn, had suggested that he contact me. He is unhappy about the way the police dealt with his wife's case, initially treating it as one of the strongest cases, but subsequently "down grading " it. I explained that I couldn't really comment on this, which he accepted.
He then wanted confirmation that I have received all the papers relating to his wife - medical records and witness statements taken by the police. Following the conversation with him, I have checked the position. We do have a set of medical records, which were sent to us by the GMC sometime ago, but we do not have any other documents, including the witness statements. When I spoke to him he said that the witness statements had been sent to the GMC.
Having checked which documents we currently hold, I need to revert to him. Before doing so, I need to consider with you how I should best deal with him. I assume that he believes that we, on behalf of the GMC, will be looking at his wife's case, and that he has been in touch to make sure that I have all the relevant paperwork. Mrs Stephens's case is not included in the 13 cases which I am currently looking at, as her case was not included in the "top ten" catagory 3 cases and is not one of the cases which have already been referred .
As mentioned when we last spoke there is a huge amount of material to consider with reference to the 10 catagory 3 cases - over 50 lever arch files, and the police are going to send me some more papers shortly relating to their investigation of 3 of the 5 patients who have already been referrred to the panel, but which do not feature in the "top Ten". I am making good progress in the reading in process and by the end of the week will be able to send you my initial views - at least with reference to the top ten cases, (pending receipt of the further documentation from the police relating to the other cases) and based on a selected reading of the files.
The point I need you to consider in the meantime is whether I am authorised to look at any other cases , including 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 certain number of cases.
Regards
Rob

Direct Dial: Code A

International: Code A
www.eversheds.com

attendance

Client	General Medical Council	Date	26 January 2007
Matter	Barton	F/E	Robert Ryder
Attendees	Robert Ryder		

I telephoned Paul Hylton in response to the e-mail which he sent to Luisa earlier in the week. He had asked Luisa if we were in a position to give any indication on time estimate for the Barton case hearing.

I briefed Paul on recent developments - my visit last week to the Hampshire Police and the collection of all their documents - some 60 files. Although a fair proportion of this documentation (about 20 files) consists of medical records, there is a significant amount of evidence in the form of witness statements, experts reports etc which I need to read and analyse.

I referred Paul to the reading which I have done this week (approximately 7 files) which deals with the position in 1991 when staff members raised concerns about the use of syringe drivers and diamorphine. This was when Dr Barton was the Clinical Assistant working at Gosport, albeit subject to the supervision of at least one consultant.

I also explained to Paul how the Police had gone about their investigation i.e. the fact that they looked at over 90 cases and whittled them down to 10 cases which had been investigated more closely. A team of experts had been involved initially in categorising cases as either optimal care, sub-optimal care or possible negligence. The work of these experts had been vetted by Matthew Lohm and by filtering the cases in this way, the Police had ended up with the 10 cases which they felt were the strongest.

The Police then instructed two new experts, one in palliative care and one in geriatric medicine to prepare detailed reports in respect of each case. I have not yet read any of the reports or at any of the evidence relating to the individual cases.

I explained to Paul that I would need to do more reading to give a sensible estimate of the time that it would take to fully prepare the case and how long the hearing is likely to last. He told me that at the very earliest he would be looking to list it in January - February next year but he appreciates that even that may be a little optimistic. He believes that the MDU may make an application to strike out the claim on grounds of delay. He would like to list a case as soon as possible and call their bluff. I mentioned that the 10 cases which the Police looked at all related to the period 1996-1999. I think that the 5 cases already referred to the GMC fall within this period. Paul said that he had succeeded in the past in resisting applications to strike out cases where there had been even greater delays.

I mentioned that when Dr Barton was interviewed by the Police, she produced a written statement in respect of each complaint. I have not yet looked at the statement or the detail in the statement. However, it may be difficult for her to say now that she cannot remember events in sufficient detail.

It was agreed that I would revert to Paul as soon as possible (as I indicated within two weeks) with some further thoughts.

I also mentioned that as soon as possible we would like to arrange a strategy meeting.

Ryder, Robert

From: Ryder, Robert

Sent: 22 December 2006 14:06

To: Paul Hylton Code A

Subject: Dr. Barton

Dear Paul

I refer to the summaries of expert evidence prepared by the police for each of the fourteen "category 3" cases which they investigated. I understand from Luisa that you have already been sent copies.

The summaries are all critical of the quality of care afforded to patients and will almost certainly form the basis of a strong case of serious professional misconduct. Clearly the GMC will wish to review the IOP position in this case. Peter and I have considered whether there is sufficient material in the attached summaries to put before an IOP. In our view, whilst the summaries are useful, without seeing the reports which have been summarised, we have no way of knowing whether the summaries are accurate. Therefore I think we need to see the reports and these would need to be made available to the IOP. There is a further difficulty in that some of the summaries appear to criticise some of the Doctors and other medical staff working with Dr. Barton. It is not clear from the summaries in some cases, whether the criticisms made relate in part to other Practitioners. I think this needs to be clearly understood and clarified before the IOP can deal with the matter.

We have already been in touch with the police to ask them for disclosure of evidence relating to the fourteen cases. They have told us that this comprises 45 lever arch files and that they will start to copy this immediately after Christmas in the expectation that the material will be ready to be collected by us by the middle of January.

Given the importance of experts reports in the context of a possible IOP review I have sent an email today asking the police to prioritise the copying of experts reports in hope that these can be made available to us before the middle of January.

Regards.

Robert
Associate

Direct Dial: Code A
International
www.eversheds.com

Ryder, Robert

From: Jones, Peter
Sent: 22 December 2006 12:16
To: Ryder, Robert
Subject: FW: IOP

From: Morris, Luisa
Sent: 21 December 2006 15:00
To: Jones, Peter
Subject: IOP

The IOP can receive any evidence which appears to it to be fair and relevant. There aren't any rules other than this on admissibility, so it seems to me that the police summaries are capable of being used in evidence.
Luisa Morris
Solicitor

Direct Dial: Code A
International: Code A
www.eversheds.com

Morris, Luisa

From: Morris, Luisa
Sent: 20 December 2006 15:52
To: 'Paul Hylton [Code A]
Subject: Barton
Attachments: CAR_LIB1-#1735974-v1-letter_to_Det_Supt_Williams.DOC

Hi Paul

Please find attached a draft letter that I propose sending to Dave Williams. Our team here has got together this morning to consider a possible strategy going forward. Of the 5 cases referred to the PCC, only 2, Arthur Cunningham and Robert Wilson were included in the 10 cases selected by the police. We are obliged to continue with the original 5 cases referred (unless any reason emerges for cancellation) and therefore we need any material that remains in the police possession relating to these 5. It also seems to us that we will need to consider the evidence, particularly the expert evidence in respect of the remainder of the 10 police cases, before we consider with you how many to continue with.

Kind Regards

Luisa Morris
Solicitor

Direct Dial: [Code A]
International: [Code A]
www.eversheds.com

Det Supt Dave Williams
Hampshire Constabulary

Date 20 December 2006
Your ref
Our ref 4/LXM
Direct dial Code A
Direct fax
Code A

Dear Det Supt Williams

Operation Rochester

Further to the stakeholder meeting of yesterday, as we discussed we are keen to progress the GMC's investigation swiftly. Therefore, I would be grateful if you could provide, or make available to us to inspect at your offices:

1) the summary document that we discussed yesterday outlining the evidence in respect of the 10 cases that were identified for the CPS to consider, namely Elsie Devine, Elsie Lavender, Leslie Pittock, Ruby Lake, Arthur Cunningham, Robert Wilson, Enid Spurgin, Geoffrey Packman, Helene Service, and Sheila Gregory.

2) all witness statements, expert evidence, transcripts of police interviews and medical records relevant to the investigation of the above 10 cases together with any evidence that remains in your possession relating to Eva Page, Alice Wilkie and Gladys Richards.

3) an index of all evidence obtained to date.

I understand that you are awaiting consent from family members in respect of some of the documentation, but request that you provide such documentation as is available as soon as possible, even if that means providing the information in a piecemeal fashion. This will then enable the GMC to make an early assessment of the individual cases.

I look forward to hearing from you.

Yours sincerely

Luisa Morris
FOR EVERSHEDS LLP

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car_lib1\1735974\1\morrislx

Morris, Luisa

To: Paul Hylton Code A

Please find attached a draft letter that I propose sending to Dave Williams. Our team here has got together this morning to consider a possible strategy going forward. Of the 5 cases referred to the PCC, only 2, Arthur Cunningham and Robert Wilson were included in the 10 cases selected by the police. We are obliged to continue with the original 5 cases referred (unless any reason emerges for cancellation) and therefore we need any material that remains in the police possession relating to these 5. It also seems to us that we will need to consider the evidence, particularly the expert evidence in respect of the remainder of the 10 police cases, before we ~~decide~~ how many to continue with.

consider with you

Kind Regards

Luisa Morris
Solicitor

Direct Dial: Code A
International: Code A
www.eversheds.com

Det Supt Dave Williams
Hampshire Constabulary

Date 20 December 2006
Your ref
Our ref 4/LXM
Direct dial **Code A**
Direct fax
Code A

Dear Det Supt Williams

Operation Rochester

Further to the stakeholder meeting of yesterday, as we discussed we are keen to progress the GMC's investigation swiftly. Therefore, I would be grateful if you could provide:

1) the summary document that we discussed yesterday outlining the evidence in respect of the 10 cases that were identified for the CPS to consider, namely Elsie Devine, Elsie Lavender, Leslie Pittock, Ruby Lake, Arthur Cunningham, Robert Wilson, Enid Spurgin, Geoffrey Packman, Helene Service, and Sheila Gregory.

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I look forward to hearing from you.

Yours sincerely

Luisa Morris
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telephone

Client	General Medical Council	Date	6 November 2006
Matter	Barton	F/E	Luisa Morris
Attendees	Paul Hylton		

LM acknowledged receipt of boxes relating to the Barton matter and asked what the current state of play is on this case. The boxes are all documents that should have been forwarded to us with the previous set of papers, but have only recently been found.

Paul Hylton used to have weekly telephone calls from the complainants, but there has recently been silence from those complainants, the police, and from everyone. The police were supposed to notify the GMC back in August if they were prosecuting, but nothing has been heard. LM asked whether there is anything we should be doing at the moment. We should be getting the files ready so that as soon as we have the work we can go straight away. Also, he'd like us to draft a letter to the police asking for an update and a list of those individuals whose death their investigation was focusing upon, because if they see the GMC has solicitors instructed it might push them to think that they should be doing something too.

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useful chronology - initial letter to GMC

Mr Peter Swain
General Medical Council
350 Euston Road
LONDON
NW1 3JN

Date	12 November 2004
Your Ref	
Our Ref	JONESPW/002200-009001
Direct Dial	Code A
Direct Fax	
E-mail	

By Fax

Dear Peter

Dr Jane Barton

I refer to the meeting that Robert and I had with yourself and Paul earlier in the week. As requested, I write to confirm the advice that was given at that meeting.

Chronology

Our discussion, and our advice, was against the following brief chronology:

1. Five deaths occurred to patients at the Gosport War Memorial Hospital between February and October 1998. In each case, the patient was elderly; there was a suspicion that under the medical supervision of Dr Jane Barton who was clinical assistant at the hospital, the individual patients were improperly treated by her in that she wrongly prescribed medicines to the patients that either killed them or hastened their deaths. The relatives of the deceased in each case say that the deaths resulted relatively quickly after the prescribing by Dr Barton of a heavy cocktail of drugs, applied by syringe driver. The allegations are that the prescribing and giving of drugs in this method was inappropriate in each of the circumstances.

2. You were notified by the Hampshire Constabulary on 27 July 2000 that they were investigating the possibility that the first patient, Gladys Richards, had been unlawfully killed as a result of treatment received while Dr Barton appeared to be responsible for her care.

3. In February 2002 you were notified that the CPS had decided not to proceed with a criminal prosecution against Dr Barton in relation to the death of Gladys Richards. At that time, you were also informed of the fact that the police had been investigating four other deaths in the period stated, being the deaths of Wilson, Page, Cunningham and Wilkie. It is thus clear that for a period from possibly late 1999 or early 2000, the Hampshire Constabulary had been investigating these five cases, and the CPS had come to the conclusion that they did not warrant criminal proceedings. Their investigation thus probably proceeded for some two years before the CPS's decision not to proceed.

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4. Having considered the five cases mentioned, the PPC decided on 29 August 2002 to refer the five cases for hearing to the PCC.

5. In October 2002, it appears that following pressure from the families of the five deceased, the police decided to reopen their investigation. In the light of this, you decided to await the outcome of the police investigation before proceeding to investigate those five cases that were going to be reopened and re-examined by the Hampshire Constabulary.

6. On three occasions during the police investigation, the IOC declined to make an order in relation to Dr. Barton.

7. The present difficulty has arisen in the light of police delay in concluding their investigations, not only in relation to these five original cases but also in relation to another 60 or so which have now been considered by them. By September 2003, police investigations had concluded that fifteen of these cases warranted further investigation; it is anticipated that this would carry on until at least January 2004. No charges have been brought; no findings of an investigation have been notified to you. Indeed, we have seen from files that we have read that on 27 February 2004, in a meeting between the GMC and the Hampshire Constabulary, the police would say nothing substantive beyond the fact that they were still investigating Dr Barton's conduct, they did not know when the investigation would be complete, and did not know when they would be ready to interview Dr Barton, and were not willing to provide you with any further information or evidence absent a guarantee that such information would not be passed on to Dr Barton. You could not give such a guarantee since proceedings had been referred to the PCC, and obligations of disclosure therefore exist.

8. We have seen a letter of 5 May 2004 sent by Peter Steel to the Hampshire Constabulary which amounts to something of a desperate plea for progress and information. The letter specifically sought indications as to when the investigations would be concluded and with what result, and again sought further information which would allow you to progress your own investigations. I understand that despite that letter, and despite a subsequent meeting, you still have no indication as to when the Hampshire Constabulary will conclude its investigations, and so have no idea whether it is likely that the CPS will recommend (or otherwise) proceedings. Neither have the police given you further information to help you assess your own position. The only indication of substance that I understand has been given is that the Hampshire Constabulary believe that they have unravelled a series of other cases which demonstrate that Dr Barton's conduct of some 7 or 8 other patients may be even more culpable than the conduct she displayed in relation to those deceased whose cases have already been referred by the PPC to the PCC. They have not however told you the identity of those new cases which cause them specific concern.

9. In conclusion, our advice was sought as to what you should no do given that:-

   (a) some six years has elapsed since Dr Barton's treatment of the five deceased whose conduct has been referred to the PCC;

   (b) around 4½ years has passed since the Hampshire Constabulary became apprised of the issue, and commenced its investigation;

(c) some 2½ years has passed since you were notified of the CPS's intention not to proceed with charges in relation to the original five cases;

(d) you have been given no indication, despite the fresh investigation, that that conclusion not to prosecute the first five cases is likely to be revisited with a different result; you do not know the position on the fifteen cases identified as matters of concern in September 2003.

(e) you have repeatedly sought an end date to the Hampshire Constabulary investigation so that you can consider your position, but none has been provided;

(f) you have nevertheless sought to safeguard the public based on the information that you have by seeking interim orders against Dr Barton on no less than three occasions, but each time the interim orders committee has declined to make any order restricting Dr Barton's ability to practice;

(g) you have been given no further information from the Hampshire Constabulary that would warrant reverting for yet a fourth time to the interim orders committee to seek an order so that the public have protection pending the outcome of the police investigation (whenever that may be);

(h) it would appear from the papers that any undertakings that Dr. Barton may have given to the local health trust in relation to prescribing for the elderly have either been lapsed or have been withdrawn. Accordingly it is probably the case that no undertakings relating to restriction of practice exist from Dr Barton.

Advice

10. Against this background we advised that whereas you could not, in our view, be properly criticised to date for a failure to prosecute the five charges to the PCC in the light of the above situation, it is inappropriate - in the absence of any further information from the Hampshire Constabulary - to defer action any further. In relation to the five cases which have been referred to the PCC, you have been given no indication of which we are aware that the police's investigation has unearthed more material beyond that which they had when the decision was reached in February 2002 to bring no charges. You therefore have no grounds to believe currently that the police/CPS will revise its view and reverse its February 2002 decision.

11. Whilst you have been given an intimation that subsequent investigations may have revealed more serious activity on the part of Dr Barton, you have nevertheless been given nothing further. In circumstances where you have not even been given an end date to the investigation, and no indication of the likely bringing of charges, you are, in my view, entitled in the light of the exceptional delay of the police investigation to

assume that there is a real prospect that the police/CPS will decide to bring no charges in relation to any activity of Dr Barton at all. It is also right to say that in the absence of fresh information, there are no realistic prospects of persuading the IOC to place restrictions on Dr Barton's practice pending any PCC hearing.

12. Thus, in short, due to the lack of firm and adequate response to Peter Steel's letter of May 2004, I do not feel that you should properly delay taking steps any further if you are to maintain your obligations of taking appropriate action to protect the public.

What Action Should You Take

13. I believe that the appropriate course of action is to notify Hampshire Constabulary, due to their inability/refusal to give the assurances sought in Peter Steel's letter of 4 May, of your intention to resurrect the proceedings before the PCC in relation to the original five deaths. The police should be asked to notify you if there is a definite end date to their investigation, or if a decision has been made to prosecute, to enable you to reconsider your position.

14. This begs the question as to whether or not, on the current law, you are entitled to resurrect the PCC proceedings, given that there is an apparent ongoing police investigation. The main authorities in relation to this are "ex-parte Brindle", 1993, "ex-parte Smith", 1994 and the case that I emailed to you last week of "Ranson v The Institute of Actuaries" - October 2004. These authorities do not give a consistent outcome, but it seems clear that a disciplinary institution is entitled to proceed with its investigation unless, on the facts, there is a real risk of serious prejudice which might lead to injustice if those disciplinary proceedings were to proceed in advance of, or concurrently with, other proceedings. The case of Smith suggests that a decision of a disciplinary body to proceed should only be disturbed in exceptional cases; the case of Brindle also suggests that the balancing scales probably weigh in at the outset in favour of the disciplinary body.

15. Of course, in this case, there are no concurrent or parallel proceedings (as there were in the case Ranson v the Institute of Actuaries). You have commenced the disciplinary process; the police have not proceeded beyond investigation. Given the astonishing amount of time it has taken the police to conduct its investigation with still no end in sight, I think there are realistic prospects of being able to satisfy any Court on any Judicial Review application made by the police/Dr. Barton that in the circumstances of this case, it is right and proper for you to decide to resurrect your proceedings, and accompanying investigations.

16. Of course at present, the only proceedings that can be resurrected are those that have already been referred to the PCC. Three other Complainants have since emerged (Yates, Carby, Reeves), which may also need to be added to the proceedings.

17. If the Hampshire Constabulary are to be taken at their word, it is regrettable that the PCC is being forced into a position of proceeding in relation to five (or eight including the afore mentioned three cases) only, if there are stronger cases available to show SPM. The identity of these cases has not been disclosed to you by the police. We therefore discussed at our meeting that it would be beneficial to invoke the powers of Section 35A of the Medical Act 1983 to seek to obtain from the Hampshire Constabulary the names and the relevant papers that they have in relation

to the other fifteen cases that they believe are of more significance than those already notified to you. In looking at the wording of that Section, I do not consider that it is fatal to the invocation of Section 35A that the identity of those 7 or 8 deceased is not known to you; I believe that the Section could be exercised with reference to Dr. Barton's patients over a particular period.

18. It does of course remain a possibility that the Police will take Judicial Review Proceedings against you the moment that you seek to implement your decision to proceed with the PCC hearings. As mentioned above, I think there are realistic prospects of defeating such an application for Judicial Review in the circumstances of this case, but in the event that an application is made and it is successful (for example, if the Police do decide to prosecute, and can then better argue on the risk of prejudice), then no criticism can be levelled against you for failing to proceed with the disciplinary hearings, as a Court will have ordered this through the Order made on Judicial Review.

19. If the police comply with a request under S35A, then the information provided will need to be considered not only with a view to deciding the extent of cases to refer to the PCC, but also to consider whether a fourth application should be made to the Interim Orders Committee based on the new evidence.

If there are any aspects of this advice you wish to discuss, then please do not hesitate to telephone. Meanwhile, I have drafted a letter for you to consider sending to the Hampshire Constabulary which you will no doubt wish to discuss internally.

Yours faithfully

Code A

EVERSHEDS LLP

4013

FILE ON GMC BARTON

GMC & Barton

Notes on reading into the files in this case:

1. Field Fisher Waterhouse correspondence file ("FFW").

2. DIIS Form dated 23 September 2002 describes this as a Class 4 case: 12-15 Witnesses of Fact, 1-3 Experts, London Venue - target date for completion January 2003.

3. Notes indicate that the case was referred by the PPC to the PCC in about October 2002 **[check date]**. The PCC Hearing was originally listed in March/April 2003 **[check date].**

4. 31 October 2002 - memo on file refers to PPC considering charges based on the management of five elderly patients i.e. Eva Page, Gladys Richards, Arthur Cunningham, Alice Wilkie and Robert Wilson. These were all patients at Gosport War Memorial Hospital in Hampshire between **February and October 1998.**

5. The case was originally referred to the GMC by the Hampshire Police. The note says that each case is supported by expert opinion **[check papers to see whether expert's reports have been sent to us].** The same note refers to other possible complaints i.e. relating to a Mrs Purnell, Elsie Divine and Stanley Carby.

6. 16 October 2002 - letter from DCI Duncan of the Hampshire Police to say that DCS Watts is the Senior Investigating Officer and that DCI Duncan is co-ordinating matters.

7. 1 November 2002 - letter refers to a Hearing of the IOC on the 19 September 2002.

8. 7 November 2002 - email refers to a complaint against another doctor - Dr Lord, also employed at the Gosport War Memorial Hospital **[later in the file it becomes apparent that Dr Lord was the Consultant who supervised Dr Barton]** the letter indicates that a complaint will not be pursued against Dr Lord.

9. 20 November 2002 - memorandum refers to Witness Statements obtained by the CHI (Commission for Health Improvement).

10. 20 November 2002 - memorandum refers to the first police investigation in 1998/99 concerning the death of Gladys Richards. The police acknowledged that the investigation was not as effective as it should have been. Memo says that the police are looking at statistical analysis and similar fact evidence to establish causation. There is reference to the police considering 50 other cases. Same memo says that between 1994 and the period when Dr Barton resigned from the hospital (no date of resignation is given) 600 deaths were certified by Dr Barton. The memo notes the difficulty of proving death caused by Diamorphine. The memo says that it is possible that Diamorphine can cause respiratory difficulties but that victims were elderly and vulnerable in any event. The memo says that Barton was working in a environment where there was no prescribing policy. Note refers to lack of motive. Note indicates that Dr Barton is now a GP in private practice. Also refers to convincing arguments raised by Dr Barton at the IOC i.e. lack of resources, poor supervision and conditions of work.

11. **Should we be looking at evidence of mortality rates to compare the incidence of deaths which occurred at Gosport Hospital when Dr Barton was there. Alternatively treatment of elderly patients and incidence of death of elderly patients in Dr Barton's GP practice. We need to know when Dr Barton left her post at Gosport War Memorial Hospital (later in the file there is reference to Dr Barton being a Clinical Assistant at Gosport Hospital) when did she resign and why did she resign. Does she now practice as a sole-GP?**

12. The same note says that at the conclusion of the police enquiry all police documents will be provided to the GMC. Note refers to an investigation carried out by the CHI.

13. 2 December 2002 - letter from the police notifying the GMC of the decision to expand the police's investigation. Request by the police to the GMC to adjourn the PCC Hearing scheduled to take place in April 2003 until further notice.

14. **It is obvious from the papers that the case has already attracted media attention - echoes of Shipman - high profile case - make sure it is recorded as such on our database.**

15. 28 November 2002 - letter from FFW to the Commission for Health Improvement (CHI). Says that FFW have a copy of the report by CHI into the investigation at Gosport Hospital (a copy of the report is in the documents folder on the correspondence file).

16. File indicates that Alexander Harris Solicitors act for a number of the relatives of the deceased.

17. 18 December 2002 - GMC letter confirms that this is an **information case not a complainant's case. [who is funding the relatives legal costs what locus do they have in the Proceedings, if any?]**

18. 18 December 2002 - the GMC authorised FFW to agree to the police's request to Stay the GMC Proceedings pending the outcome of the Police Investigation. In the same letter GMC asked for FFW advice on the inclusion of Mr Carby's complaint under Rule 11 **[later FFW advise that Mr Carby's complaint can be added under Rule 11 but no steps should be taken to do this until after the police have completed their investigation].**

19. 23 December 2002 - letter from FFW to the police confirms GMC's agreement to Stay the Disciplinary Proceedings pending the outcome of the police investigations. FFW say in the letter that they will be reviewing documents held by the CHI but that FFW do not propose to take any action other than requesting copies of relevant documents and assessing which witnesses referred to in the CHI investigation, FFW would like to interview following the conclusion of the police investigation.

20. 21 January 2003 - FFW note of meeting with police. Refers to FFW's review of the CHI statement. It says that only one statement (name not given) raised concern about Dr Barton's prescribing habits - a nurse who had initiated a Grievance Procedure. **[There is a note in the documents envelope on the correspondence file with some handwritten notes it appears that this is FFW's notes of their review of the CHI Witness Bundle].**

21. 21 January 2003 - note also makes reference to the police investigating approximately 62 deaths. Experts are analysing and reviewing medical notes. The police's panel of experts is headed by **Professor Robert Forest.** The note indicates that the police have instructed experts in the following disciplines:-

1. Palliative Care.

2. Geriatric Care.

3. General Practice.

4. Epidemiology.

22. The police anticipate that Expert's Reports would be completed within 3 to 6 months i.e. by about June 2003. The note says that police think it unlikely that they will exhume bodies although this is not likely to benefit the investigation.

23. The police say that they should have a clear view of where the investigation is going by the end of 2003. The police investigation will include some statistical/mathematical analysis.

24. 5 February 2002 - attendance note with meeting between FFW and GMC. FFW have obtained copies of some documents referred to in the appendix to the CHI Report **[Have copies of these documents been provided to us?]** FFW say they have only obtained documents relating to an 1998/99 **[presumably the cases referred to the PCC relate only to these two years].**

25. Memo - 30 September 2003 of FFW meeting with police. The police say that they have instructed experts in the following disciplines:-

1. Toxicology.

2. Geriatric medicine.

3. Palliative care.

4. General practice.

5. Nursing.

26. **[Note that there is no reference to an expert in epidemiology, referred to earlier].**

27. The note refers to the conclusion reached by the police experts at approximately 20% of the 62 cases looked at (i.e. approximately 15 or 16 cases) indicate that there has been negligence and/or the cause of death is unclear.

28. The note says that the police intend to carry out further investigations and appoint additional experts to examine the 15/16 cases in more detail. The police have not interviewed Dr Barton and would not do so until the second team of experts have reported. The police say a report will not be ready until January 2004 at the earliest.

29. The police are not prepared to disclose full details of their investigations on grounds that it could jeopardise their enquiry. **[This has in effect prevented the GMC from going back to the IOC on a fourth occasion to try and get an Interim Order].**

30. 5 December 2003 - FFW attendance note refers to a report prepared by Richard Baker and commissioned by the Chief Medical Officer. **[Where is the report and what does it relate to?]**

31. 25 May 2004 - The last letter on FFW's file it refers to a letter from Linda Quinn of the GMC dated 18 May 2004. The letter is not on file.

Papers and Documents Sleeve on the Correspondence File include the following:-

(i) FFW notebook - appears to record notes of CHI Witnesses.

(ii) A copy of the CHI report prepared in July 2002. **[Note that the investigation contains a review of the systems in place at Gosport Hospital. CHI did not have a statutory remit to investigate either the circumstances around any particular death or the conduct of any individual]. The key conclusions are set out on the first page in the executive summary and include, **** insufficient local prescribing guidelines in place governing the prescription of powerful pain relieving and sedative medicines, the lack of rigours,**

routine review of pharmacy data led to high levels of prescribing on wards occurring for older people not being questioned and a lack of thorough multi-disciplinary total patient assessment to determine care needs on admission. Also the CHI had serious concerns regarding the quantity, combination or lack of review and anticipatory describing of medicines prescribed to older people 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. CHI also found that it was unable to determine whether levels of prescribing contributed to the deaths of any patients, it was clear that had adequate checking mechanisms existed in the Trust, this level of prescribing would have been questioned.

<u>Note of the Decision of the PPC to refer the matter to the PCC (undated)</u>

32. Notes of the case relates to five patients aged between 75 and 91 who attended Gosport Hospital mainly for rehabilitation. The daughter of Mrs Richards (one of the elderly patients) was an experienced nurse in elderly care and was concerned about the treatment of her mother. Her concerns precipitated the reviews of other patients. The summary refers to a report prepared by Dr Mundy and Professor Ford **[do we have copies of these reports?]** The summary describes Dr Barton as a "Visiting Clinical Assistant" who was responsible for the day-to-day management of the five patients who are the subject of the complaint. All patients were prescribed the same set of drugs. Patient Richards received no food or fluids between 18 and 21 August and died because of a combination of lack of nutrition and sedation. The Committee considered that the administration of these drugs may have shortened the patients life, which was not the same as suggesting that it killed her. Professor Ford says in his note that the prescribing regime was variously reckless, excessive or highly inappropriate. **[The committee asked for the case to be fast-tracked].**

<u>Notes on Documents in Miscellaneous Documents File complied by Maria</u>

<u>* Tab 4 ** **** prepared by FFW on 25 May 2004 for a consultation with Leading Counsel on 26 May 2004 [We do not have a note of the consultation].</u>**

33. Included in the instructions is a letter dated 5 May 2004 sent by Peter Steel, GMC solicitor to DCS Steve Watts - Head of CID in Winchester. The letter sets out the history of the matter important dates being as follows:-

(i) **27 July 2000 - Hampshire police notified the GMC of the first complaint relating to Dr Barton - an allegation relating to Gladys Richards.**

(ii) **June 2001 - The IOC considered the case but made no Order.**

(iii) **February 2002 - The CPS decided not to proceed with the criminal case and the police disclosed its papers to the GMC. This included a report on the management of a further four patients at the Gosport Hospital.**

(iv) **21 March 2002 - The IOC considered the case again including the additional information obtained from the police relating to the four patients. However no Order made.**

(v) **11 July 2002 - A Rule 6 letter was sent to Dr Barton with draft charges in respect of five patients.**

(vi) **27 August 2002 - The Medical Defence Union replied to the Rule 6 letter on behalf of Dr Barton.**

(vii) **29 August 2002 - The PPC referred the five cases to the PCC [note that subsequently a PCC Hearing scheduled to take place in April 2003 but the Hearing was vacated and the GMC investigation was suspended pending the outcome of the police investigation].**

(viii) **19 September 2002 - The matter went back before the IOC for the third time. The IOC again made no Order.**

(ix) **September / October 2002 - The police re-opened their investigation and the GMC's investigation was put on hold. The police decided to investigate all deaths of patients under Dr Barton's care at the hospital.**

3

(x) **30 September 2002 - Police completed the first stage of their analysis of the case with assistance of a team of experts. They looked at 62 patients all together and on the basis of advice received from experts concluded that in the case of 15/16 it appeared that there had been negligence of the cause of death was unclear. The police indicated that their investigation would move on to a new stage using new experts to review the 15/16 cases in more detail. Since then the police have been undertaking further enquiries. I have nothing on file to indicate what stage they have now reached. The PCC Proceedings have been put on hold the GMC are concerned about the delay hence the instructions to Leading Counsel referred to above.**

Tab 1 - Copy of the papers put before the PPC in August 2002

(xi) Pages 4-8 is a copy of the Rule 6 letter dated 11 July 2002. The complaints relate to the following 5 patients: Eva Paige, Ellis Wilkie, Gladys Richards, Arthur Cunningham, and Robert Wilson. **The conduct complained of is said to have taken place between 27 February 1998 and 16 October 1998. The complaints focus on the inappropriate and/or unprofessional prescribing of certain opiates and sedative drugs, principally Diamorphine, Hyoscine and Midazolan. However, certain other drugs were also prescribed to some of the individuals. The main allegation in each case is that Dr. Barton knew or should have known that the opiates and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to the individual patients. Note that it is not alleged that the prescriptions did actually cause harm and/or contribute to the deaths of these patients.**

(xii) **A slightly odd feature of the complaints relating to Mrs. Richards and Mr. Cunningham is that Dr. Barton is alleged to have made a note in the patients' medical records that she was "happy for nursing staff to confirm death". In the case of Mrs. Richards, this comment was made in the records on 11 August, but she did not die until 24 August.**

Privileged and Confidential

Case Analysis

This document sets out our advice. It contains a summary of our analysis of the evidence gathered to date. This document follows from the Case Outline. If any of the facts in the Case Outline change, then that may have an impact on the contents of this Case Analysis. Together we will keep this Case Analysis up to date as matters unfold and the case progresses.

Legal Analysis

We have prepared the following rough analysis of the strengths and weaknesses of the allegations, based on work carried out to date.

1. **Pittock** 96

1.1 Aged 82 on admission. One of the experts - Black - believes patient was probably terminally ill on admission.

1.2 Patient was assessed by Dr. Lord on the day before his admission - assessed his prognosis as being poor. Chances of survival slim. Unlikely to survive for long.

1.3 On transfer to Dryad Ward, Dr. Tandy, Consultant Geriatrician, had overall medical responsibility. (She worked on the Ward until late 1996.) Her responsibilities included a Ward Round once a fortnight.

1.4 Dr. Tandy saw the patient on 10 January 1996, five days after he was admitted. She prescribed 5mg Oramorph to alleviate pain and distress.

1.5 Dr. Barton, in her witness statement, "believes" (emphasis added) that she reviewed the patient on 15 January 1996 and "believes" that his condition had deteriorated with significant pain and distress.

1.6 It appears that Barton prescribed Diamorphine on 15 January 1996 - it also appears that this was without reference to Dr. Tandy.

1.7 Dr. Tandy, in her witness statement, comments that she would have used a lower dosage of Diamorphine and Midazolam - her practice being to use the lowest dose to achieve the desired outcome, and to reduce adverse effects.

1.8 Nurse Hamblin, the Sister, refers to an increased dosage of Diamorphine on 18 January, six days before the patient died.

1.9 The key clinical team observed that the patient was physically and mentally frail. The team concluded that the patient was probably Opiate toxic, but

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notwithstanding this, the dose was not reduced. Cause of death - unclear. Opiates "could" have contributed.

1.10 Two experts have reviewed the case, Dr. Wilcock, expert in Palliative Medicine, Dr. Black, a specialist in Geriatric Medicine.

1.11 As a general observation in this and the other cases, Dr. Wilcock tends to be more bullish in his conclusions compared to Dr. Black who is more circumspect.

1.12 Wilcock refers to Barton's poor medical note keeping. In her witness statement, Barton admits to this, but seeks to explain the deficiency with reference to substantial work place demands. Says that a choice had to be made between detailed note making or spending more time with the patients. Also seeks to explain the policy of "pro-active prescribing" with reference to the demands of work.

1.13 Wilcock says that the patient's pain was not appropriately assessed. We need to check how he reached this conclusion. Is it a case that there was no written assessment? Is there any evidence that a proper assessment was made, but not recorded in the notes?

1.14 Wilcock refers to the inappropriate administration of Opiates to relieve anxiety and agitation.

1.15 Wilcock refers to doses of Diamorphine in the range 40-120mgs as being excessive to the needs of the patient and far in excess of an appropriate starting dose. Says that an appropriate dose would be 10-15mgs.

1.16 Wilcock's overall conclusion is that Barton breached her duty of care to the patient by failing to provide treatment with skill and care, but "it is difficult to exclude completely the possibility that the dose of Diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death".

1.17 Wilcock also believes that the certified cause of death - Bronchopneumonia appears to be the most likely cause of death.

1.18 Dr. Black, in his report, refers to the patient's condition being extremely frail. The patient was at the end of a chronic period of disease spanning more than 20 years. The patient suffered from depression and drug related side effects.

1.19 Black refers to a problem in assessing the standard of care due to a lack of documentation. He agrees with Wilcock in that the lack of notes represents poor clinical practice.

1.20 Black refers to "suboptimal" drug management.

1.21 Black notes that the starting dose of 80mgs of Morphine was approximately three times the dose that is conventionally applied. Black also says that the combination of drugs (Diamorphine and Midazolam/Noizinan) are likely to have caused excessive sedation and may have shortened the patient's life by a short period of time - "hours to days" - "medication likely to have shortened the patient's life, but not beyond all reasonable doubt".

1.22 Other features noted include the following: the patient's own GP, Dr. Brigg, was consulted about the patient on 20 January 1996 - four days before the patient died.

1.23 Police have taken a statement from the patient's daughter, Mrs. Wiles, who is also a retired Registered Mental Nurse. Her understanding is that her father was transferred to Dryad Ward for terminal care. She believes that he died through "self neglect" - he was extremely frail and had lost the will to live. She did not take issue with the fact that her father was prescribed Morphine and she considered this to be appropriate.

Initial View

1.24 There is sufficient evidence to pursue the charges relating to inadequate note keeping, inadequate assessment (possibly) and prescribing/administering medication, including Diamorphine, in excess of the patient's needs. The conclusions of the two experts are not strong enough to sustain a charge that the standard of care resulted in premature death. Further work needs to be done with the experts to particularise the charges and to clarify whether Dr. Tandy is also culpable.

1.25 The police file contains 19 statements taken from witnesses of fact. Approximately ten of these would appear to be "key witnesses".

1.26 Our overall assessment is that this case is possibly suitable for a referral to the Fitness to Practice Panel, but is not one of the strongest cases.

2. **Lavender** 96.

2.1 The patient was aged 83 when she was admitted to Daedelus Ward on 27 February 1996.

2.2 Her son refers to the fact that she was transferred to Daedelus from the Haslar Hospital where she had been recovering from a fall. The son says she was making an excellent recovery and the Occupational Therapist was considering a possible return of the patient to her home. She was coherent and walking with the assistance of a frame. A couple of days after admission to Daedelus Ward, Dr. Barton told the son that his mother had "come here to die". His mother

deteriorated rapidly. The witness was not aware that Diamorphine was being administered by a syringe driver until the day prior to her death.

2.3 The patient was seen by Consultant Geriatrician, Dr. Tandy a few days before she was transferred to Daedelus Ward. The Doctor recorded that the patient had most likely suffered a brain stem stroke leading to the fall. Agreed to transfer of the patient to Daedelus Ward for rehabilitation.

2.4 Barton's statement confirms that she did an assessment on the patient's transfer to Daedelus Ward. It says that the prognosis was not good. The patient was blind, diabetic, had suffered a brain stem stroke and was immobile.

2.5 Morphine was first prescribed on 24 February. The dose was increased on 26 February because the patient's bottom was very sore (pressure sores).

2.6 Barton wrote up a "pro-active prescription" for further pain relief which included Diamorphine. It was "pro-active" on the basis that nursing staff could contact her if necessary and she could authorise dosages as necessary within the dosage range.

2.7 Barton saw the patient again on 29 February and 1 March and noted that her condition was slowly deteriorating.

2.8 On 4 March, the dosage of slow-release Oramorph was increased.

2.9 Barton saw the patient again on 5 March and claims that the pain relief was inadequate. Barton authorised the administration of Diamorphine and Midazolam by syringe driver. Barton claims that the doses were appropriate in view of the uncontrolled pain. The patient died on 6 March. Barton certified death as Cerebrovascular Accident.

2.10 Dr. Black reports that it is likely that the patient was suffering from several serious illnesses and entering the terminal phase of her life when she was admitted. He notes that she was suffering constant pain to her shoulders (in addition, there were serious abnormalities in various blood tests).

2.11 He believes that the patient was mis-diagnosed (presumably both prior to her admission to Daedelus Ward (at the Haslar Hospital) and after her admission). The patient had, in fact, suffered a quadriplegia resulting from a spinal cord injury, secondary to her fall.

2.12 Black says that negligent medical assessments took place both at the Haslar and the Gosport Hospitals. In particular, her medical diagnosis was made to determine the cause of the pain, which he says is consistent with spinal cord fracture.

2.13 Both Black and Wilcock refer to excessive doses of Diamorphine/Midazolam (Wilcock, in addition, thinks that earlier dosages of Morphine may also have been inappropriate/excessive to the type of pain experienced).

2.14 Wilcock says that the excessive doses of Morphine/Midazolam could have contributed towards her death. Black cannot say beyond all reasonable doubt that the patient's life was shortened.

Initial Views

2.15 The probability that the cause of pain was misdiagnosed, not only by Dr. Barton, but by the doctors at Haslar, before the patient was transferred to Gosport, makes this case more difficult to assess.

2.16 Further work needs to be done to determine whether a stronger case can be made relating to Dr. Barton's failure to seek specialist advice in view of the deterioration in the patient's condition leading to increased dosages of Morphine and the use of Diamorphine.

2.17 Both experts agree that at least some of the dosages of Diamorphine/Midazolam were excessive to the patient's needs. The opinions of the experts are not strong enough to sustain a charge that the patient's life was shortened.

2.18 Police took 32 witness statements and approximately 15 witnesses would fall within the category of "key witnesses".

2.19 There is sufficient evidence to refer the case on the basis of the excessive use of Diamorphine/Midazolam and possibly the failure to seek specialist advice, as part of an assessment to diagnose the underlying cause of a patient's pain.

2.20 The inappropriate prescribing of Diamorphine/Midazolam may only relate to one or two particular occasions. There may be other cases where prescribing took place over a longer period and where a stronger case may be made out.

3. **Lake** 98

3.1 The patient was aged 84 when she was admitted in August 1998. She had suffered a fall and broken a hip. She spent 2-3 weeks at the Haslar Hospital where she received a new hip. She was transferred to Gosport to recuperate and was expected to be discharged at some stage.

3.2 Patient died within 3 days of admission. On the first day at Gosport, she was able to talk to her family. On the second day, she became agitated and distressed. The next day, she was asleep and unable to respond either orally or through hand gestures. During the last two days of her life, she was receiving medication through a syringe driver. Despite these and other ailments, at the time of her fall, she was usually mobile, independent, and self caring. Following

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her hip replacement operation, she had problems with vomiting and shortness of breath. Blood tests revealed on-going renal impairment. On 10 August, she was reported to be unwell, drowsy and experiencing vomiting and diarrhoea. Her pulse increased and became irregular.

3.3 An x-ray revealed an infection at the base of the left lung and no heart failure. She was given antibiotics intravenously and started to improve.

3.4 Her improvement continued and on 12 August, antibiotics and intravenous fluids were discontinued. Her post-operative recovery was slow.

3.5 She was assessed by Dr. Lord who recorded "It is difficult to know how much she will improve" and she was referred to Gosport for continuing care. The summary in Dr. Lord's assessment recorded the patient as being "frail and quite unwell" and it uncertain as to "whether there will be a significant improvement".

3.6 Nursing records for 15 August record some pain due to arthritis.

3.7 On 17 August, the medical notes record that she was well, did not have a raised temperature or chest pain, that she was mobilising slowly and awaiting transfer to Gosport.

3.8 Her transfer letter written for staff at Gosport noted that she had made a slow recovery from the operation, exacerbated by bouts of angina and breathlessness.

3.9 Dr. Barton made an entry in the patient's medical notes on the day of transfer. This included reference to her operation, and past medical history including angina and congestive heart failure.

3.10 Nursing notes confirm that Morphine was administered on 18 August (5mgs) and 19 August (10mgs). The reason for the dose of Morphine on 18 August is not apparent. The nursing notes indicate that she had settled quite well and was fairly cheerful. On 19 August, she awoke very distressed and anxious and the nursing notes record that the Oramorph that had been given to her had very little effect.

3.11 The nursing notes on 19 August indicate that she was walking, albeit unsteadily. There is also reference in the notes of the patient being very breathless and complaining of chest pains.

3.12 There are various references to prescriptions for Diamorphine. The dosages ranging between 20mgs and 60mgs.

3.13 Dr. Wilcock and Dr. Black highlight a lack of information recorded in the patient's notes. Black regards this as a major problem in assessing the level of care. Both experts make assumptions that the patient was not adequately assessed by

Dr. Barton, because there is no indication in the records that a proper assessment took place.

3.14 Dr. Wilcock also assumes that a further assessment did not take place when the patient complained of chest pain.

3.15 Both Doctors are critical of the lack of justification given for the prescription of Morphine and the decision to commence the use of a syringe driver.

3.16 Dr. Wilcock states that the lack of documentation makes it difficult to understand why the patient may have deteriorated so rapidly. He says that a thorough medical assessment when the patient complained of chest pain may have (emphasis added) identified treatable causes of the pain, e.g., chest infection.

3.17 Wilcock also says that it is possible (emphasis added) that the patient's deterioration was temporary/reversible.

3.18 Wilcock refers to the apparent (emphasis added) inappropriate use of medication.

3.19 There is evidence to show that whilst this patient suffered complications following the hip replacement operation, at the time she was transferred to Gosport, there is a possibility that she would make a recovery. The experts are not able to explain the rapid deterioration in her condition leading to her death, within 3 days of transfer. The experts are hindered by the lack of documentation. They assume that thorough medical assessments have not taken place. Dr. Barton may disagree with this, but in any event, she will admit that she failed to keep proper notes.

3.20 The police took 41 statements from witnesses of fact. The statements will need to be analysed to identify the key witnesses. For present purposes, assume that approximately 15 witnesses will fall into the key witness category.

Initial Views

3.21 Lack of documentation in this case has made it difficult for the experts to reach any firm conclusions. There is certainly sufficient evidence to bring charges in relation to inadequate note keeping and possibly inadequate assessment of the patient's condition on transfer and after the patient complained of chest pains. On the available evidence, it would be more difficult to pursue charges relating to excessive use of Morphine/Diamorphine.

3.22 Further investigation will need to be undertaken to assess the role of Dr. Lord. It is possible that as the patient was only at Gosport for three days, she was not seen by Dr. Lord and Dr. Lord did not review the medication prescribed by Dr. Barton.

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4. **Wilson** 97.

4.1 The patient was 74 when he was admitted to the Hospital in October 1998. He died four days after admission.

4.2 Admitted with a fracture to the left humerus. Before his transfer, whilst he was being cared for at the Queen Alexandra Hospital, he was prescribed Paracetamol and Codeine for pain relief.

4.3 On transfer to Gosport, Dr. Barton prescribed Oramorph despite the fact that the patient had liver and kidney problems Code A and these problems made the body more sensitive to the effects of Oramorph.

4.4 Patient deteriorated and was converted to a syringe driver and received Diamorphine. Over the next two days, the dose was increased without obvious indications.

4.5 It appears that Dr. Knapman was the GP who covered for Dr. Barton. In his police statement, he says that the prescriptions written up by Dr. Barton were not excessive.

4.6 In the days immediately preceding the patient's death, on 17 and 18 October, he was seen by Dr. Peters, a Clinical Assistant at the Haslar Hospital. Dr. Peters was covering for Dr. Barton.

4.7 Dr. Barton, in ~~his~~ her statement, justifies writing up a "pro-active regime" of Diamorphine in the event of the patient's deterioration. She states further that it was her expectation that the nursing staff would endeavour to make contact with her or the duty doctor before starting the patient on Diamorphine at the bottom end of the dose range.

4.8 Dr. Wilcock refers to the patient's multiple medical problems - cirrhosis/liver failure, heart failure and kidney failure. Patient also suffered from dementia and depression.

4.9 Wilcock notes that the pain he experienced following his fracture progressively improved during his stay at the Queen Alexandra Hospital. The doses of Morphine given there were reduced to 3mgs.

4.10 On his transfer to Dryad, he was prescribed 5-10mgs of Morphine, as required for pain relief. He received doses of Morphine despite the general expectation that the pain from the fracture would continue to improve over time.

4.11 Dr. Wilcock refers to a lack of clear note keeping and an inadequate assessment of the patient and he places blame for this on Dr. Barton and Dr. Knapman, the Consultant.

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4.12 Dr. Wilcock also refers to doses of Diamorphine being administered - initially 20mgs, subsequently increased to 60mgs. Dr. Wilcock states that the increase in dose is "difficult to justify" as the patient was not reported to be distressed by pain.

4.13 Dr. Wilcock cannot state with any certainty that the doses of Morphine or Diamorphine contributed to the patient's death because of the possibility that heart and/or liver failure caused the death.

4.14 Dr. Black refers to "weaknesses" in the documentation of the patient's condition on admission, when strong Opiate Analgesia was commenced.

4.15 Black says that if clinical examinations were undertaken, they have not been recorded.

4.16 Black refers, in particular, to the prescription of 50mgs of Oramorph on 15 October which he believes was not an appropriate clinical response to Mr. Wilson's pain.

4.17 Further, Black considers that the medication prescribed in the period 15-16 October more than minimally contributed to the patient's death on 19 October.

4.18 Professor Baker has also prepared a report. He says firstly that the Death Certificate inaccurately recorded that Mr. Wilson died of renal failure.

4.19 Professor Baker also believes that the administration of Opiate medicine was an important factor leading to the patient's death. On the evidence available, Baker says that the initial prescribing of Opiate medication was inappropriate and the starting dose was too high.

4.20 Baker refers to the reasons for not using non-opiate drugs for pain relief are not given in the medical notes.

4.21 A further expert report has been obtained from Dr. Marshall, a Gastroenterologist. He describes the administration of high doses of Morphine as "reckless". This is because warnings about using Morphine in the context of liver disease are readily available in the Standard Prescribing Guides.

4.22 Dr. Marshal considers that the impact of regular Morphine administration is likely to have hastened the patient's decline.

4.23 Note that this patient's case was investigated by the police as part of their initial investigation into four other patients. At the earlier stage in the investigation, the police instructed two different experts, Dr. Mundy and Dr. Ford. The former is a Consultant Physician and Geriatrician, the latter is a Professor of Pharmacology.

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4.24 Mundy is critical of the standards of care given in this case - in particular, the fact that non-opiate analgesia was not initially considered and the fact that there was large dose range for Diamorphine. However, Mundy does express a view that the palliative care given in this case was appropriate.

4.25 Dr. Ford's conclusions concerning this patient need to be checked.

4.26 The summary of police evidence refers to a statement taken from Dr. Lord, the Consultant Geriatrician. She was on leave between 12 and 23 October.

Initial Views

4.27 We have the benefit of six expert reports in this case. [The reports obtained from the two experts at the outset of the police investigation need to be checked.] However, the four reports obtained during the more detailed part of the police investigation, clearly support charges relating to the excessive use of Morphine which hastened the patient's death. For this reason, this is one of the strongest cases and the evidence will support a referral to the FTP Panel.

4.28 The police obtained statements from approximately 40 witnesses of fact and a detailed examination of all the evidence will be required to determine the number of key witnesses. For present purposes, we should assume that there will be at least 20 key witnesses of fact.

5. Spurgin 99

5.1 The patient was aged 92 when she was admitted to the Hospital in March 1999.

5.2 She fractured her hip as a result of a fall, and initially was admitted to the Haslar Hospital. She underwent surgery there to repair the hip.

5.3 There were complications following the surgery and she developed a haematoma.

5.4 She experienced some pain and discomfort following her operation and, as a result of the haematoma. After transfer to Dryad Ward, she was given Oramorph. The pain persisted and it appears that her wound became infected. Dr. Barton prescribed antibiotics.

5.5 There is a suggestion that the hip may have been x-rayed. However, the results of the x-rays have not been found.

5.6 The dosage of Morphine was increased, followed by a decision to use Diamorphine with a syringe driver.

5.7 Dr. Barton prescribed a range of 20-100mgs and the patient was started on 80mgs. Dr. Reid reviewed this and reduced the dose to 40mgs.

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5.8 The summary of Dr. Barton's witness statement indicates that the starting dose of 80mgs of Diamorphine was discussed with her before it was administered by the nurses.

5.9 Dr. Wilcock, in his report, is highly critical of Dr. Barton and, to a lesser degree, Dr. Reid, the Supervising Consultant. Dr. Wilcock's criticisms include the following: insufficient assessment and documentation of the patient's pain and treatment; failing to seek an orthopaedic opinion when the pain did not improve over time, but instead increasing the dose of Morphine which is associated with undesirable side effects; the doses of Diamorphine were excessive to the patient's needs.

5.10 Further work needs to be done with the expert to give a more detailed analysis of dates, entries in notes in which Doctor (Barton/Reid) were responsible at a particular time.

5.11 Dr. Black refers to an "apparent" (emphasis added) lack of medical assessment and the lack of documentation relating to this patient.

5.12 Dr. Black is also critical of the use of Oramorph on a regular basis without considering other possible analgesic regimes.

5.13 Black believes that some of the management of the patient's pain was within acceptable practice with the exception of the starting dose of Diamorphine - 80mgs. Black describes it as being "at best poor clinical judgment".

5.14 A further report has been obtained from a Consultant Orthopaedic Surgeon, Dr. Redfern.

5.15 He is very critical of the doctors' failure to investigate the cause of the internal bleeding into the patient's thigh following her operation. Redfern criticises those responsible for her care at Gosport Hospital and at the Haslar Hospital.

Initial View

5.16 The findings of the experts support charges relating to poor note keeping, failure to assess the patient's pain and the use of excessive doses of Diamorphine. There is a complicating factor in that Dr. Reid is also criticised by the experts.

5.17 The police interviewed approximately 20 witnesses of fact. For present purposes, we should assume that the majority of these would be required to give evidence.

6. **Devine** 99

6.1 The patient was aged 88 at the time that she was admitted in October 1999. She died 32 days after her admission.

6.2 The summary of the patient's medical history prior to her admission indicates that in the summer of 1999, she was well enough to provide emotional and domestic support to her daughter, who was suffering from Leukaemia. However, by October 1999, she was admitted to Queen Alexandra Hospital where she was reported to be confused and aggressive.

6.3 On 14 October 1999, she was seen by a Dr. Taylor who concluded that it was likely she was suffering from Dementia.

6.4 On 21 October 1999, she was transferred to Dryad Ward for rehabilitation/respite care under Dr. Reid.

6.5 On the day of her admission, Dr. Barton prescribed Morphine to be taken as required.

6.6 Between 25 October and 1 November 1999, she was described as being physically independent and continent although she required supervision. She remained confused and disorientated.

6.7 On 16 November, Dr. Barton referred the patient to Dr. Lusznat due to a deterioration in the patient's renal function.

6.8 On 18 November, Dr. Taylor noted that her mental health had deteriorated and she was becoming increasingly restless and aggressive. Her physical condition, at that stage, was stable.

6.9 On 19 November, Dr. Barton recorded that there had been a marked deterioration and she was then prescribed a combination of Diamorphine (40mgs) and Midazolam. On 19 November 1999, the patient's family were also informed that the patient had suffered kidney failure and was not expected to survive more than 36 hours.

6.10 A police summary records that the Registrar refused to accept the recorded cause of death which resulted in an amendment of the Certificate by Dr. Barton.

6.11 After the patient's death, the family complained about the quality of her care and this resulted in the Health Authority setting up an independent review panel.

6.12 The Panel was asked to review, inter alia, the appropriateness of the clinical response to the patient's medical condition. Oral evidence was heard from various witnesses including Dr. Barton.

6.13 The Panel found that the dosage of drugs given to the patient was appropriate - including the dose of 40mgs of Diamorphine. The Panel also found that the dosage and devices used to make Ms. Devine comfortable on 19 November were an appropriate and necessary response to an urgent medical situation.

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6.14 In her police witness statement, Dr. Barton says that Dr. Lusznat, a Psychiatrist, recorded that the patient was suffering from severe Dementia. Barton says that this was confirmed by a CT scan on 18 November 1999.

6.15 The case was reviewed by three different experts: Dr. Wilcock, Dr. Black and Dr. Dudley, a Consultant Nephrologist.

6.16 Dr. Wilcock is highly critical of the standard of care, in particular, he refers to an inadequate assessment of the patient's condition and the inappropriate prescribing of medication, including Diamorphine. He describes these as being unjustified and excessive to the patient's needs.

6.17 The list of criticisms made by Dr. Wilcock would form the basis of a strong case. However, the findings of the other two experts are not critical to the same degree.

6.18 Dr. Black refers to a lack of documentation, and the difficulty of deciding whether the level of care was below an acceptable standard.

6.19 He appears to criticise certain aspects of medication regime, but expresses the view that the patient was terminally ill and appeared to receive good palliatation of her symptoms. He is not able to say that Dr. Barton's prescribing had any definite effect on shortening the patient's life in more than a minor fashion.

6.20 Dr. Dudley observes that after a period of stabilisation, the patient's condition worsened and she suffered severe renal failure. He says that although it may have been possible to stabilise her condition, this would not have materially changed the patient's prognosis as death was inevitable.

6.21 Further, Dr. Dudley considers that the patient was treated appropriately in the terminal phase of her illness with strong Opiods to ensure comfort.

Initial View

6.22 It is difficult to reconcile the views expressed by the experts in this case: Dr. Wilcock is highly critical, whereas Doctors Black and Dudley - in particular, Dr. Dudley - are far less critical. Also, the Independent Review Panel findings support Dr. Barton.

6.23 The police took approximately 60 witness statements and, further evidence was given to the Independent Review Panel. It is possible that evidence given by witnesses to the Panel has been recorded and retained.

6.24 Dr. Reid, in his police witness statement, confirms that he saw this patient on three occasions: 25 October and 1 and 15 November 1999. He says that the "as required" Oramorph was prescribed by Dr. Barton on 21 October was

reasonable. He also claims that the use of a syringe driver to administer Diamorphine and Midazolam was appropriate in these circumstances.

6.25 The difference in views expressed by the experts in this case and the fact that Diamorphine was used in conjunction with the syringe driver only at the very end of the patient's life, makes this one of the weakest cases.

7. **Service** 97

7.1 The patient was 99 years old when she was admitted in June 1997.

7.2 The patient died within two days of admission. When she was admitted, she was suffering from various medical problems, including Diabetes, heart failure, confusion and sore skin.

7.3 On transfer, she was placed on sedation via a syringe driver. She became less well the following day and Diamorphine was added to the driver. (She had not required Analgesia other than Paracetamol at the Queen Alexandra Hospital, where she had been before she was transferred.)

7.4 On the day of transfer, Dr. Barton carried out an assessment and noted that the patient was suffering from heart failure, was very unwell and probably dying. In her witness statement, Dr. Barton says that the care of the patient would have been more appropriate at Queen Alexandra Hospital and a transfer by ambulance would not have been in the patient's best interest. Barton claims that Diamorphine and Midazolam were prescribed and administered solely with the intention of relieving the patient's agitation and distress. Diamorphine was also prescribed to treat symptoms of the patient's heart failure.

7.5 Dr. Wilcock casts doubt on whether the patient was dying on the day of her admission, as alleged by Dr. Barton. He refers to blood test results to support his views; however, the summary of his evidence indicates that he is not absolutely sure as to whether or not the patient was dying. He says that if she was not dying, the failure to re-hydrate her and the use of Midazolam and Diamorphine "could" (emphasis added) have contributed more than negligibly to her death.

7.6 If, on the other hand, she was in the process of dying, Dr. Wilcock concludes that it would have been reasonable not to re-hydrate her and to use Midazolam/Diamorphine.

7.7 The police obtained a further opinion from Dr. Petch, a Consultant Cardiologist. He refers to the patient's history of heart disease and states that the patient's terminal decline in 1997 was not unexpected. Further, he says that palliative care with increasing doses of Diamorphine and Midazolam was appropriate - the

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patient's prognosis was "hopeless". The administration of Diamorphine and Midazolam was reasonable in the circumstances described by Dr. Barton.

7.8 Dr. Black is in no doubt that the patient was entering the terminal phase of her illness. He says that an objective assessment of the patient's clinical status is not possible from the notes made on admission. The notes were below an acceptable standard of good medical practice.

7.9 Further, Dr. Black says that the 20mgs dose of Diamorphine combined with a 40mgs dose of Midazolam was higher than necessary, and "it may have slightly shortened her life".

7.10 Police took statements from 20 witnesses of fact. Without a detailed review of the evidence, it is not possible to say, at this stage, how many of these would be regarded as "key" witnesses.

Initial View

7.11 In the light of the views expressed by the Consultant Cardiologist who considers that the use of Diamorphine and Midazolam was appropriate, there seems little prospect of success in this case.

8. **Cunningham** 98

8.1 The patient was aged 79 on the date of his admission in September 1998. He died within five days of admission.

8.2 When he was admitted, the patient was suffering from Parkinson's Disease, Dementia, Myelodysplasia. He also had a necrotic pressure sore.

8.3 Dr. Lord, the Supervising Consultant, prescribed Oramorph. Dr. Barton considered that this may not have been sufficient in terms of pain relief and wrote up Diamorphine on a pro-active basis with a dose range of 20-200mgs.

8.4 In her police witness statement, Dr. Barton explains that the levels of pain relief were increased as the patient continued to suffer pain and discomfort.

8.5 Dr. Wilcock is critical of Dr. Barton's practice of prescribing Diamorphine on an "as required" basis within such a large dose range, i.e., up to 200mgs. He says this unnecessarily exposes the patient to a risk of receiving excessive doses of Diamorphine.

8.6 However, in this case, Dr. Wilcock concludes that the patient was dying in an expected way and the use of Diamorphine and Midazolam were justified in view of the patient's chronic pain. The expert also concludes that although the dose range prescribed by Dr. Barton was excessive, in the event Mr. Cunningham did not receive such high doses.

8.7 Wilcock criticised Dr. Barton's lack of clear note keeping and, on the basis of the notes, he also considers that Dr. Barton failed to adequately assess the patient.

8.8 Dr. Black regards this particular case as an example of the complex and challenging problems which arise in Geriatric Medicine. He notes that the patient suffered from multiple chronic diseases and, in Dr. Black's view, the patient was managed appropriately and this included an appropriate decision to start using a syringe driver. Dr. Black has only one concern - the increased dose of Diamorphine just before the patient's death. He says that he is unable to find any justification for the increase in dosage in the nursing or medical notes. He says that this "may" (emphasis added) have slightly shortened the patient's life, i.e., by a few hours/days.

8.9 The police took 47 statements from witnesses of fact in this case. Without a detailed analysis of the evidence, it is not possible to say how many of these can be regarded as being "key" witnesses.

Initial View

8.10 Whilst Dr. Wilcock, in particular, is critical of the large dose range prescribed by Dr. Barton, he considers that the dosages administered to the patient in this particular case were reasonable. He concludes that the patient was managed appropriately.

8.11 This case has already been referred to the FTP Panel, presumably on the basis of reports from other experts obtained earlier in the police investigation. [We will need to review the earlier reports.] However, on the basis of the opinions expressed by Dr. Black and Dr. Wilcock, there is no realistic prospect of proving that the doses of Diamorphine administered in this particular case was inappropriate.

9. **Gregory** 99

9.1 This patient was aged 99 when she was admitted in September 1999.

9.2 This case is slightly different from the majority of the other cases in that the patient spent nearly 3 months on Dryad Ward until her death. In the other cases, apart from Mrs. Devine who was at the Hospital for about a month before she died, all the other patients died in a period of 2-18 days.

9.3 Whilst the patient was on Dryad Ward, she was seen on various occasions in September, October and November 1999 by the Supervising Consultant, Dr. Reid. In his police statement, Dr. Reid expressed a view that whilst Dr. Barton's note keeping may have been poor, the patients were managed appropriately by Dr. Barton.

9.4 Dr. Reid, in retrospect, feels that it was inappropriate of Dr. Barton to prescribe Diamorphine as early as 3 September 1999, in the absence of documented pain or distress. However, Dr. Reid believes that it was appropriate for Dr. Barton to prescribe Opiates on 20 November, as the patient was in the terminal stages of her life.

9.5 When the patient was admitted to Dryad Ward, she had recently fractured her femur. She had a history of heart disease. She was regularly reviewed by Dr. Barton and Dr. Reid and was noted to be suffering poor appetite, agitation, variable confusion and no significant improvement in her mobility.

9.6 Between 15 and 18 November, her condition deteriorated following a chest infection. She became distressed and breathless. Dr. Barton was abroad from 12 to 16 November, but on her return on 17 November, she prescribed Oramorph. On 18 November, she prescribed Diamorphine.

9.7 Dr. Wilcock considers that the patient's decline over a number of weeks was in keeping with the natural decline into a terminal phase of her illness. He considers the dose of Diamorphine was unlikely to have been excessive.

9.8 Dr. Black refers to the patient's history of heart failure and lung disease. The patient was very elderly and frail when she fractured her femur. Dr. Black observed that in circumstances there was a very significant risk of mortality and morbidity.

9.9 Dr. Black reports that Dr. Barton failed to record a clinical examination, apart from some brief details concerning the patient's history.

9.10 Dr. Black notes that within a short period of her transfer to Dryad Ward, it is likely that she suffered a small stroke. Essentially, she made no improvement in rehabilitation in the two months that she was in hospital.

9.11 Dr. Black refers to the patient's rapid deterioration on 18 November. He says the prescribing of oral Opiates was an appropriate response to a patient who had an extremely poor prognosis.

9.12 He also considers that a decision to start the patient on Diamorphine was a reasonable decision. He regards the dosages of Diamorphine to have been in the range of acceptable clinical practice.

9.13 He does express a concern about Dr. Barton's practice of prescribing strong Opioid Analgesia in anticipation of a patient's decline. Notwithstanding this, he concludes that no harm came to Mrs. Gregory as a result of this practice.

9.14 Apart from a lack of clinical examination (or possible failure to document such an examination), both on the date of her patient's admission and during the period

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that her condition deteriorated, Dr. Black appears to be satisfied that the dosages of Diamorphine administered in this case were reasonable. He confirms that the patient died of natural causes.

9.15 The police took 22 witness statements during their investigation relating to this patient.

Initial View

9.16 A case of inappropriate prescribing cannot be made out on the basis of the views expressed by the expert save to the limited extent that one of the experts criticises the practice of "anticipatory" prescribing.

9.17 There are additional concerns raised with regard to lack of note keeping and the possibility that clinical examinations were not carried out. This is one of the weakest cases.

10. **Packman** 99

10.1 The patient was aged 67 when he was admitted in August 1999. He suffered from gross morbid obesity (in April 1999, he weighed in excess of 23 stone). He was first admitted to the Queen Alexandra Hospital on 6 August 1999, having suffered a fall at his home. On admission to QAH, he was noted to have an abnormal liver function and impaired renal function. He also had leg ulcers and cellulitis (infection of the skin) and pressure sores over his buttocks and thighs.

10.2 It is not clear whether he suffered a gastrointestinal bleed whilst he was at QAH (the experts seem to think that if a bleed occurred, it was not significant or life threatening at that stage).

10.3 On his admission to Dryad Ward on 25 August 1999, he was examined by Dr. Ravindrane, a Registrar working under Dr. Reid, the Consultant.

10.4 On 25 August, he was seen by a Locum GP, Dr. Beasley (it is not clear why Dr. Beasley was involved and Dr. Beasley's name does not appear in the list of witnesses interviewed by the police).

10.5 On 26 August, the patient was seen by Dr. Ravindrane following a report that the patient had been passing blood rectally.

10.6 It appears that the patient's condition deteriorated during the course of the day on 26 August. The experts conclude that a blood test taken on that day revealed a large drop in the patient's haemoglobin, which made a significant gastrointestinal bleed likely.

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10.7 In her police statement, Dr. Barton indicated on 26 August, she was concerned that the patient might have suffered a myocardial infarction. In addition, she believed that the patient had suffered a gastrointestinal bleed.

10.8 The experts, in particular, Dr. Wilcock, criticise Dr. Barton for not transferring the patient to an acute ward for treatment for the underlying cause of the bleeding - thought by Dr. Wilcock to be a peptic ulcer.

10.9 In her police statement, Dr. Barton says that the patient was very ill and a transfer to an acute unit would have been inappropriate given the likely further harmful effect on his health.

10.10 Dr. Barton does not say in her statement why she did not consult anybody - Dr. Ravindrane or Dr. Reid - before taking a decision not to transfer and/or before prescribing Diamorphine and Midazolam. Note that the police do not appear to have interviewed Dr. Reid in connection with this case, even though Dr. Wilcock, in his report, believes that Dr. Reid, albeit to a lesser degree than Dr. Barton, failed to provide treatment with a reasonable amount of skill and care. It is possible that Dr. Reid only saw the patient on one occasion, i.e., on 9 September, two days before the patient died. Therefore, it may be that Dr. Reid was unaware of the gastrointestinal bleed which occurred on 26 August 1999 - if that is the case, then Dr. Wilcock's criticism of Dr. Reid seems to be limited to the subsequent use of Opioids.

10.11 The police obtained an expert opinion from a Consultant Gastroenterologist, Dr. Marshall. He concludes that a transfer to surgery should have been considered on 26 August when the possibility of a G/I bleed was first considered. He indicates that surgery, in this case, may have resulted in the patient's death because the patient was morbidly obese.

10.12 The police obtained 27 witness statements in this case.

Initial View

10.13 There appears to be at least an arguable case that Dr. Barton should have sought assistance from a Consultant before she made the decision not to transfer the patient to an acute unit following the G/I bleed. Dr. Wilcock, in particular, is critical of this and the decision to prescribe Opiates. His view is that prescribing Opiates contributed "more than minimally" to the patient's death. Dr. Black takes the view that these deficiencies probably made very little difference to the eventual outcome.

10.14 The role of the other practitioners in this case will need to be considered in more detail - i.e., Dr. Beasley, Dr. Ravindrane and Dr. Reid.

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11. Overall, there is sufficient evidence to refer this case to the Case Examiner. **Page** 97 .

11.1 The patient was aged 80 when she was admitted in February 1998. She was a frail elderly lady with probable carcinoma of the bronchus. She also suffered from depression, dementia, ischaemic heart disease and congestive heart failure. Her health had been deteriorating during the two weeks prior to her admission to Dryad Ward.

11.2 Her son, Bernard Page, contacted the police in 2001, having first been made aware of concerns about the treatment of elderly patients from reports in the local press. In the bundle, there is a letter from the son to the GMC dated 17 May 2002 which refers to a letter sent by the son to the police on 9 April 2001. A copy of this letter is not in the papers. I will ask the police for a copy; or, alternatively, ask Mr. Page if he has retained a copy.

11.3 This is one of five cases which has already been referred to the GMC. Refer to the GMC's Rule 4 letter to Dr. Barton dated 11 July 2002, which sets out some draft allegations.

11.4 The only evidence which appears to have been collated in this particular case is the reports prepared by Dr. Mundy and Professor Ford.

11.5 The police do not appear to have taken any statements from witnesses of fact.

11.6 The draft allegations referred to in the Rule 4 letter appear to have been framed with reference to Dr. Mundy's report.

11.7 Charge2(b)(ii) alleges that at the time the patient was prescribed opiate and sedative drugs there was no indication in the medical or nursing records to indicate that the patient was distressed or in pain. However, this appears to ignore the apparent reference in the medical notes of 2 March which is a note from Dr. Barton suggesting the use of Opioids to "control fear and pain". This is referred to in paragraph 6.7 of Professor Ford's report. See also Ian Barker's letter to GMC of 27 August 2002 in response to the Rule 4 letter sent by GMC on 11 July 2002. Mr. Barker is Dr. Barton's legal representative. On page 5 of Mr. Barker's letter, he acknowledges, on Dr. Barton's behalf, that when the patient was admitted she was not in pain. However, Mr. Barker goes on to assert that by 2 March, the patient was, in fact, in pain. In the absence of other evidence, it is unlikely that the GMC will be able to prove the allegation in paragraph 2(b)(ii) of the Rule 4 letter. Take a statement from Bernard Page?

11.8 Dr. Mundy's report contains only a brief summary of the medical and nursing care in this case. He concludes that the patient was started on Opioid Analgesia inappropriately, although he does not clearly explain his reasons.

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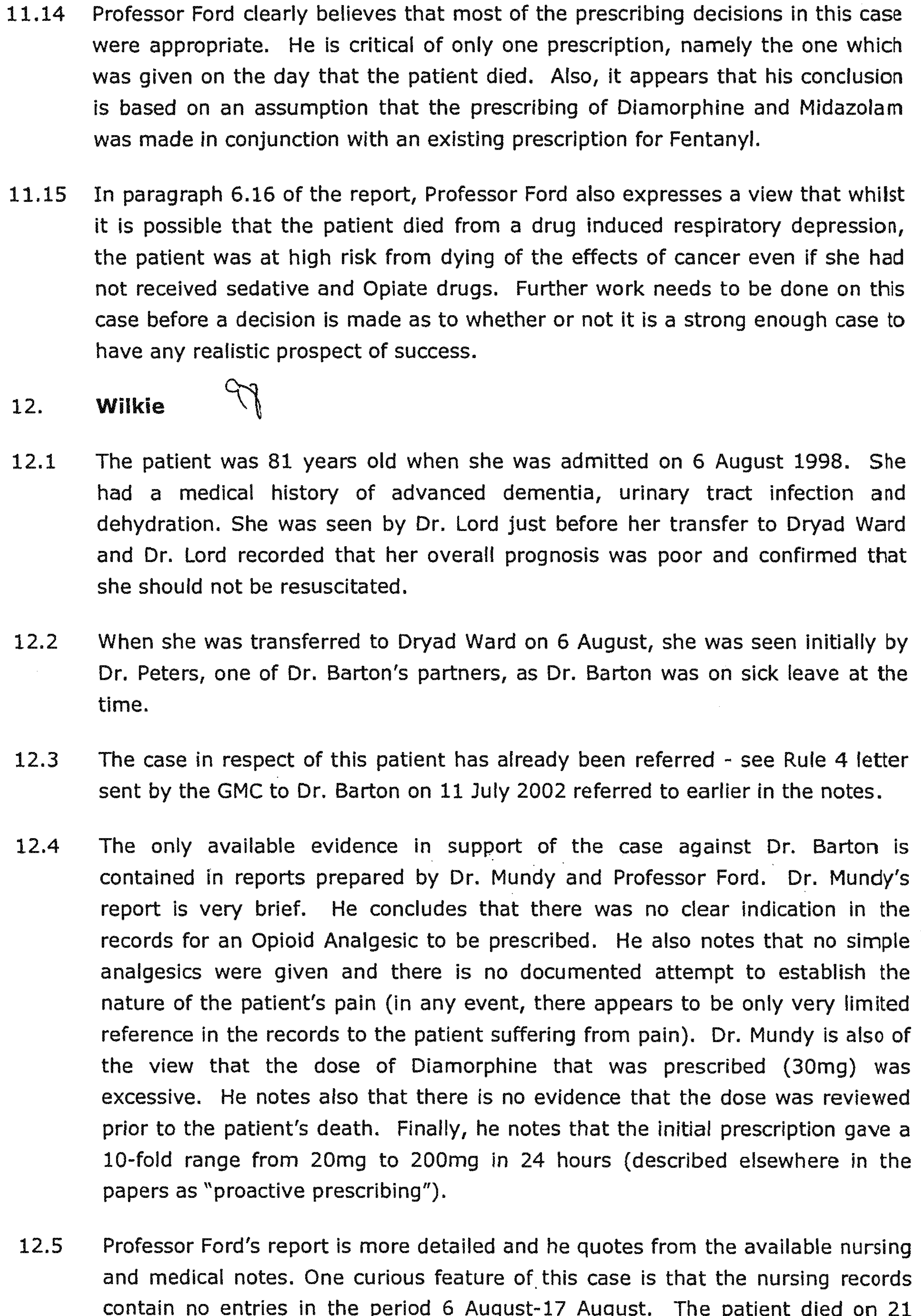
11.9 Professor Ford's report is far more detailed. In paragraph 6.6, Professor Ford's report refers to an entry in the patient's medical notes by a Dr. Laing, Duty GP, on 28 February, being the day after the patient was admitted to Dryad Ward. Dr. Laing notes that the patient was "not in pain".

11.10 At paragraph 6.7 of the report, Professor Ford refers to Dr. Barton's note in the patient's records on 2 March - "I suggest adequate Opioids to control fear and pain". This therefore suggests that although the patient was not in pain when she was admitted on 27 February, the position had changed by 2 March. The summary of the medical notes in paragraphs 6.7, 6.8 and 6.9 of Professor Ford's report raise a number of questions. In paragraph 6.9, he refers to two doses of Diamorphine on a date or dates which he says are not discernible from the records. However, in stating this, he seems to ignore the references in the medical notes to Diamorphine being administered in paragraph 6.7 of his report. In paragraph 6.9, where he deals with a record of daily prescriptions, he omits the Diamorphine administered on 2 March; he fails to comment on the apparent fact that Diamorphine was administered shortly after the patient received Fentanyl.

11.11 In paragraph 6.9, he also makes an important assumption, which may or may not be correct. He says that the medical notes do not indicate that the Fentanyl patch was removed before the Diamorphine and Midazolam infusion was commenced.

11.12 In paragraph 6.11 of his report he comments on the prescription of Opiates on the patient's admission to the Ward, when it appears to be acknowledged that there was no evidence that the patient was in pain. However, he concludes that as the patient was suffering from inoperable carcinoma, there was a reasonable indication for the use of Opiates in the palliative care of the patient. This undermines somewhat the conclusion of Dr. Mundy in his report. It also tends to undermine the allegation in paragraph 2(b)(i) in the Rule 4 letter referred to earlier.

11.13 At paragraphs 6.15 and 6.18, Professor Ford expresses the following views: the majority of the management and prescribing decisions made by the medical and nursing staff in this case were appropriate. He notes one exception, namely, the prescription of Diamorphine and Midazolam on the day of the patient's death - 3 March. His reasons are elaborated in paragraph 6.13 of the report. He says that it was poor management to commence using both Diamorphine and Midazolam in a frail, elderly and underweight patient who has **already** received Fentanyl [emphasis added]. His view that the prescription was inappropriate, therefore appears, at least in part, to rely on an assumption that Fentanyl was being used at the same time. We need to check to see whether the conclusion would be any different if it was the case that the use of Fentanyl ceased before the use of Diamorphine and Midazolam commenced.



Initial View

11.14 Professor Ford clearly believes that most of the prescribing decisions in this case were appropriate. He is critical of only one prescription, namely the one which was given on the day that the patient died. Also, it appears that his conclusion is based on an assumption that the prescribing of Diamorphine and Midazolam was made in conjunction with an existing prescription for Fentanyl.

11.15 In paragraph 6.16 of the report, Professor Ford also expresses a view that whilst it is possible that the patient died from a drug induced respiratory depression, the patient was at high risk from dying of the effects of cancer even if she had not received sedative and Opiate drugs. Further work needs to be done on this case before a decision is made as to whether or not it is a strong enough case to have any realistic prospect of success.

12. **Wilkie**

12.1 The patient was 81 years old when she was admitted on 6 August 1998. She had a medical history of advanced dementia, urinary tract infection and dehydration. She was seen by Dr. Lord just before her transfer to Dryad Ward and Dr. Lord recorded that her overall prognosis was poor and confirmed that she should not be resuscitated.

12.2 When she was transferred to Dryad Ward on 6 August, she was seen initially by Dr. Peters, one of Dr. Barton's partners, as Dr. Barton was on sick leave at the time.

12.3 The case in respect of this patient has already been referred - see Rule 4 letter sent by the GMC to Dr. Barton on 11 July 2002 referred to earlier in the notes.

12.4 The only available evidence in support of the case against Dr. Barton is contained in reports prepared by Dr. Mundy and Professor Ford. Dr. Mundy's report is very brief. He concludes that there was no clear indication in the records for an Opioid Analgesic to be prescribed. He also notes that no simple analgesics were given and there is no documented attempt to establish the nature of the patient's pain (in any event, there appears to be only very limited reference in the records to the patient suffering from pain). Dr. Mundy is also of the view that the dose of Diamorphine that was prescribed (30mg) was excessive. He notes also that there is no evidence that the dose was reviewed prior to the patient's death. Finally, he notes that the initial prescription gave a 10-fold range from 20mg to 200mg in 24 hours (described elsewhere in the papers as "proactive prescribing").

12.5 Professor Ford's report is more detailed and he quotes from the available nursing and medical notes. One curious feature of this case is that the nursing records contain no entries in the period 6 August-17 August. The patient died on 21

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August. Also, there are no entries in the medical notes from the 10 until 21 August. Clearly whilst there are good grounds to substantiate charges of poor/inadequate record keeping, the fact that there are no records for most of the period leading up to the patient's death may cause some difficulty in trying to establish that the medication prescribed and/or administered was inappropriate. Perhaps statements obtained from the relatives will fill in missing information.

12.6 Professor Ford notes that Diamorphine and Midazolam were only first administered on the day before the patient's death. There is no clear evidence that the patient was in pain at the time, although there was reference to a "marked deterioration" in her condition. Professor Ford considers that in the absence of any indication in the notes to justify the use of Diamorphine, other oral analgesics such as Paracetamol and mild opiate drugs could and should have been tried first.

12.7 Professor Ford considers it to be poor and hazardous management to initially commence both Diamorphine and Midazolam because he says this could result in profound respiratory depression. He says it would have been more appropriate to review the response to Diamorphine alone before commencing Midazolam.

12.8 Professor Ford concludes that it is possible that the patient's death was due, at least in part, to respiratory depression resulting from the Diamorphine; alternatively, Diamorphine could have led to the development of bronchopneumonia.

Initial View

12.9 We need some detailed statements from the patient's relatives to clarify the patient's condition in the period leading up to her death. We also need to take statements from Dr. Lord and Dr. Peters, although it is possible that they will have no recollection of this particular patient. In the absence of any detailed medical or nursing notes in the crucial period, Dr. Barton is going to find it difficult to justify prescribing Diamorphine and Midazolam, even if the medication was not, in fact, administered on the first occasion until the day before the patient died.

13. **Richards** 98

13.1 The patient was aged 91 when she was admitted in August 1998.

13.2 This was the first case that the police investigated, following complaints received from the patient's daughters, Mrs. MacKenzie and Mrs. Lack.

13.3 Mrs. Richards was transferred from the Haslar Hospital to GWMH following an operation to implant an artificial hip joint. This followed an accident when she

fractured her thigh bone. She appeared to be making a reasonable recovery at the Haslar. However, shortly after she arrived at GWMH she dislocated her hip. She went back to the Haslar Hospital where the dislocation of the hip was reduced. She then returned to GWMH.

13.4 There is some suggestion that the method of her transfer and/or lack of care by handlers during her transfer caused her further discomfort/injury. Following her transfer she spent a further three days at GWMH before she died. The cause of death was recorded as bronchopneumonia.

13.5 A total of three experts considered Mrs. Richards' case as part of the police investigation: Professor Livesley (who prepared reports in December 2000 and July 2001); Professor Ford who reported in December 2001 and Dr. Black who reported between May and August 2005. It is not clear why Dr. Black's report was prepared so long after the start of the police investigation and several years after both Professor Livesley and Professor Ford had issued their reports.

13.6 The principal findings in Professor Livesly's first report are recorded in paragraph 19 of the Case Outline though these details have been extracted from a summary of his evidence prepared by the Police. We do not currently have a copy of Professor Livesley's report dated December 2000. In the extract referred to in the Case Outline, Professor Livesley concluded that Dr. Barton prescribed Diamorphine and other drugs in such a manner as to cause the patient's death. He also concluded that Mrs. Richards had been unlawfully killed. In Professor Livesley's second report dated July 2001 prepared following legal advice after his first report had been prepared, he concluded that the patient's death occurred earlier than it would have done from natural causes.

13.7 In his July 2001 report, Professor Livesley makes the point in paragraph 8.3 that there is no evidence in the patient's records to show that she had any specific life threatening or terminal illness from which she could not be expected to recover. Professor Livesley also concludes that there is evidence to show that the patient was capable of receiving oral medication for the relief of pain that she experienced on the 17 August, being the date that she received Diamorphine and other drugs from a syringe driver. There is a strong inference in the conclusion to Professor Livesley's report that the administration of Diamorphine and other drugs by the syringe driver was inappropriate although he does not say so in clear terms. He makes the point that during the period that Diamorphine and the other medication was administered, the patient was not given any food or fluids to sustain her.

13.8 In Appendix A of Professor Livesley's report, he lists all the evidence which he considered during the preparation of his report. We do not appear to have received from the police everything set out in the schedule of evidence.

13.9 Whilst the conclusions in Professor Livesley's report are clearly stated, there are a number of potential weaknesses in the report. For example, the report makes no reference to the explanations given by Dr. Barton in her witness statements concerning her management of the patient's care. Also there is very little, if any, reference to any of the evidence obtained from the other witnesses. Instead, Professor Livesley appears to have reached this conclusion totally or primarily with reference to the patient's medical records. Further, as already mentioned, Professor Livesley does not state in clear terms that the prescribing of diamorphine and other drugs by syringe driver was inappropriate; neither does he say whether the initial prescribing of Oramorph on 11 August was inappropriate. Also, he does not comment on Dr Barton's practice of prescribing a broad range of dosages. Therefore, more detailed work will be required on the report if it is decided to use Professor Livesley as a witness in this case.

13.10 Professor Ford's report in contrast to the report prepared by Professor Livesley, does contain some reference to the evidence provided by Dr Barton. However, for some reason which is not apparent, Professor Ford appears to have been provided with only a selection of the evidence which was made available to Professor Livesley [it is possible that the person instructing Professor Ford has made some assessment of the relevance of documents and only provided copies of witness statements etc which were deemed to be of particular relevance].

13.11 Professor Ford criticises the assessment of the patient's medical condition when she was first admitted to GWMH on 12 August. Professor Ford also criticises Dr Barton's apparent failure to establish whether the patient's screaming in the days following her admission was due to pain or other causes (dementia?).

13.12 In paragraph 2.21 Professor Ford considers it likely that Dr Barton's initial prescription, which included "as required" doses of Oramorph, Diarmorphine and other medication, was made at a time when the patient was not suffering any pain. Professor Ford notes that in the latter stages of the patient's treatment at the Haslar Hospital, she received intermittent doses of non-opiate pain relieving drugs. In Professor Ford's view, it was not appropriate to administer intermittent doses of Oramorph before first prescribing other types of analgesic drugs.

13.13 Professor Ford criticises Dr Barton's failure to seek assistance from a consultant geriatrician or the orthopaedic team following the dislocation of the patient's hip.

13.14 At paragraph 2.26 of his report Professor Ford states that the decision to prescribe subcutaneous Diamorphine to Mrs Richards, following her initial admission, was inappropriate because it exposed her to the risk of developing adverse affects of excessive sedation and respiratory depression. He describes the decision as "reckless".

13.15 In paragraph 2.28 Professor Ford expresses a view that the medical (and nursing) records are not of an adequate standard. He notes that the medical records failed to adequately account for the reasons why Oramorph and then infusions of Diamorphine were used.

13.16 In the conclusions to his report, Professor Ford considers it "highly likely" that the use of opiates and sedative drugs, in combination, produced respiratory depression, which led to the patient's death. In Professor Ford's opinion it is likely that the administration of the drugs hastened the patient's death. However, he goes on to qualify this by saying that there is some evidence that the patient was in pain during the last three days of her life and the administration of opiates could have been justified to deal with the pain. He also says that the patient was at high risk of developing pneumonia and it is possible that she would have died from pneumonia even if she had not been given sedative and opiate drugs.

13.17 Professor Ford and Professor Livesley therefore both conclude that the combination of drugs given to the patient in the last few days of her life resulted in premature death. Note however, that the material provided to Professor Ford included a copy of Professor Livesley's report. Therefore, there is the possibility that to a certain degree Professor Ford may have been influenced by Professor Livesley. Note also that the allegations relating to this patient in the GMC's Rule 4 Letter sent to Dr Barton on 11 July 2002, allege that Dr Barton knew or should have known that the opiate and sedative drugs were prescribed in amounts and combinations which were excessive and potentially hazardous to a patient in Mrs Richard's condition. The allegations in the Rule 4 letter do not therefore make the more serious allegation that Dr Barton's prescribing actually hastened the patient's death.

13.18 Dr Black prepared a series of reports between May and August 2005. It appears that revisions to the first report were made with reference to additional evidence provided by the Police. The additional information supplied by the Police does not appear to have caused Dr Black to make any material amendments to his initial report.

13.19 In paragraph 6.9 Dr Black criticises Dr Barton's failure to liaise with the surgical team at the Haslar Hospital or with the patient's consultant, when the patient returned to GWMH on the second occasion, following the reduction of her dislocation, when it was evident that the patient was in significant pain.

13.20 In paragraph 6.9 Dr Black also expresses the view that as the patient was in significant pain at that stage, it would not be unreasonable to provide palliative care and pain relief. Note therefore a marked difference in opinion with the other two experts. However, in paragraph 6.9 Dr Black states that the starting dose of Diamorphine was "unnecessarily high".

13.21 In paragraph 7.2 Dr Black refers to the lack of detail in the medical notes and concludes that this amounts to poor clinical practice. He also expresses concerns about the anticipatory prescription of opioid analgesia on the patient's admission to GWMH. He also confirms that the starting dose of Diamorphine prescribed on 17 August was "sub optimally high".

13.22 Finally, Dr Black expresses the view that the dose of Diamorphine did not contribute "in any significant way" to the patient's death and that her death was by natural causes.

Initial view

13.23 All of the experts are critical of Dr Barton's management of the patient. The evidence obtained from the experts supports the draft charges set out in the Rule 4 letter. We need to check that all the experts have seen all the relevant evidence, including all the witness statements and transcripts of police interviews. If having reviewed all the evidence their conclusions remain the same, there is sufficient evidence to take this case to the panel.

Case Strategy

This document sets out in detail the actions that will be required, who will undertake each step and in what timescale. The document also sets out a budget for each step.

This document is our project management tool for the work outlined. We will use it to monitor current tasks, timescales and costs. It will form the basis for our regular update meetings. We will amend it as the case develops.

This document follows from the Case Outline. If the Case Outline changes as the case unfolds, then this will also have an impact on the Case Strategy, which will be updated appropriately.

Summary of Strategy

1. A total 13 cases have been considered in this review.

2. In summary our assessment of the individual cases is as follows:

2.1 **The Cases which have already been referred to the PCC.**

2.1.1 **Richards [August 1998]**

The Police have gathered evidence from most of the relevant witnesses of fact and expert reports have been obtained. There is some inconsistency in the evidence but overall this is a case which has a reasonable prospect of success.

2.1.2 **Cunningham [September 1998]**

This case was included in the initial Police investigation and was subject to a subsequent, more detailed, investigation. The expert evidence obtained on behalf of the Police after the case was referred to the PCC casts significant doubt on the prospects of success. We therefore recommend that this case should be considered for cancellation.

2.1.3 **Wilkie [August 1998]**

The case was referred to the PCC on the basis of two expert reports obtained by the Police during their initial investigation. The experts have referred to a lack of documentation and so at least some of the conclusions are based on assumption. The Police did not interview

witnesses of fact as part of their investigation. If this case proceeds a detailed investigation will be required to investigate the factual background. This could either strengthen or weaken the case depending on the available evidence.

2.1.4 **Wilson [October 1998]**

The case was fully investigated by the Police, with regard to both factual and expert evidence. It is one of the strongest cases and on the basis of the available evidence has a reasonable prospect of success.

2.1.5 **Page [February 1998]**

This case was referred to the PCC on the basis of an opinion of one of the two experts used by the Police. The other expert, who prepared a more detailed report, was of the opinion that most of the patient's care was appropriate, although the expert is critical of prescribing on the day of the patient's death. The Police did not interview witnesses of fact as part of their investigation. Given the differences of opinion expressed by the experts, this is one of the weaker cases. A detailed investigation of the facts may strengthen or weaken the case.

2.2 **The cases which have not yet been referred to the PCC**

2.2.1 Of the cases which have not yet been referred we have identified four which, on the basis of the available evidence, stand a reasonable prospect of success. These are:

2.2.2 **Lavender [February 1996]**, **Pittock [January 1996]**, **Spurgin [March 1999]** and **Packman [August 1999].**

2.3 We have prepared draft allegations in each of these cases which are attached.

2.4 In each of these cases the Police have conducted a detailed investigation of the facts and obtained reports from experts. This material is available for consideration by a case examiner.

2.5 In all of the cases, including those where the Police have interviewed and taken statements from the witnesses of fact, further investigation is required to seek additional evidence. Although the Police interviewed and took statements from a large number of witnesses many of the statements do not, in our view, cover the points in issue in sufficient detail. Having said this, the fact that statements have already been obtained in these cases will undoubtedly save time in preparing the case. It would not be necessary or indeed desirable to seek to question witnesses about the evidence which they have already given. The

purpose of re-interviewing, therefore, would be to fill in any gaps in the evidence.

2.6 Generally, the quality of the expert evidence already obtained appears to be satisfactory, and it should be possible, subject to the agreement of the experts in question, to rely on the work which they have already done. However there is a different emphasis with regard to expert evidence in GMC proceedings and evidence obtained as part of a criminal investigation. Therefore, reports will have to be reviewed and rewritten to a certain extent, and will also need to take into account any evidence obtained by way of further investigation.

2.7 The recommended strategy is to select a sample of cases to go forward to the PCC. On the basis of this review we suggest the following cases: Richards, Wilson, Lavender, Pittock, Spurgin and Packman. In our view, this is a representative sample which highlights the concerns which have been identified by the experts.

2.8 Our overall view is that this is a case which will end up focusing on allegations of prescribing opiates in excess of patients' needs. In some, but not all cases there is evidence that this practice **may** have resulted in premature death, by a matter of hours or, at the most, days. We do not believe that a case can be made out that Dr. Barton embarked on a systematic and/or deliberate course to kill patients.

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27 April 2007

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FITNESS TO PRACTISE PANEL HEARING

On 8 June – 21 August 2009 a Fitness to Practise Panel will consider the case of:

Dr Jane Ann BARTON
GMC Reference Number: 1587920
Registered Address: Code A

The hearing will commence at 09:30 at:

General Medical Council
Third Floor
350 Euston Road
London
NW1 3JN

Type of case: New case of impairment by reason of misconduct.

The case is expected to last 55 days.
The Panel will not be sitting on 18 June and 23 July 2009.

Panel Members: Mr A Reid, Chairman (Lay)
Mr J Campbell (Lay)
Ms J Julien (Lay)
Mrs P Mansell (Lay)
Dr R Smith (Medical)

Legal Assessor: Mr Francis Chamberlain

If you require any further information or assistance, please call Adjudication Management Section on 020 7189 5189, or visit the GMC website www.gmc-uk.org.

If an emergency arises out of hours that may prevent your attendance at the required time please call 020 7189 5189 and leave a message. We will not be able to call you back at the time, but it will enable us to act on your message as soon as the office opens the next working day.

The Panel will inquire into the following allegation against Jane Ann Barton, BM BCh 1972 Oxford University:

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

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

PITTOCK

'2. a. i. Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care, A

ii. between 5 and 10 January 1996 you prescribed Oramorphine 5mg 5 times daily, as well as Diamorphine with a dose range of 40 - 80 mg over a twentyfour hour period to be administered subcutaneously ("SC") on a continuing daily basis, A

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

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

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

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

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

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

ii. the dose range was too wide,

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

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

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

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

i. inappropriate,

ii. potentially hazardous, A - RE 2(a)(iii) ONLY

iii. not in the best interests of Patient A;

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

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

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

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

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

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

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

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

c. Your actions in prescribing the drugs described in paragraphs 3.a. ii., iii. and/or iv. were,

i. inappropriate,

ii. potentially hazardous, A - RE 3(a)(iii)+(iv) ONLY

iii. not in the best interests of Patient B,

d. In relation to your management of Patient B you,

i. did not perform an appropriate examination and assessment of Patient B on admission,

ii. did not conduct an adequate assessment as Patient B's condition deteriorated,

iii. did not provide a plan of treatment,

iv. did not obtain the advice of a colleague when Patient B's condition deteriorated, A

e. Your actions and omissions in relation to your management of patient B were,

i. inadequate,

ii. not in the best interests of Patient B;

'4. a. i. on 27 February 1998 Patient C (PAGE) was transferred to Dryad Ward at GWMH for palliative care, A

ii. on 3 March 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20-80mg to be administered SC over a twentyfour hour period on a continuing daily basis, A

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

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

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

c. Your actions in prescribing the drugs described in paragraph 4.a. ii. were,

i. inappropriate,

ii. potentially hazardous, A

iii. not in the best interests of your patient;

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

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

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

i. the dose range was too wide, A

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

c. Your actions in prescribing the drugs as described in paragraph 5.a.ii. were,

i. inappropriate,

ii. potentially hazardous, A

iii. not in the best interests of Patient D;

'6. a. i. Patient E [handwritten: ~~E~~ Richards] 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, A

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

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

b. In relation to your prescription for drugs described in paragraph 6.a.iii.,

i. the dose range was too wide, A

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

c. Your actions in prescribing the drugs described in paragraph 6.a. ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous, A - re 6(a)(iii) only

iii. not in the best interests of Patient E;

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, A

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

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

b. In relation to your prescription for drugs described in paragraph 7.a.iii.,

i. the dose range was too wide, A

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

c. Your actions in prescribing the drugs described in paragraphs 7.a. ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous, A - RE 7(a)(iii) ONLY

iii. not in the best interests of Patient F;

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, A

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

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

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

i. the dose range was too wide, A

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

c. Your actions in prescribing the drugs described in paragraphs 8.a.ii. and/or iii. were,

i. inappropriate,

ii. potentially hazardous, A - re 7(a)(iii) only

iii. not in the best interests of Patient G,

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

'9. a. i. Patient H [Wilson] was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease as a result of alcoholism and other medical conditions, A

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

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

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

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

i inappropriate,

ii. potentially hazardous,

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

iv. not in the best interests of Patient H,

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

i. the dose range was too wide, A

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

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

i. inappropriate,

ii. potentially hazardous, A re 9(a)(iii) + (iv) only

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

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

'10. a. i. Patient I [Spurgin] was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital, A

ii. on 12 April 1999 you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twentyfour hour period on a continuing daily basis, A

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

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

i. inadequate,

ii. not in the best interests of Patient I,

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

i. the dose range was too wide, A

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

d. Your actions in prescribing the drugs described in paragraph 10.a. ii. were,

i. inappropriate,

ii. potentially hazardous, A

iii. not in the best interests of Patient I,

e. The dosage you authorised/directed described in paragraph 10.a. iii. was excessive to Patient I's needs. This was,

i. inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient I;

'11. a. i. PACKMAN 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, A

ii. on 26 August 1999 you gave verbal permission for 10 mg of Diamorphine to be administered to Patient J, A

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', A

iv. you did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition, A

v. on 26 August 1999 you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, A

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

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

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

ii. the dose range was too wide, A

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

c. Your actions in prescribing the drugs described in paragraphs 11.a. ii. and/or v. were,

i. inappropriate,

ii. potentially hazardous, A - RE 11(a)(v) ONLY

iii. not in the best interests of Patient J,

d. Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11.a. iv. was,

i. inappropriate,

ii. not in the best interests of Patient J;

'12. a. i. Patient K (DEVINE) 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, A

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

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

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

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

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

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

ii. the dose range was too wide,

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

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

i inappropriate,

ii. potentially hazardous,

iii. not in the best interests of Patient K,

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

STEVENS

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

ii. on 20 May 1999 you prescribed, A

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

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, A

c. Midazolam with a dose range of 20 to 80 mgs to be administered SC, A

iii. you further prescribed Oramorphine 10 mgs in 5 mls 4 times a day and 20 mgs nocte (at night) as a regular prescription to start on 21 May 1999, A

iv. doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient ~~in~~ on 21 and 22 May 1999, A

b. In relation to your prescription for drugs described in paragraph 13.a.ii. and/or iii.,

i. there was insufficient clinical justification for such prescriptions,

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

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

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

a. Inappropriate,

b. Potentially hazardous, A - re 13(a)(ii)(b) only.

c. Not in the best interests of patient L,

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

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

i. the findings upon each examination, A

ii. an assessment of the patient's condition, A

iii. the decisions made as a result of examination, A

iv. the drug regime,

v. the reason for the drug regime prescribed by you, A

vi. the reason for the changes in the drug regime prescribed and/or directed by you, A

b. Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were,

i. inappropriate, A

ii. not in the best interests of your patients; A

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

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

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

The GMC

and

Dr Jane Barton

Opening

INTRODUCTION

1. This case concerns the treatment provided to twelve patients at the Gosport War Memorial Hospital all of whom were in-patients there between 1996 and 1999. Dr Barton was employed during the period as a clinical assistant which meant that she had day-to-day care of the patients on the two relevant wards which were Daedalus and Dryad.

2. The Hampshire Primary Care Trust boasted four hospitals at the relevant time in the Portsmouth Area. The Queen Alexandra Hospital which has a number of sites clustered around the top of Portsmouth; St Mary's Hospital which is in Portsmouth itself; the Royal Haslar Hospital which was once the Royal Naval Hospital, the first version of which was built in the middle of the 18th Century; and finally the Gosport War Memorial Hospital (GWMH).

3. The GWMH was opened in 1923. Since then it has occasionally been extended. At the relevant time that you will be asked to consider, the

GWMH was effectively a cottage hospital which would receive patients who required longer term or rehabilitative care. Prior to the period we are considering the GWMH had been spread around a number of sites, but by the relevant time period it was centred in a single building.

4. It was a community hospital and did not have an acute ward nor any emergency facilities. Originally palliative care patients or those terminally ill were cared for in part of the Gosport War Memorial Hospital (GWMH) called the Redcliffe Annex which was some miles from the main hospital. That was a geriatric ward for patients who could not cope on their own, it was closed in 1995 and all of their patients were sent to Dryad Ward which was one of three wards at the GWMH. The other two elderly care wards being called Daedalus and Sultan Ward.

5. Emergencies arising on the wards of the Gosport War Memorial Hospital would have to be transferred by ambulance to one of the local hospitals where emergency treatment could be provided.

6. Dr Barton was a local GP practising in Gosport in Hampshire. She qualified at Oxford University in 1972 as a Bachelor of Medicine and a Bachelor of Chemistry. She became a GP, initially as an assistant and then as a partner. In 1980 she was appointed to the General Practitioner medical staff at the GWMH (see - Samuel) and in 1988 she applied for and was appointed to the post of Clinical Assistant at the Gosport War Memorial Hospital. The period of her employment there upon which this case will focus was between 1996 and 1999.

7. During her period at the hospital she continued in her full time post as a GP doing morning surgeries every day and evening surgeries on a rota basis with her other GP partners. She was also doing one night a fortnight on call and one weekend on call in four (police statement of Dr Barton re: Gladys Richards).

8. Dr Barton had not specialised in either Geriatric or Palliative medicine and had no specific training of which we are aware other than her experience over the years. Dr Barton's main job was as a GP in a local Gosport practice. She would conduct ward rounds at GWMH as a general rule between 7.30 and 8 a.m. Monday to Friday on a daily basis (Barrett). She would also, according to the witness Philip Beed and according to the statement Dr Barton made subsequently to the police, attend at midday to clerk any new admissions. She would be fairly reliant on nursing staff to flag up any problems and would not necessarily see every patient every day (Beed, Interview 7/25).

9. There are two wards at the GWMH to which all of the twelve patients upon whom we are focussing were admitted.

10. Dryad Ward which was an elderly care ward consisted of 20 beds.

11. Daedalus Ward was a 24 bed ward. 8 of those beds were for slow stream stroke patients and the remaining beds were for the continuing care of elderly patients. Many of the patients admitted to these wards were expected to be rehabilitated sufficiently so that they could either return home or to care homes. This was not a hospice although of course some patients were very ill and inevitably were not going to leave hospital.

12. Additionally GWMH had an old age psychiatric ward by the name of Mulberry.

13. Dr Barton appears to have developed a practice on the two wards Dryad and Daedalus, of prescribing large quantities of opiates on an 'in-case' or, as she called it, an 'anticipatory' basis. 'In case' the patient found themselves to be in pain or 'in case' the patient's pain was uncontrolled by the opiates already given, or in case Dr Barton was away or it was a weekend. Many of the patients you are going to hear about were opiate naïve, in other words, until they set foot inside the GWMH, they had never been given opiates as a form of pain relief. In the view of the GMC expert Professor Ford none of the patients, about whom you are going to hear, were properly and appropriately prescribed opiates by Dr Barton.

14. There was a series of failures which led to patients being over medicated and unnecessarily anaesthetised. The failures included a lack of proper assessment before opiates were prescribed and a wholly irresponsible method of prescribing opiates. There was an almost universal failure by Dr Barton to make proper notes either of assessment of the patients if such assessments were taking place or to justify her actions in prescribing opiates. Frequently opiate medication was increased with no explanation noted.

15. The favoured method of prescribing to these patients was to provide for a variable dose of the drugs Diamorphine and Midazolam which were to be administered by way of syringe driver. The dose range prescribed by Dr Barton was, in each case that you are going to consider, far too wide and breached acceptable medical practice.

16. Prior to the syringe driver being administered many of the patients were unnecessarily prescribed oral morphine in the form of liquid morphine called 'Oramorph' or slow release Morphine tablets (MSTs).

17. Philip Beed one of the nurses and Clinical Manager of Daedalus Ward puts it in this way (police interview p.28/37) – "it's the nursing staff who really have the full picture of how a patient has been and then we would discuss and talk about how we would do it with the medical staff making decisions about care. We would call a doctor if we needed to, but we would have discussed the patient's ongoing care and prognosis on each occasion we saw the doctor so we are empowered to initiate a syringe driver. The syringe driver would be written up and the instruction would be 'if this patient's condition worsens you can utilise the syringe driver to keep that patient pain free'". There appears therefore to have been considerable discretion left with the nursing staff as to commencement of the syringe drivers and the quantity of opiate to administer.

18. When the patients became agitated they were then administered increasing quantities of Diamorphine and Midazolam by the nurses under Dr Barton's prescriptions, until they were agitated no more. Many of the patients who are described in the nursing notes as 'calm and peaceful' were, in fact, according to Professor Ford, in 'drug induced comas'.

19. Professor Ford is the Professor of Pharmacology of old Age at the University of Newcastle upon Tyne and practices as a consultant Physician in clinical Pharmacology at the Freeman Hospital. He is the co-editor of Drugs and the Older Population published in July 2000.

20. He has examined each of the cases which we have placed before you and he is highly critical of Dr Barton's practice in terms of her prescribing, her lack of assessment of patients and her failure to make relevant and necessary notes.

21. Dr Barton may claim that she was entitled to rely on the experience of the nurses when prescribing the huge quantities of Diamorphine and Midazolam which she did. She may say that she was entitled to rely on the nurses not to provide the medication which she was prescribing unless it was necessary. However, there was a lack of a proper system to ensure that patients were not overmedicated and in the view of Professor Ford, over-medication was a frequent and recurring problem. Dr Barton effectively delegated responsibility for her patients in relation to the administration of opiates to the care of the nurses and there were frequent occasions when the nurses went on to use those prescriptions inappropriately.

22. As she said in her police statement – "on a day to day basis mine was the only medical input".

CONSULTANTS

23. There were three consultants who had duties in relation to these two wards. The wards were visited on a weekly basis by one consultant or the other. However in general they were reliant upon what they were told about the patient by Dr Barton.

24. The consultants were Dr Tandy, Dr Reid and Dr Lord. None of them saw the patients more than once a week on the wards and the day to day control was left to Dr Barton and her nursing staff. Dr Tandy was away on maternity leave from April 1998 until February 1999 and her post was not filled by a locum.

25. **Dr Jane Tandy** was a Consultant Geriatrician at the Queen Alexandra Hospital Portsmouth who was ostensibly responsible for Dryad Ward at GWMH as consultant from 1994. She was away on sick leave for a month from 11 July to 12 August 1996 and again from 16 September to 22 November. From the 23 November 1996 to 1 September 1997 she went on maternity leave. When she was there she carried out a ward round once every two weeks on Wednesdays. She was only there during the period when patients A and B were on the ward and would have left by the time patient C arrived.

26. She describes Dr Barton as more experienced than her in long term and palliative care.

27. **Dr Reid** was based at the Queen Alexandra Hospital in Portsmouth. He was a consultant Geriatrician. He carried out one session a week at the Dolphin Day Hospital and from February 1999 was the consultant in

charge of Dryad Ward. He was in post at the times that Patient I, J and K were admitted to Dryad Ward.

28. He would carry out a ward round on Monday afternoon. On alternate weeks Dr Barton would accompany him. He would therefore only see her once a fortnight. He was not aware that Dr Barton was writing up prescriptions for patients with a variable dose in advance of them complaining of pain. He spoke to her on one occasion about a variable dose he saw and appears to have accepted her explanation.

29. He was aware that Dr Barton was working very hard and believed that without her GWMH would not have been able to function.

30. **Dr Lord** would carry out a consultant ward-round once a week alternating between Dryad and Daedalus (Beed).

31. She is in New Zealand and careful consideration has been given as to whether she should be called as a witness. A review of the notes of the twelve patients with whom you are specifically concerned reveals that although she provided medical services to a number of them prior to their transfer to the GWMH her input post transfer was very limited indeed. She had no role in the prescribing treatment at GWMH for Patients A, B, E, F, H, I, J, K or L.

32. Her role in relation to patients C, D, G was very limited as you will hear and is in any event revealed by the notes. In the circumstances it has been decided that she will not be called by the GMC.

33. Dr Barton may say she was overworked and under pressure and if that is shown to be true, that may be some mitigation for what occurred, but it

does not provide a defence for some of the practices which built up and which were directly contrary to Good Medical Practice.

34. In due course Dr Barton did resign apparently because of the pressures of work but there was unfortunately quite clearly a period of time under her management when her patients were receiving very substandard care.

THE DRUGS + PROTOCOLS

35. Of the drugs that you will be hearing about there are four which are central to this case: Oramorph, Diamorphine, Midazolam and Hyoscine.

36. Oramorph is an oral solution of Morphine. It is suitable to be given as an opiate where the patient is able to swallow. It has the effect of depressing respiration and causing hypotension. It should be avoided for acute alcoholics.

37. Diamorphine, as you will know, is what drugs users call 'Heroin'. It is a powerful opioid analgesic and is given via syringe. Apart from removing the sensation of pain it has a depressive effect on the vital functions and frequently causes nausea and vomiting. Its use should be avoided in the case of acute alcoholism. Great care has to be taken when exchanging oral morphine for subcutaneously delivered Diamorphine. The dosage delivered subcutaneously should, according to the BNF, be one third to one half of the oral dose of Morphine. So an oral dose of 30 mgs Morphine over 24 hours should be replaced by a dose of 10-15 mgs as a subcutaneous infusion over 24 hours (Ford).

38. Midazolam is a sedative and anti-epileptic and said to be suitable for the very restless patient. It can be mixed in a syringe driver with Diamorphine. Midazolam can cause respiratory and cardiovascular depression, hypotension and ultimately death.

39. Hyoscine has the effect of reducing salivary and respiratory excretions. In the elderly particularly it can cause drowsiness.

40. Specific advice is given in the BNF (File 1 Tab 3 page 7) that dosages for elderly patients should generally be substantially lower than for younger patients. Doses should generally start with 50% less than the normal adult dose.

41. Drugs may be prescribed 'PRN' (pro re nata) or 'as the occasion arises' or 'as required'. This can be appropriate and is often used but it is important to provide clear instructions as to what event will trigger the use of the drug.

42. The 'analgesic ladder' is a phrase which will crop up in the course of this hearing. It describes the simple concept which you are entreated to apply at the sanction stage of a FTP case. In other words you should consider the lowest sanction first. The analgesic ladder provides, in a similar way, that drugs are classified into three groups depending on the severity of the pain that they are intended to meet. The starting point is non-opioid analgesics such as aspirin, paracetemol and Ibuprofen. Next there are more potent anti-inflammatory drugs such as Diclofenac and Codeine. Except in an emergency, which did not arise in any of the cases you will consider, it is only for patients for whom those first two stages have

proved ineffective to control their pain that Morphine and Diamorphine are recommended. The lowest starting dose should be used at the commencement of pain relief and increased if necessary by 50% on subsequent occasions.

43. You will hear reference to a document called the 'Wessex Protocol'. This is also known as the Palliative Care Handbook (File 1 Tab 4). This sets out guidance as to best practice when applying a palliative care regime. That means a medical regime to ensure that the patient is comfortable and pain free when their illness is no longer responsive to potentially curative treatment. In other words, when it is recognised that the patient is dying and can not or should not be saved by medical intervention.

44. One of the issues in the case is whether the nurses were in fact following the guidance given and whether in respect of certain patients the decision was taken inappropriately to treat patients under a palliative regime as opposed to a curative regime.

NURSES

45. The GMC proposes to call a number of the nurses who cared for the patients and who administered doses of Diamorphine and Midazolam of which criticism is on occasion made. Many of the nurses who worked on the relevant wards can remember nothing beyond the notes that they made and it has not been thought necessary or relevant to parade those nurses before you. Some of the nurses do have recollection of the patients or the practices at the hospital and will be called by the GMC. Many are likely to

be highly supportive of Dr Barton with whom they worked over many years.

46. The Panel will have to be alert when listening to the evidence of those nurse witnesses to guard against biased or self serving evidence.

47. Lynne Barrett by way of example was a senior and experienced nurse who worked at GWMH from the late 1980s. She had no concerns about the use of syringe drivers nor the quantities of drugs that were being prescribed by Dr Barton. She takes the view that as a result of the issues raised at GWMH, patients will not now get the pain relief that they need. She feels that Dr Barton is being used as a scapegoat. You will need to assess that evidence, but it is called so as to provide you with as complete a picture as possible. Some nurses we are not calling if in the GMC's view they are so biased as to be not capable of belief. If the defence wish to call them then that is a matter for them.

48. Sister Hamblin was the clinical manager and Ward sister and it is clear from a substantial body of evidence that she was a formidable person who effectively ran the wards in Dr Barton's absence. She is too unwell to be called to give evidence and the GMC have taken the view that it would not be appropriate to rely upon her evidence in statement form.

49. Freda Shaw takes the simple line that 'syringe drivers were always used correctly and only when necessary'.

50. Other nurses have expressed concern about the extent to which both Diamorphine and syringe drivers were used on the wards. Some nurses speak about the use of Diamorphine without adopting the analgesic ladder

first. They speak of the considerable trust that Dr Barton appears to have placed in Gill Hamblin (see Carol Ball) and concerns appear to have been raised back in the early 1990s.

51. For a period Dr Barton had worked on the Redcliffe Annex prior to the transfer. Nurse Tubritt remembers that once she started the ward was better organised and syringe drivers were introduced at around that time. It was prior to the transfer to Dryad and Daedalus that nurse Tubritt remembers concerns being raised in the early 1990s about the use of Syringe Drivers and the quantity of Diamorphine being used.

52. Meetings were held between nurses and management and Dr Barton attended at least one of those meetings. Unfortunately although there were calls for a formal written policy on the use of Diamorphine and Syringe drivers no such policy appears ever to have been produced (See Exhibits to Turnbull's GMC statement in Bundle 1 Tab 6).

53. Nurse Turnbull was similarly concerned and certainly initially she was worried that the analgesic ladder was not being used appropriately. However her view once the ward was moved to become Dryad Ward, was that the culture did change and that syringe drivers were only used when needed.

54. Nurse Turnbull does however reflect in her evidence that the regime allowed the Nurse in Charge to increase the dosage of drugs at their discretion provided it was kept within the parameters set by Dr Barton. Those parameters were however set very wide indeed.

55. Meetings were held and fears apparently therefore were allayed. It will be a matter for the Panel to consider whether the concerns should in fact have continued and whether or not they had been addressed by a real change of culture.

56. Phillip Beed was the manager of Daedalus Ward from 1998. He describes how Dr Barton would attend the ward at 9 am every morning and carry out a review of the patients. He is very supportive of Dr Barton and had no concerns about her. It was a very busy ward according to Mr Beed.

57. Nurse Giffin remembers concerns about syringe drivers being raised in the early 1990s and there were meetings with Dr Barton and hospital management about their excessive use. Nurse Giffin appears eventually to have stopped complaining about what was going on and continued working with the others although in her view things did not in fact improve.

58. Ms Shirley Hallman was a senior nurse and only one grade lower than Gill Hamblin. She did not start work at the GWMH until 1998. She was new to palliative care and had a difficult working relationship with Ms Hamblin. She ran the ward when Nurse Hamblin was on leave or away. She describes Nurse Hamblin as an excellent nurse but 'her word was law'.

59. She did not feel that the analgesic ladder was appropriately adhered to. She describes how on Dryad it had become standard practice to double the dosage if it was deemed that the patient needed a higher dosage of opiates.

60. She was troubled by the fact that it appeared that Dr Barton would prescribe opiates and then hand the responsibility over to the nurses.

61. The GMC will call a number of nurses and you will have to analyse their evidence carefully. Some of the evidence may be founded on self protection or even upon a misguided loyalty. What may matter to your inquiry however is the evidence which actually supports the administration of opiates or in many cases, the lack of evidence as to why opiates were in fact administered or increased.

NOTE KEEPING

62. One of the allegations which is made in respect of every patient relates to the very poor quality of the notes kept by Dr Barton. In the cases you will be looking at there was a lack of a proper note of the first assessment by Dr Barton and a lack of reassessment notes or a proper diagnosis or treatment plan. The administration of Opiates was regularly increased with only a nurse's note to show it.

63. Dr Barton's explanation to the police was, in short, that she was too busy to make a note and that she had to decide whether to look after the patients or make notes about it.

64. She said this in one of her statements – "I was left with the choice of attending my patients and making notes as best I could or making more detailed notes about those I did see but potentially neglecting other patients" (see for example Dr Barton's generic statement and her statement re: Arthur Cunningham). The GMC does not accept that to be a

legitimate approach. Unless a proper note is made assessing the patient on admission and when there are significant changes in their state of health, then it is very likely that the treatment of that patient will be adversely effected.

65. There will be no baseline or benchmark from which to work. Other medical staff will not know what the finding and diagnosis was. The treating doctor may not remember what the state of health of the patient was when first assessed. Nursing staff will not be able to track the patient's progress nor will they know the appropriateness or not of administering analgesia. Nursing staff may not appreciate when a patient is opiate naïve nor might they understand the significance of that in setting the first dose.

66. Good notes are a critical element in the patient's care and in this case the notes were terribly inadequate and that may have led in some cases to failures in patient care.

BUNDLES AND PAPERS

67. Before turning to the individual patients let me introduce some of the paperwork you will be receiving. There are individual files for each of the twelve patients. We have put into each file only those documents which we think are immediately relevant to your consideration but we have all of the patient notes available should more documents become relevant. These are working files. We have retained the original pagination but at the front of each file you will find a chronology prepared by Mr Fitzgerald

which relates to the most important features of that patient's care and which follows the care afforded to each patient as shown in the notes. The original records are much larger and we have made efforts to restrict the amount of documentation that you need to see. If at any stage you feel the need to see more, or if either side wish to add to the material, then that can be done during the course of the hearing.

68. There are several further files. One is a file containing all of Professor Ford's reports. *[We are going to provide you with those in advance of his evidence and we would invite you to read his report in advance of hearing from the witnesses who we intend to call in relation to each patient. That will give you the context of the witnesses' evidence and highlight the issues which you may want to consider when you hear from the witnesses. It will mean that if anything occurs to you, to be of potential relevance during the course of the evidence of the witnesses themselves, you will be enabled to put the relevant question at the appropriate point in the evidence].*

69. A further file contains miscellaneous material which is called Panel Bundle 1.

70. A final file contains the statements produced by Dr Barton when questioned by the police. There have been a number of investigations into what went on at this hospital. There was a substantial police investigation as well as an investigation by the CHI. When Dr Barton was interviewed by the police she made no answer to the many hours of questions which were put to her about what had happened within these two wards. Instead, Dr Barton chose to draft a series of statements which she provided to the police in advance of her interviews. Those statements are self serving in

the sense that they are drafted by Dr Barton or by her lawyers and they were never tested under questioning by a police officer. Nevertheless, it is proposed that you should receive those statements as her account at the time of her actions. They must be regarded as self serving statements and we will have to wait and see whether or not Dr Barton chooses to give evidence so that she can be tested upon her account.

71. Most recently there was a coroner's inquest which looked into the deaths of a number of the patients. There was a degree of publicity about that inquiry and again if you heard anything about that through the press or internet you no doubt well understand that you should ignore anything you have previously heard. All that matters so far as your consideration of these charges is concerned is the evidence you now hear put before you by both sides. The findings of those other hearings and inquiries are at this stage irrelevant to your considerations except in so far as you may hear witnesses being cross-examined upon the evidence that they may have given previously in the course of other enquiries.

Patient A – Leslie Pittock (January 1996)

72. The first patient with whom you are concerned is patient A (Leslie Pittock). He was 82 years old when he was admitted on **5th January 1996** to the GWMH to Dryad Ward. He had previously been admitted to Mulberry Ward on the **13th December 1995** which was a psychiatric ward within the GWMH where he was under the care of Dr Banks. He suffered from depression and mobility problems.

73. He was verbally aggressive and was not mobilising well. Following his admission he developed a chest infection.

74. On the **3rd and 4th January** he had been assessed first by Dr Banks and then by Dr Lord who recorded that he was completely dependent upon nursing case, he had a urinary catheter in place, an ulceration on his left buttock and hip and low protein in his blood. Dr Lord indicated that she would transfer him to the GWMH to a long stay bed. It was thought to be unlikely that he would return to a residential care home. He was noted to be very depressed.

75. His daughter Lynda Wiles commented that she felt he had lost the will to live.

76. He was transferred on Friday **5th January 1996** to the GWMH to Dryad Ward where Dr Barton made a short entry – p.196. "Transfer to Dryad Ward from Mulberry. Present problems immobility, depression, broken sacrum small superficial areas on right buttock. Ankle dry lesion, both heels suspect. Catheterised. Transfers with hoist. May need help to feed himself long standing depression on lithium and sertraline".

77. On Tueday **9th** January Dr Barton noted that the patient's right hand was painful and he had increased anxiety and agitation.

78. Dr Tandy made an entry on **10th January** that the patient was for 'TLC' Tender Loving Care. She appears to have seen the patient prior to the administration of prescription of Oramorph later that day. That was during a ward round with Dr Barton and Nurse Hamblin.

79. At p.200 the drug chart indicates that Dr Barton prescribed Oramorph 5 mgs 5 times a day on **10th January**. There is also an undated prescription for between 40-80 mgs Diamorphine to be given over a 24 hr period subcutaneously. It is likely that that prescription was written out on the **10th** January at the same time as the Oramorph prescription because it appears to have been superseded the following day on the **11th January** when Dr Barton wrote another prescription for Diamorphine, but this time for a variable dose between 80-120 mgs to be delivered Sub-Cutaneously (SC) together with Midazolam 40-80 mgs. Dr Barton describes her first prescription for opiates by syringe driver as a 'proactive' one.

80. Two doses of oral morphine appear to have been administered on the day they were prescribed ie: the **10th** , and that became the regular prescription for the next five days.

81. Of the higher prescription on the 11th January Dr Barton says this – " I would have been concerned that although it was not necessary to administer the medication at that stage, (the patient's) pain anxiety and distress might develop significantly and that appropriate medication should be available".

82. According to Professor Ford the prescription on the **11th January** for a variable dose of Diamorphine of 80-120 mgs was poor practice and potentially hazardous and the lowest dose was still inappropriately high because it amounted to a four-fold increase on the opiate dose she was already receiving orally. His view is effectively the same so far as the Midazolam is concerned. The prescriptions ran a high risk of producing respiratory depression and potentially coma.

83. No Diamorphine was in fact administered until Monday the **15th January** when it was started at a rate of 80 mgs over a 24 hour period. Midazolam at 60 mgs over a 24 hour period was started at the same time. The only note that appears to give any justification for that medication was a nursing note that the patient 'appeared agitated'. That was a four-fold increase as compared to the oral dose which he had been receiving. Dr Barton claims she would have seen the patient on that Monday but made no note about it. She says – "I believe, I may have been told that his condition had deteriorated considerably over the weekend". "I believe my assessment of his condition at this time was that he was in terminal decline".

84. There is a note in the nursing record (p.208) for the **15th January** which simply states – 'S/B Dr Barton, has commenced syringe driver at 08.25'.

85. The dose of Midazolam, both that prescribed by Dr Barton and that administered by the nurses was excessively high. An appropriate starting dose for a frail older man, if an SC dose was justified at all would have been in the region of 10 mgs over a 24 hour period rather than a range of 40-80 as prescribed and 60 mgs as administered particularly in light of the fact that Diamorphine was started at the same time.

86. The lowest dose of Diamorphine prescribed and administered (which was unnecessary in the first place) was also far too high given that the patient had, until that point, been on only 30 mgs morphine orally per 24 hours on the **14th January**. The equivalent dose, even if necessary, should have been one of around 15-20 mgs going up to 30 mgs if the patient was sill in pain. The Midazolam was also according to Professor Ford excessively high. There was no explanation for it in the notes and no assessment to justify it.

87. On the **16th** Dr Barton added Haloperidol to the mix. A nursing note (p.26) records that the patient was agitated but that may have been a reaction to the Morphine he was being administered. There should at least have been a reassessment.

88. Apparently on the 18th but it may have in fact been on the **17th** Dr Barton again increased the dose of Diamorphine to 120 mgs and Midazolam to 80 mgs. Those doses were given from the 17th onwards. Dr Barton says that the increases were made on the 17th because the patient was tense and agitated. The nursing record for the 17th indicates (p.210) "S/B Dr Barton, medication increased as patient remains tense and agitated… remains distressed on turning".

89. Although the <u>oral</u> morphine prescribed by Dr Barton may have been justified by reason of the pressure sores from which the patient was suffering, there is nothing else in the notes to reflect why such a dramatic increase in the use of opiates was thought to be necessary by Dr Barton. The patient was not noted to be in any particular pain although he was agitated at times.

90. No clinical assessment seems to have been conducted before the prescriptions for the use of major opiates were issued. The high point so far as an assessment is concerned is that the nursing notes on **17.1.96** (p.210) indicate – 's/b Dr Barton, Medication reviewed and altered.'

91. On the **18th** January there is noted by Dr Barton –'further deterioration, sc analgesia continues, difficulty controlling symptoms, try Nozinan'.

92. On the **18th January** Dr Barton prescribed a new drug – Nozinan at 50 mgs. Nozinan is a sedating drug used to control terminal restlessness and agitation. A note the previous day on the 17th made prior to administration of that drug recorded that the patient appeared to be 'more peaceful' (p.210) and it is difficult to see what the justification was for adding another sedative to the potent mix that the patient was already receiving.

93. On Saturday **20th January** there is a medical note (p.198) that Dr Briggs was consulted (presumably because Dr Barton was not available over the weekend) and that the Nozinan was to be increased from 50 mgs to 100 mgs and Haloperidol was to be stopped on the verbal order of Dr Briggs. He did not attend the patient and this appears to have been done over the telephone. His reason for doing so was that Staff Nurse Douglas expressed a suspicion that the Haloperidol may be causing a side effect and he was concerned about the interaction of the drugs which the patient had been prescribed.

94. Between the 17th and 23rd January the daily syringe driver was filled with 120 mgs Diamorphine and 80 mgs Midazolam.

95. These drugs in conjunction with one another and with Haloperidol which the patient was also prescribed by Dr Barton, carried a high risk of producing coma and respiratory depression.

96. The patient died four days after the 20th on the **24th January 1996**.

97. Dr Barton may well claim that she was performing regular assessments but if that is so then she made no note of them and it is difficult to see how she could assess the needs of the patient on subsequent occasions when she had no assessment baseline from which to work. An assessment with no notes is clinically fairly pointless for the purposes of the future management of the patient.

98. Professor Ford is very critical of the note keeping in relation to the drug charts as well. At one stage there were three active prescriptions for Diamorphine which was extremely hazardous and in addition there were two actively running prescriptions for Haloperidol which put the patient at risk of coma had they been administered.

99. The infusions of Diamorphine, Midazolam and Haloperidol and then Nozinan very likely led to respiratory depression and shortened Patient A's life although he was expected to die in the near future.

Patient B – Elsie Lavender (February 1996)

100. Patient B was born in [Code A] and was 83 years old when she was admitted to the Royal Hospital Haslar on **5th February 1996** following a fall at home where she lived alone. She was registered blind. She was X rayed and no bony injury was found but there was concern that she might have suffered a CVA (Cerebral Vascular Accident or stroke). She had pain in her left shoulder and abdominal pain.

101. According to her son Alan, she made very good progress at the Haslar and was, by the time she moved to the GWMH, talking coherently and understanding what was being said to her. She was also mobile with a stick.

102. Some weeks after her accident, on the **22nd February,** she was transferred to the GWMH Daedalus Ward for rehabilitation and hopefully for return to a rest home. She died two weeks later on the 6th March.

103. Upon transfer she was seen by Dr Barton (p.175) on the **22nd** who noted that the patient had leg ulcers, was incontinent of urine, and suffered from insulin dependent diabetes Mellitus. She prescribed Dihydrocodeine which is a powerful synthetic opioid pain-killer on the second level of the Analgesic ladder.

104. Professor Ford notes that there was no assessment of the patient's pain nor of her neurological function. There should have been a clinical review but there was not, or at least none that was properly noted. The patient's son Alan recalls Dr Barton telling him that his mother had come to the hospital to die. He was surprised as that had not been his understanding.

105. On the **24th** there is a nursing note that the patient's pain was not being controlled by DF118 (DHC) and she had a sacral sore. She was commenced by Dr Barton on Morphine 10 mgs twice daily (p.1021).

106. Two days later on the **26th** Dr Barton noted that the patient's bottom was very sore and needed a Pegasus mattress. 'Institute SC analgesia as necessary'. She wrote out prescriptions that day for Morphine MST (Morphine Sustained Release tablets) at 20 mgs twice daily, and Diamorphine at a variable dose as required of 80-160 mgs, 40 – 80 mgs Midazolam and 400-800 Mcgs Hyoscine. None of those medicines were in fact administered. In respect of those prescriptions however Professor Ford is very critical. He describes them as 'not justified, reckless and potentially highly dangerous' (para 11). Even the lowest dose of Diamorphine would have amounted to a four-fold increase in opiates.

107. Dr Barton's explanation in her police statement was that this was 'pro-active' prescribing for pain relief, in case the patient experienced uncontrolled pain. She claims that she would have seen the patient on the 28th, 29th February and 1st March but appears to have made no note about those assessments whatever. The 2nd and 3rd March was the weekend.

108. On Monday **4th March** the notes record that Dr Barton increased the MST prescription from 20 mgs twice daily to 30 mgs twice daily.

109. Dr Barton's next entry was on the **5th March** when she noted that the patient had deteriorated and was not eating or drinking (p.975). She noted that the patient was in 'some pain, therefore start SC analgesia'. A nursing note records that the patient's pain was uncontrolled and the patient was

distressed (p.1013, 1022). Nurse Couchman, whose note that was, explains that she would have been relying on the night staff in order to make that entry and the dose was authorised by Dr Barton.

110. The syringe driver was commenced by the nurses at 09:30 that day with Diamorphine at 100 mgs and Midazolam at 40 mgs over a 24 hour period (p.1022) which doses were allowed for by Dr Barton's prescription for Diamorphine of between 100-200 mgs over a 24 hour period. Her prescription of Midazolam was between 40-80 mgs over 24 hours. Dr Barton (police statement) says that that this was necessary to relieve the patient's pain and distress.

111. An equivalent dose to that which the patient was already receiving orally but to be given S/C would have been in the range of between 20-30 mgs per 24 hours. So, even though the nurses were in fact starting at the minimum dose prescribed by Dr Barton even that was over three times greater than her previous equivalent dose of opiates. If the intention was to control the patient's pain by increasing the dose then a 50% increase at most might have been appropriate. Professor Ford describes the prescribing by Dr Barton as 'reckless and dangerous' (para 13).

112. The following day 6th **March** Dr Barton noted that the SC analgesia had commenced and the patient was now comfortable and peaceful, she also wrote: 'I am happy for nursing staff to confirm death'. A nursing note (p.1023) says that the patient was seen by Dr Barton that day and the medication other than through the Syringe Driver was discontinued as the patient was unrousable.

113. Professor Ford states that the description of the patient as being comfortable and peaceful was more likely to reflect the reality that the patient was by that stage in a drug induced coma (para 14).

114. At 9.28 pm that evening the patient died. In Professor Ford's view the administration of the sub-cut Diamorphine and Midazolam led to patient B's deterioration and contributed to her death.

115. In respect of each patient Dr Barton is charged with prescribing drugs in such a way as to create a situation whereby the patient could be administered drugs which were excessive to their needs and that such prescribing was inappropriate, potentially hazardous and not in the patient's best interests. It may be thought to be relevant specifically to those charges that there is evidence that in some of these cases excessive drugs were indeed administered and that the hazard did indeed arise.

116. Additionally in Professor Ford's view, when the patient's condition deteriorated there was a duty upon Dr Barton to consult with her consultant colleagues as to the best approach to future treatment.

Patient C – (Eva Page) (February 1998)

117. Patient C was 87 years old when she was admitted on **6th February 1998** to the Queen Alexandra hospital having experienced a general deterioration over a five day period and was complaining of nausea and a reduced appetite. A suspected malignant mass was seen in her chest and the notes recorded on 12th February that she should be managed with palliative care on Charles Ward to which she was transferred on the **19th February**.

118. On the 23rd February she was diagnosed as being depressed and suffering from possible carcinoma of the Bronchus, Ischeamic heart disease, and congestive heart failure. She was plainly not at all well but she does not appear to have been in any pain.

119. She was transferred to GWMH on 27th February 1998, according to Dr Barton's note 'for continuing care'. Her Barthel score was zero to 2 which meant she needed help with all of her basic bodily functions. The Barthel scoring system is a method of assessing a patients ability to cope with their daily living requirements (an example of which appears in Bundle 1 Tab). A Barthel score of 20 would indicate that the patient was fully competent in all daily living requirements, a score of 0 indicates that help is needed with all activities.

120. A note made by Dr Laing (the duty GP) on 28th February records that she was 'confused and felt lost' but was not in any pain. She was distressed however and she was given Thioridazine and a small dose of Oramorph (2.5mgs) to help her.

121. On 2nd March Dr Barton suggested the use of adequate Opioids to control fear and pain. A Fentanyl 25 microgram patch was started that day as well as a small amount of Diamorphine 5mgs given by injection. Fentanyl is a very powerful synthetic opioid which comes on a patch which can be applied to the skin. It is particularly useful in circumstances where it is difficult to inject the patient. By its nature its effect is less immediate but may be longer lasting and the effects remain long after the patch is removed.

122. That patch was the equivalent, according to Professor Ford, of a 90 mg oral dose. All of those drug prescriptions up to this point are approved of by Professor Ford who regards them to have been a reasonable response to the patient's anxiety despite the lack of pain although the Fentanyl patch is very likely to have caused the patient to become very drowsy.

123. On 3rd March a rapid deterioration in the patient's condition is recorded with her neck and both sides of her body rigid. That same day Dr Barton prescribed Diamorphine with a variable range from 20-200mgs daily and Midazolam at 20-80 mgs daily by syringe driver. There is no note that the Fentanyl patch was removed or directed to be removed at that time. That syringe driver was commenced at 10.50 hours with 20 mgs of each drug and 11 hours later at 9.30 pm she was pronounced dead.

124. Those prescriptions of Diamorphine and Midazolam were in Professor Ford's expert opinion not justified. Her deterioration on the 3rd could have been as a result either of a stroke or an adverse reaction to the Fentanyl patch. However there was no indication that the patient was at that stage in any pain. The drugs would be expected to result in depression of the

level of consciousness and respiratory depression. The prescriptions were not consistent with Good Medical Practice and the analgesic ladder was not followed.

Patient D - Alice Wilkie (August 1998)

125. Patient D was born in Code A and was 81 years old when she was admitted on **31st July 1998** from the Addenbrooke Rest Home to the Queen Alexandra Hospital Portsmouth Philip Ward which was within the department for elderly medicine. She had had a fall and was refusing fluids. She was severely dependent and had a 0 mental test score when she was transferred to GWMH Daedalus Ward on **6th August 1998**. The nursing notes reveal that she was for 'assessment and observation and then decide on placement'. A further note reveals – 'pain at times, unable to ascertain where'.

126. Dr Lord assessed the patient on **10th August 1998** – 'Barthel 2/20, eating and drinking better, confused and slow. Give up place at Addenbrookes. Review in one month. If no specialist medical or nursing problems discharge to a new home'. (Probably this would have meant a continuing care bed within the NHS).

127. An entry on **17th August** in the nursing notes records that there had been a deterioration over the weekend and the patient's daughter had agreed that active intervention was not appropriate'. 'To use syringe driver if patient is in pain'.

128. There is in the notes an undated prescription written by Dr Barton for a variable dose of between 20-200 mgs of Diamorphine and 20-80 mgs of Midazolam per 24 hours and by syringe driver. That prescription must have been written on or before the 20th when a syringe driver was started.

129. On **20th** the syringe driver was started with 30 mgs Diamorphine and 20 mgs of Midazolam. Prior to that point this patient had not been receiving any analgesic drugs but her daughter Marylyn Jackson who visited her that day did notice that she appeared to be in pain. In this case it is difficult to see how the analgesic ladder was being applied.

130. The next entry in the notes by a doctor is on the **21st August** by Dr Barton – 'marked deterioration over the last few days. SC analgesia commenced yesterday, Family aware and happy'. A nursing note of the same day records that the patient is 'comfortable and pain free'.

131. At 6.30 pm that day the patient's death was confirmed.

132. In Professor Ford's opinion there was nothing to justify the use of a syringe driver in this case, there being no record of specific pain. Even if there were such a record, milder analgesics could and should have been tried first. A medical assessment was required before prescribing those drugs when the deterioration was apparent.

133. The variable range prescribed by Dr Barton was poor practice, very hazardous and in Professor Ford's view unjustified.

134. So far as the notes are concerned in Professor Ford's view the only acceptable medical note was that made by Dr Lord on 10th August during the entirety of the patient's stay at the GWMH.

Patient E - Gladys Richards (August 1998)

135. Patient E was born in Code A and she was 91 years old when she was admitted as an emergency via the A&E department at Haslar Hospital on **29th July 1998**. She had fallen on her right hip which was then painful. She was found to have a fractured neck of femur. Surgery by way of hip replacement was performed on the **30th July**.

136. On 3rd August she was seen by Dr Reid. He found her to be confused but pleasant and cooperative. He took the view that despite her dementia she should be given the opportunity to be remobilised and with that in mind he organised her transfer to GWMH.

137. Between that assessment and transfer on the 11th she had an episode on the **8th August** when she was recorded as being agitated and she was calmed down with Haloperidol and Thioridazine.

138. Her daughter Lesley O'Brien remembers that she made a good recovery after the operation and was soon up on her feet and walking with the use of a Zimmer frame.

139. On **11th August** she was transferred to Daedalus Ward at the GWMH. By this stage she was fully weight bearing and walking with the assistance of two nurses and she was continent but needed total care with washing and dressing. The purpose of her admission appears to have been rehabilitation.

140. Dr Barton's note on admission was – 'Impression frail hemi-arthroplasty, not obviously in pain, please make comfortable. Transfers with hoist,

usually continent, needs help with ADL (Activities of Daily Living) Barthel 2, I am happy for nursing staff to confirm death'.

141. Professor Ford describes this note as revealing a much less proactive not to say pessimistic attitude towards this patient's rehabilitation. Dr Barton's failure to recognise the patient's rehabilitation needs may have led to subsequent sub-optimum care for this unfortunate patient. Philip Beed also says that she was, in his view, in pain from her hip but that was not recorded at the time and the notes on the 12th (p.50) specifically state that the patient did not seem to be in pain.

142. Dr Barton wrote a prescription that day (the **11th**), effectively upon the patient's admission for a variable dose of between 20-200 mgs of Diamorphine together with 20 – 80 mgs Midazolam to be administered via a syringe driver. Very fortunately none of that prescription was in fact administered at that time though the Midazolam was administered at a later stage when the patient was re-admitted to the hospital.

143. She also prescribed Oramorphine 10 mgs on the 11th which was administered on the morning of the patient's admission. That prescription Professor Ford regards as inappropriate in the circumstances and may in fact have precipitated what followed.

144. The following night on the **12th** the patient was very agitated possibly as a result of her new surroundings but potentially also as a result of the commencement of opiate analgesia and she had to be settled with a dose of haloperidol. Philip Beed describes the patient as agitated and he ascribes pain as being the cause of that agitation but he does not appear to have

made a note to that effect. The patient's daughter Lesley visited her mother on the day after her admission, ie: on the 12th and was very surprised to find that her mother was unrouseable. She remembered that up until her transfer to GWMH her mother had been enjoying three meals a day.

145. On the **13th** she was found on the floor having fallen from her chair. That fall may well have caused a dislocation of her repaired hip and it certainly appears to have caused the patient pain. Her daughter Lesley remembers this being obvious and that her mother was weeping and calling out. The staff at the GWMH at first instance seem to have thought that this was as a result of the patient's dementia.

146. The following day on the **14th** the patient was assessed by Dr Barton who noted that sedation and pain relief had been a problem and that the patient was very sensitive to Oramorph. The patient was referred to the surgeons at Haslar again having been given a small amount of Oramorph and a further operation was undertaken. Again she appears to have recovered well from that operation and to have been treated well at the Haslar (Lesley O'Brien).

147. On the **17th** August she returned to the GWMH and the transfer unfortunately appears to have been performed inappropriately. She was transferred without the use of a canvas sheet which once again may have put too much pressure on her hip causing it further damage. The decision appears to have been taken not to send her back to the Haslar Hospital again.

148. On that day Dr Barton wrote out a further prescription for a variable dose of 40-200 mgs of Diamorphine. The patient was then dosed with 40 mgs of Diamorphine but at that stage, given the patient's pain Professor Ford takes the view that although high, the dose was not unreasonable.

149. On the **18th** she was recorded by Dr Barton as being 'in great pain' and was put onto a syringe driver on the direction of Dr Barton. She was dosed with 40 mgs Diamorphine, 20 mgs Midazolam and 5 mgs Haloperidol. That dosage continued until her death.

150. The expert's view is that Midazolam which had in fact been prescribed 7 days earlier on the 11th should not have been added to the cocktail of drugs because the combination of drugs was likely to lead to respiratory depression and coma. Dr Barton's explanation in her police statement was that it was used as a muscle relaxant to assist her movement and to make her as comfortable as possible.

151. On the 21st she was recorded by Dr Barton as being 'I think more peaceful, needs Hyoscine for rattly chest' and she died later that day.

152. The focus of the charges in respect of this patient is upon the original prescription by Dr Barton back on the 11th August of Diamorphine and Midazolam before the patient had her second fall and dislocated her hip. That prescription was say the GMC unjustified and dangerous and allowed for the administration of Midazolam to the patient at the end of her life of which Professor Ford is also critical.

153. Professor Ford is most critical of that early prescription where there was little or no indication that the patient was in pain at all. In the last days of

her life there are certainly indications that the patient was in pain and did require pain relief by opiates but there is a total lack of any suggestion that the patient was in pain when she first arrived at the hospital.

154. Indeed Dr Barton, when she was interviewed by the police indicated that the patient did not appear to be in pain. Immediately prior to her arrival at GWMH the patient had not been on regular analgesics at all and had last taken two tablets of cocodamol.

155. The expert is of the opinion that it was simply inappropriate to start the patient on opiate medication before trying milder analgesics.

156. The decision immediately to prescribe subcutaneous Diamorphine, Haloperidol and Midazolam was inappropriate, reckless and placed the patient at serious risk of respiratory depression and coma if they had been administered. The administration of the Midazolam in the last days of the patient's life when added to the other drugs was unjustified and inappropriate. That administration would appear to have been upon Dr Barton's direction and it was her prescription.

Patient F - Ruby Lake (August 1998)

157. Patient F was born in Code A and was 84 when she was admitted to Royal Hospital Haslar on **5th August 1998** for treatment for a fractured neck of femur following a fall at home. She was operated upon the same day and was transferred to GWMH two weeks later on **18th August to Dryad Ward**. One of her daughters Pauline Robinson who saw her on the weekend of the **15th and 16th** describes her as being 'very lucid' and 'up-beat'. She was mobile with a Zimmer frame on transfer and could wash her top half independently but suffered from leg ulcers, angina and breathlessness. She died three days after her admission on the **21st**.

158. Her Barthel score (p.373) was 9 and so she was able to wash and feed herself but needed help getting dressed and some help with walking.

159. Dr Barton's note on admission (p.78) recorded the history of the fall and her Barthel score of 6. Her note then reads 'gentle rehabilitation. I am happy for nursing staff to confirm death'. Nurse Hallman for one was surprised when she saw that annotation in this patient's notes. The patient was started on Oramorph and 5 mgs was given to her just after lunch at 14.15. The nursing notes record that the patient had two sacral pressure sores and ulcerated legs (Barrett xp.375).

160. That night the patient became anxious and distressed and wanted someone to sit with her – she was given 10 mgs of Oramorph instead. The following day on the **19th** at 11.50 Nurse Shaw describes how she administered the patient with Oramorph oral solution 10mgs in 5 mls.

That drug is of course a pain killer. The patient was complaining of chest pains which were not radiating down her arm.

161. In Nurse Shaw's words she was just continuing the prescription which had been started the night before, she was unable to comment on the pain that the patient was suffering. That may be an indication of the regime to which nurses had become used and which therefore they pursued without much thought.

162. In her police statement Dr Barton claims that she reviewed the patient on the morning of the 19th but made no note about it. She says that she was concerned that the patient was going to die shortly and wanted to be sure she had appropriate pain relief for the pain from her fractured hip and her sores and also from her anxiety and distress.

163. Either on the **18th** or more probably on the following morning **19th** , the day after Patient F's admission, Dr Barton prescribed her a variable dose of Diamorphine at a range of 20-200 mgs and Midazolam 20-80 mgs over a 24 hour period. The prescription is undated but we know was administered on the **19th** at 16:00 by Syringe Driver at 20 mgs together with Midazolam at 20 mgs. Nurse Hallman made an entry in the notes that the patient's pain was only being relieved for short periods and she was very anxious (xp.394).

164. On the **20th** the Diamorphine was increased in the afternoon to 40 mgs. Nurse Turnbull notes that the patient was still suffering some distress when moved. Her daughter Dianne Mussell went to visit her on the 20th,

she had been a regular visitor up until that point. She noted a marked deterioration in her mother's response.

165. A day later on the **21st** those drugs were increased to 60 mgs each at 07:35. Although Dr Barton says that she may have been unaware of that increase she would in any event have approved it. The patients **death was recorded at 18.25**

166. Professor Ford is critical of all of Dr Barton's prescriptions. On the night of the 18th it is unfortunate that the response of the staff to the patient's agitation was to provide her with a dose of Morphine when she simply wanted someone to sit with her. In the alternative a dose of Temazepam would have calmed the patient.

167. The lack of clear instructions as to what the morphine was to be used for may explain why it was given for distress and anxiety when there was no indication of pain. It is not an appropriate first line treatment for stress or anxiety, indeed morphine can in fact promote or exacerbate exactly those symptoms.

168. There is no indication from Dr B why she thought it right to prescribe either the Diamorphine or the Midazolam and there appears to have been no adequate assessment of the patient. If there was an assessment there was no note made of it.

169. The patient deteriorated rapidly after the commencement of the syringe driver and there was no medical assessment as to why that was happening. It may well have been due to the sedative effects of the opiates that were

being automatically injected into her body. The reaction to the patient's deterioration was to increase the quantities of opiates she was receiving.

170. It is likely that this patient died as a result of the combined effect of the drugs in her system.

Patient G – Cunningham (September 1998)

171. Patient G was 79 years old when he was admitted to GWMH Dryad Ward on **21st September 1998** under the care of Dr Lord the Consultant to whom he was known.

172. He had been admitted to Mulberry Ward on 21st July 1998 when he was depressed and tearful, and since the 27th August he had been living in a local nursing home 'The Thalassa'.

173. He had been seen at the Dolphin Day Care Hospital by Nurse Pamela Gell where he was found to be very frail with a large necrotic sacral sore, he was depressed suffering from dementia and was diabetic. Dr Lord admitted him for treatment of his sacral ulcer, a high protein diet and Oramorph if he was in pain. Dr Lord notes that the nursing home was to keep his bed available for him to return for at least 3 weeks. His prognosis was described as being 'poor'.

174. Dr Barton saw him on the day of his admission on the **21st** and made the following note (p.647) – 'Transfer to Dryad Ward. Make comfortable, give adequate analgesia. I am happy for Nursing staff to confirm death'.

175. It appears that she prescribed Diamorphine at a variable dose of 40-200 mgs and Midazolam between 20-200 mgs on that very day. The prescription is undated (p.758) but it has to be presumed to be the 21st because he was, on the day of his admission, put onto a syringe driver delivering those opiates to him automatically. Dr Barton's explanation for her prescription (in her police statement dated 21.4.05) was that she was

concerned that the Oramorph might become inadequate in terms of pain relief.

176. The patient's step-son Charles Stewart-Farthing went to see him that day and found him to be cheerful but complaining that 'his behind was a bit sore'. He was started at a rate of 20 mgs Diamorphine and 20 mgs Midazolam on the **21**st, and according to Nurse Lloyd's notes (p.754) the other drugs he had been on Coproxamol and Senna were not given because the patient was being or about to be sedated. P.867 reveals the patient remained agitated until approximately 20.30. The notes reveal that the patient had been behaving pretty offensively However, the driver was not commenced until 23.10 that night when the patient is described as 'peaceful'. It is hard to glean therefore from the notes what caused the commencement of the syringe driver. Nurse Lloyd states that although the patient was peaceful, it was not certain that he would remain that way.

177. On the **23**rd that medication was increased to 20 mgs Diamorphine and 60 mgs Midazolam. A note (p.868) by Nurse Hallman records that he was seen by Dr Barton on the 23rd, he had been chesty overnight and so Hyoscine was added to the driver. His stepson was informed of a deterioration and asked if it was due to the commencement of the driver. He was informed that the patient was on a small dosage which he needed. Charles Stewart Farthing saw his step-father again that day and was shocked at the difference in his condition. He found his step-father to be unconscious. He was so concerned that he asked for the syringe driver to be stopped so that he could have a conversation with the patient but this was denied.

178. He insisted on a meeting with Dr Barton who informed him that the patient was dying due to his bedsores and that it was too late to interrupt the administration of the drugs. Dr Barton claims that she reassessed the patient on a daily basis but failed to make any notes about it. She refers to the doses the patient received as 'small and necessary'.

179. On the **24th** the Midazolam was increased to 80mgs and on the **25th** the Diamorphine was increased to 60 mgs. That followed a further prescription from Dr Barton dated the **25th** for a variable dose between 40-200 mgs Diamorphine and 20-200 mgs of Midazolam. On each occasion that the dose was increased Dr Barton claims in her police statement that she 'anticipates' (as she puts it) 'that the patient's agitation might have been increasing'.

180. The following day the **26th** , the Diamorphine was delivered to the patient's body at a rate of 80 mgs and the Midazolam at a rate of 100 mgs. The patient died that day at 23:15 of broncho-pneumonia.

181. The first prescriptions on the day of his admission by Dr Barton are described by Professor Ford as 'highly inappropriate' and 'reckless' particularly in light of Dr Lord's assessment that he should be prescribed intermittent Oramorphine if in pain (PRN). There is no doubt that the patient would have been in pain from his sacral sore but there was no indication that the patient would not be able to take any medication for his pain orally if he needed to.

182. The prescription written by Dr Barton which allowed the nurses to administer the Diamorphine and Midazolam was undated but must have

been written on the day of admission and was for a dose range of between 20-200 mgs Diamorphine, and 20-80 Midazolam. It was poor management to prescribe those drugs to an elderly frail underweight patient and it created the hazard that the combination of drugs could result in profound respiratory depression

183. The increases on the **23rd** and thereafter are described as inappropriate and dangerous by Professor Ford who also expresses the concern as to whether the nursing staff would have understood how long it takes for the opiates delivered through a syringe driver to take full effect which in this case would have been between 15 and 25 hours (para 3.11). The result of this would have been that they were increasing the doses before the earlier dose had a chance to be fully effective.

184. As his condition worsened, in all likelihood as a result of the drugs which were being administered to him, there was no reassessment to discover the cause.

185. The various dose increases without explanation is described as very poor practice. Even if that was being done independently by the nurses, Dr Barton had created the situation where that had become possible.

186. The administration of 100 mgs Midazolam and 80 mgs Diamorphine would produce respiratory depression and severe depression of the consciousness level.

187. In addition to all of this there is no note that the patient was provided with food or fluid during the period following his admission until his death five

days later and that is despite the note from Dr Lord that the patient was to be provided with a high protein diet.

188. The cause of death was bronchopneumonia which can occur as a secondary complication to opiate induced respiratory depression.

Patient H – Robert Wilson (October 1998)

189. Patient H was 75 years old when he was admitted to Queen Alexandra Hospital on **21st September 1998**. He had sustained a fracture of his humerus bone following a fall. Whilst at the QAH he was given relatively small doses of morphine for pain. On assessment his Barthel score was 5.

190. On 7th October it was noted that he did not want to go into care but wanted to return home. He was seen by Dr Luznat who was a consultant in old age psychiatry and she noted Code A during the previous 5 years. She thought he may have developed early dementia.

191. On **13th October** he was assessed by his consultant physician Dr Ravindrane who found that he needed both nursing and medical care and that a short spell in long-term NHS care would be appropriate. Dr Ravindrane felt that he would remain at risk of falling until fully mobilised and he thought that the patient's kidney function should be reviewed. He prescribed his patient Frusemide which is a diuretic and Paracetamol for pain relief. The patient could, according to the doctor, have stabilised or alternatively died quite quickly.

192. The patient was visited that day by his son Iain (Wilson) who remembers him on the **13th**, the day before his transfer to GWMH, sitting up in bed and having a joke.

193. On his discharge from the QAH he was taking Paracetamol and Codeine as required for pain but he had only required four doses of codeine over the five days prior to his transfer. He was a heavy man weighing 93 Kilos.

194. On the **14th October** he was transferred to Dryad Ward for continuing care and Dr Barton noted on his admission that he needed help with his daily living activities, his Barthel score was 7, and he lived normally with his wife. He was continent and the plan was for further mobilisation. She also noted that he had alcohol problems. He also had congestive cardiac failure.

195. Professor Ford has noted that there was no record of any symptomatic medical problem at that time (para 5.8 police report). His blood pressure was not taken nor was there any clinical examination. It is important to note that this patient was not admitted for palliative care but for rehabilitation.

196. His wife Gillian Kimbley saw him on the day of his transfer to GWMH and indeed travelled with him in a minibus which was used for the transfer. She remembers him being lucid that day and able to hold a conversation.

197. The nursing note at GWMH on the **14th** recorded that the patient had a long history of drinking and LVF (Left Ventrical failure) and chronic oedematous legs.

198. On the day of his admission into the GWMH (**14th**) Dr Barton prescribed him Oramorph 10 mgs in 5 mils, 2.5-5 mls 4 – hourly despite the fact that in the days leading up to his transfer he had only been on Codeine for pain relief.

199. That prescription for Oramorph was administered twice that day, once in the afternoon at 14.45 and again in the evening at 22.45.

200. The following day **15th** he was administered 10 mgs in 5mls every four hours. That was given according to the nursing notes because he was complaining of pain in his left arm. Up until the stage of his admission to GWMH his pain had been controlled by Codeine and Professor Ford regards that very first prescription of morphine to have been inappropriate. His son Iain saw him that day and describes how his father was in 'an almost paralysed state'.

201. On the **16th** he was seen by Dr Knapman who noted that the patient had deteriorated overnight and he was for active nursing care. His son Iain describes him as being almost in a coma and unable to speak.

202. Later on the **16th** it was noted by Nurse Hallman that his chest was very bubbly and a syringe driver was commenced with 20 mgs Diamorphine and 400 mcgs Hyoscine. That was on the basis of a prescription written by Dr Barton which may have been written, according to Dr Barton, on the day of admission for a variable dose of Diamorphine between 20 and 200 mgs over a 24 hour period by syringe driver. That was, according to her police statement, one of Dr Barton's 'proactive' prescriptions for pain relief.

203. There appears to have been no re-examination by Dr Barton prior to that prescription being administered by the nurses. Indeed from her police statement it appears that she was away that day. It is quite possible according to Professor Ford that the Morphine the patient had been receiving was the cause of his deterioration.

204. On the following day, the **17th**, his secretions had increased and so the Hyoscine was also increased (Florio). In the afternoon the dosage of Diamorphine was increased to 40 mgs and Midazolam was started at 20 mgs. The date of Dr Barton's prescription for Midazolam at a variable dose between 20-80 mgs is unclear but it must have been on or before the 17th being the date it was administered. Hyoscine which was the drug used to dry up secretions was also increased. There was no record made of the reason for starting the Midazolam and at the time the notes suggest that the patient was in fact comfortable. Professor Ford views the use of Midazolam in these circumstances to have been highly inappropriate (para 5.15).

205. No consideration appears to have been given by Dr Barton or by the nursing staff to the real possibility that the reason for the patient's deterioration may well have been the infusion of the cocktail of opiates which he was receiving automatically through a syringe driver. The prescription of continuous subcutaneous Diamorphine is not an appropriate treatment for a diagnosis of myocardial infarction and heart failure in a patient who is otherwise pain free.

206. A particular issue with this patient was his previous chronic alcoholism which had been noted by staff and appears to have been known to Dr Barton. The use of opioids in patients with liver disease as a result of alcoholism has to be very carefully monitored and preferably not used unless required to deal with severe pain. If he was in pain then a low dose of morphine would have been a more appropriate response.

207. On the night of the **17th and into the morning of the 18th** that dosage was continued but in the afternoon of the **18th** it was increased again from 40 to 60 mgs Diamorphine and from 20 to 40 mgs of Midazolam. During none of this period was there any note made by either nurses or doctors that the patient was in pain though there were many notes that the patient was deteriorating.

208. At 23:40 on the night of the **18th** the patient's death was recorded four days after he entered that ward at GWMH. It was recorded that he had died from congestive heart failure. Professor Ford is of the view that the cocktail of drugs is highly likely to have led to respiratory depression and or bronchopneumonia.

Patient I – Enid Spurgin (March 1999)

209. Patient I was 92 when she was admitted to the Royal Haslar on **19th March** 1999 following a fall in which she had broken her hip. Prior to her fall she had been living at home and caring for herself. According to her medical notes she had been active and in good health. The fracture is described by an Orthopaedic surgeon Daniel Redfearn who has examined her notes, and was instructed by the police as an expert in her case, as a 'relatively complicated one'.

210. At the Haslar she had initially been given 3 doses of 5 mgs Morphine over the 20th and 21st March which had resulted in Hallucinations and so a note was made by the anaesthetist – nil further opiates. She was operated upon on the **20th** a right dynamic hip screw inserted. The only other analgesic prescribed for her was paracetamol (Redfearn).

211. She appears to have had post operative complications by way of bleeding, a haematoma developed and she had a painful hip.

212. Dr Reid reviewed her on the 23rd March and noted that she was still in a lot of pain and that was proving a barrier to mobilisation.

213. She was transferred that day **26th March** to GWMH Dryad Ward. Prior to transfer she was mobile and walking short distances with a Zimmer Frame and two nurses. She was continent during the day but not at night and her only analgesia was paracetamol. [Her nephew Carl Jewell who visited her at the Haslar fully expected his Aunt to be discharged from the GWMH and returned to her home].

214. Dr Barton made a note on admission (p.27) of her transfer to Dryad Ward '…PMH nil of significance, Barthel, not weight bearing, tissue paper skin, not continent, plan sort out analgesia'.

215. Dr Barton prescribed her Oramorph on the day of her admission 10mgs in 5 mls 2.5 mgs 4 times a day. A note (p.106 and see Tubbritt) asserts that the patient had complained a lot of pain. Oral morphine was administered on the **26th, 27th and 28th March** and then discontinued because the patient was vomiting it. She was given codydromol as an alternative (Barrett and Lloyd).

216. On the 27th, although it was a Saturday, Dr Barton believes she reassessed the patient although if she did she made no note, and she increased the prescription for Oramorph to 10 mls 4 times a day with 20 mls at night.

217. The care plan records that the patient was experiencing pain on movement (p.84).

218. If pain was uncontrolled by less powerful analgesics then those prescriptions were appropriate, according to Professor Ford. However, there is no note from Dr Barton recording her assessment or her reasons for prescribing as she did. The patient should not have been in severe pain unless something had gone wrong with the hip repair which would have required re-assessment.

219. The fact that Dr Barton has recorded that the patient was not weight bearing is not consistent with the notes made at the Royal Haslar and is either inaccurate or indicates that there had been a change in the patient's mobility. That should have triggered a re-assessment which does not

appear to have taken place. A nursing note (p86) reveals that on the 4th April the wound was oozing serous fluid and blood and the wound was redressed.

220. On the 31st March Dr Barton has prescribed 10mgs of Morphine Sulphate to be given twice a day. There is no note of any review by her.

221. [The patient's nephew Carl remembers visiting her on about the 1st April when she was still talking about leaving the hospital. His impression was that she was very rarely seeing a doctor].

222. On the **6th April** Dr Reid suggested that there may have been a problem with the hip screw and requested that an X-ray be arranged. Unfortunately that was never actioned. That day, Dr Barton increased the dose of Morphine by slow release tablets to 20 mgs twice daily. In her police statement she reveals that she would have seen the patient that morning but made no note about it.

223. A note by Nurse Shaw (p.106?) of that consultation with Dr Barton reveals that Enid has been incontinent a few times but was insistent about not going into a care home. There was in that note no mention of pain. Those doses were administered until the **11th** April.

224. By the **11th** April the patient was very drowsy but still in pain if moved.

225. On the **12th** April Dr Barton prescribed Diamorphine by syringe driver at a variable dose between 20-200 mgs over a 24 hour period as well as 20-80 mgs of Midazolam. There is no note of any further assessment by Dr Barton on the 12th.

226. Those prescriptions are described by Professor Ford as 'reckless and inappropriate'. The patient was already described as 'very drowsy' and any dose over about 30 mgs sub-cut would be highly likely to produce coma and respiratory depression.

227. In fact the dose administered by Nurse Shaw, apparently either on her own calculation or under Dr Barton's direction on **12th April,** was 80 mgs Diamorphine together with 30 mgs Midazolam. Those doses were well within the variable dose that Dr Barton had prescribed but in fact were much higher than the dose of Morphine that the patient was already receiving and extremely dangerous. Nurse Lynne Barrett could not explain why the patient was prescribed such a large dose and she in fact thought that the dose was only 60 mgs.

228. When Dr Reid noticed that the patient was receiving 80 mgs of Diamorphine he reduced it down to 40 mgs (p.108 and Barrett) however the patient died the following day. In Professor Ford's view the drugs she was being administered were a direct contributor to the patient's death.

229. Mr Redfearn the orthopaedic expert raises concerns in relation to the lack of response to the patient's pain which should have prompted the doctors to look for a possible orthopaedic explanation for her symptoms. This was never done.

230. The charges reflect on this occasion specifically the lack of assessment by Dr Barton given the patient's condition on entry onto the ward. Criticism is also made of the prescriptions written by Dr Barton on the 12th and the direction to administer such a high dose on the same day.

Patient J – Geoffrey Packman (August 1999)

231. Patient J was born in Code A and he was 67 years old when admitted to Dryad Ward on 23rd August 1999. He was suffering from bi-lateral leg oedema (swelling) and venous hypertension. He was very obese, suffered from atrial fibrillation and had poor mobility. He had a poor Barthel score. He was not a well man.

232. Some weeks earlier he had suffered an accident in his bathroom at home. He was admitted to A&E on the **6th** August to Anne Ward at the Queen Alexandra Hospital. On the 8th August it was noted that he had very severe sores on his sacral area. The annotation was made in his notes on two occasions – "not for 555" meaning that he was not to be given resuscitation in the event of a life threatening event.

233. Eventually, according to his wife Betty, he made a good recovery and looked better than he had for years.

234. He was, on the **23rd August, transferred to Dryad Ward** for recuperation and rehabilitation.

235. When he was assessed on Dryad Ward by Dr Ravindrane on the **23rd** the problems recorded were: obesity, arthritis in both knees, pressure sores. His mental test score was however good there being no significant cognitive impairment. His Barthel score had by now improved to 6. Nurse Hallman however remembers this patient as having the worst pressure sores she had ever seen.

236. Dr Barton believes, according to her police statement about this patient, that she must have reviewed him on the morning of the **24th** but made no

note about it. On the **24th** August a drug called Clexane was prescribed which he received to reduce the risk of a DVT as well as Temazepam

237. On the **25th** August he was vomiting and passing fresh blood. Again there is no note of any review by Dr Barton though she thinks she performed one. The notes reveal that when it was noted that the patient was passing fresh blood through his rectum Dr Beasley was contacted and directed that Clexane which was an anti-clotting agent should be stopped.

238. His wife Betty recalls visiting him with friends on around the 25th or 26th and meeting Dr Barton for the first time. Dr Barton took her into a room and told her bluntly that her husband was going to die and she should look after herself now. Betty was very shocked and surprised.

239. On **26th** August Dr Barton made this note – 'called to see. Pale clammy unwell. Suggests ?MI (Myocardial Infarction) treat stat Diamorph, and Oramorph overnight. Alternative possibility GI (gastrointestinal) bleed but no haematemesis (vomiting of blood). Not well enough to transfer to an acute unit, keep comfortable. I am happy for nursing staff to confirm death.'

240. No note of pulse, blood pressure or any other indications of a clinical examination are present.

241. However on that day (Thursday **26th)** Dr Barton appears to have given a verbal order to give Diamorphine intra muscularly which was injected that day. She also prescribed Oramorph 10 mgs in 5 mls 4 times a day which was administered daily thereafter from the 27th August until the syringe driver was commenced on the 30th August. There is also an undated

prescription written by Dr Barton for a variable dose of Diamorphine of between 40-200 mgs and Midazolam of 20-80 mgs. Dr Barton says in her police statement that she wrote that prescription out on the **26th** and that may well be right. Dr Barton says however that she had no intention that it should be administered at that time.

242. The following day, on Friday **27th** , the patient is noted to be in discomfort particularly when his dressings were changed. Dr Barton claims she would have reviewed him but made no note of it.

243. The syringe driver was commenced on Monday the **30th** August which was a Bank Holiday, with Diamorphine at a rate of 40mgs and Midazolam at 20 mgs. There is no note from Dr Barton about that and she is not sure if she would have gone in on a bank Holiday. It seems therefore that the syringe driver was started at the discretion of the nurses as was the amount of opiate to be administered within the range set by Dr Barton and at the lowest dose. Dr Barton believes the nurses would have spoken to her but there is no note of that recorded.

244. Those same doses were administered on the **31st August** when it was also noted that he had passed a large amount of black faeces which was an indication of a significant gastro-intestinal bleed.

245. On the **1st September** the Diamorphine was increased to 60 mgs and the Midazolam to 40 and then 60 mgs on the same day and then the following day they were increased again.

246. On the 1st Betty visited him and he did not wake up throughout the visit. His daughter Victoria remembers that her Dad deteriorated once he was in

the GWMH and that he appeared to be 'spaced out'. She describes the change as 'dramatic'.

247. On the 2nd **September** the Diamorphine was increased to 90 mgs and the Midazolam was increased to 80 mgs in a 24 hour period. Jeanette Florio (nurse) says that she could not imagine such an increase taking place without the authority of a doctor. Dr Barton says that she would have reviewed the patient but made no note of it. She says this – "I anticipate again that (the patient) would have been experiencing pain and distress". If that is so it is very surprising that no note has been made about it.

248. The patient's daughter Victoria sat with him throughout the 2nd. He was unconscious throughout the day.

249. The patient **died on the 3rd September** at 13.50.

250. In Professor Ford's opinion the patient's death from a massive gastrointestinal bleed was contributed to by the Clexane he was prescribed on the 24th August although it was stopped the following day, and possibly by the opiate induced respiratory depression. He was not dying nor expected to die prior to his deterioration on Dryad Ward on the 26th August. He had pressure sores but those were treatable. He had been transferred for recuperation and rehabilitation. Before deciding that the patient should not be transferred to an acute unit, which Dr Barton did on the 26th, she should have had further discussion with a senior consultant colleague.

251. Her assessment of the patient was inadequate and her verbal order to administer Diamorphine was inappropriate.

252. There is no proper explanation for the doses of subcutaneous Diamorphine or Midazolam that she prescribed and no explanation for the dramatic increase in quantities of those drugs being administered.

253. The dose ranges were inappropriate and hazardous and unjustified by an assessment of the patient's condition.

Patient K – Elsie Devine (October 1999)

254. Patient K was an 88 year old lady when she was admitted on 9th October 1999 to the Queen Alexandra hospital with an episode of acute confusion. Her problems are summarised by the letter at xp.29 and 30 by Dr Taylor a clinical assistant in old age psychiatry.

255. She was confused, disorientated and sometimes aggressive. She had a medical history of treated hypothyroidism and chronic renal failure. She was independent and able to wash but tended to get herself lost.

256. She was transferred to GWMH on the **21st October 1999**. The referral letter (p.21) written by Dr Jay a consultant geriatrician who saw her on the 19th stated – that she was alert and could stand but was unsteady on walking. She was increasingly confused and had been aggressive until she got to know the staff.

257. Dr Barton's note on admission on the **21st** stated that she was for continuing care. That she needed help with all her daily living needs and she had a Barthel score of 8. 'Plan get to know. Assess rehab potential probably for rest home in due course'.

258. On the **25th October** and **1st November** there are entries by Dr Reid indicating that the patient was continent but mildly confused and wandering during the day, she was suffering from renal failure, but was physically independent although she needed help with bathing.

259. Two weeks later on Monday the **15th** November there is a note that she had been aggressive at times and needed Thioridazine to calm her down. Lynne Barrett was one of the nurses who helped to look after her and she

recalls a specific aggressive incident when the patient grabbed a nurse and would not let go and kicked out at Ms Barrett.

260. Dr Reid saw her on his ward round that day but that was the last time he saw her. He noted that there was not a single entry on her clinical notes since the last time he had seen her two weeks before. He made a full examination of her. Her heart, chest, bowels and liver were all normal. Her legs were however badly swollen. He wanted the patient to be seen by Dr Luznat the psychiatrist and made a note to that effect.

261. On the **18th** the patient was seen by Dr Taylor one of Dr Luznat's team (Consultant Old age Psychiatry) and arrangements were being made to transfer her to an old age psychiatry ward for assessment and management.

262. However, that same day she was confused and aggressive (18th) and Dr Barton prescribed a Fentanyl patch for the patient. Fentanyl is an opiate which is applied to the skin on a patch. There was no indication in the notes as to why Dr Barton thought it appropriate to start the patient on opiates and there is no reference anywhere in the notes to this patient being in pain. Dr Barton in her statement to the police about this patient stated that the patch was 'an attempt to calm her, to make her more comfortable and to enable nursing care'. The patch was applied at 09:15 on the 18th and can take up to 24 hours before it becomes fully effective (Reid) and remains in the system for between 12 and 24 hours after the patch itself is removed (Reid).

263. A note made by Dr Barton on the **19th** indicates that there had been a marked deterioration overnight.

264. Dr Barton wrote on the **19th** – 'today further deterioration in general condition. Needs SC analgesia with Midazolam. Son aware of condition and prognosis. Please keep comfortable. I am happy for nursing staff to confirm death'. Dr Barton prescribed that day Diamorphine 40-80 mgs and Midazolam 40-80 mgs.

265. In addition at 08:30 the patient was given an injection of Chlorpromazine 50 mgs prescribed by Dr Barton following an incident in which the patient is suggested to have been aggressive with nurses. This is a tranquiliser and 50 mgs is according to Dr Reid at the upper end of the normal range of dosage. An hour later a syringe driver was started by the nurses that day (**19th**) at 09:25 containing 40 mgs of Diamorphine and 40 mgs of Midazolam. The Fentanyl patch was not removed until 3 hours later at 12:30 according to the notes. There is no record anywhere in the notes that the patient was at any time in pain. At this stage therefore on this Friday morning this patient had in her system, Fentanyl, Chlorpromazine, Diamorphine and Midazolam.

266. It is very difficult to understand why anyone would have thought it appropriate to start this patient on anything less that the minimum dose of 20 mgs Midazolam even if the patient was complaining of pain, which she wasn't.

267. The syringe driver was kept replenished for the next two days at those dosages. Dr Barton wrote in her police statement – 'this medication (Diamorphine and Midazolam) was prescribed at 09.25 and was administered with the sole intention of relieving (the patient's) significant distress, anxiety and agitation which were clearly very upsetting for her'.

268. Dr Barton again says that she had been making daily weekday reviews of this patient but accepts that she failed to make a note of any of them and that she 'relied greatly on daily reports from the nurse in charge and their nursing note entries'.

269. The patient **died** two days later on the **21st November.**

270. Dealing with the Diamorphine and Midazolam prescription on the 19th Professor Ford can not see the justification for it. Even if the patient had been in pain, for which there is no evidence, the starting doses were excessively high. An appropriate starting dose might have been 10 or 20 mgs if the patient was in pain but not double that and not when coupled with Midazolam.

271. Neither in Professor Ford's view was the Fentanyl justified. This regime of opiate medication has every appearance of being given to keep the patient quiet which would not be an appropriate use of opiates in this setting.

272. The drugs administered are very likely to have led to respiratory depression and coma.

Patient L – Jean Stevens (May 1999)

273. Patient L was 73 years old when admitted to Royal Haslar Hospital on 26th April 1999 after experiencing chest pains and collapsing.

274. She was found to have suffered a stroke as a result of a cerebral infarction in the right parietal lobe. She was looked after for several weeks and made a substantial recovery. [She was seen on the 19th May by her daughter June Bailey and was in good spirits, laughing and joking].

275. On 20th May she was transferred to Daedalus Ward but she was according to records in a very poorly condition and died two days later.

276. The criticism by the GMC of Dr Barton's care of this patient hinges around her immediate prescription upon entry onto the ward on the **20th** of Oramorphine, Diamorphine, and Midazolam in the usual very large variable ranges. This is not a case where this unfortunate patient was likely to recover or leave the hospital.

277. The only note by Dr Barton was on (Vol 3, p.20). The 2nd note was by nurse Tubritt recording death on the 22nd. According to her husband (Mr Stevens), Dr Barton did not in fact see her at all during her short stay at GWMH.

278. A nursing note on the **21st** recorded a conversation with her husband indicating that he was anxious that medications should not be given which might shorten her life.

279. The syringe driver was started on **21st** with 20 mgs Diamorphine and 20 mgs Midazolam.

280. Dr Barton's entry makes no mention of the patient being in any pain and contains no record of any physical examination of the patient. In Professor Ford's expert opinion there is no evidence that Dr Barton undertook a clinical assessment of this patient. Although the patient had previously complained of chronic abdominal pain, treatment with opiates would not have been appropriate.

281. In addition the dose ranges were far too wide and the dose of Midazolam excessively high.

CONCLUSION

282. As already indicated, Professor Ford is very critical of the quality of Dr Barton's note making. She failed to note assessments of the patients' condition if she was making them, she failed to make notes about important decisions relating to treatment and prescribing. She made few if any notes about why she regularly increased the dosages of her prescriptions.

283. Failing to make appropriate notes in relation to assessments in admission to the hospital is particularly serious because it leaves other treating medical personnel in the dark about what the baseline condition of the patient was upon admission and it left her with no notes that she could rely upon to assess properly whether the patient's condition had improved or worsened.

284. In view of the complete lack of note making it has to be inferred that no assessments were being performed properly before opiates were prescribed. The prescription of very large doses of opiates appears to have become a matter of course in the GWMH and the patient's best interests were not served as a result.

285. The prescribing by Dr Barton was, on occasion, dangerous and inappropriate and left far too much to the discretion of the nurses.

286. Patients were overdosed with opiates so much so as to become unresponsive.

BURDEN AND STANDARD OF PROOF

287. The burden of proving the charges is upon the GMC and the standard of proof in this case which is heard under the old rules is the criminal standard. In other words, before finding any of the heads of charge which have not been admitted, proved, the Panel would have to be sure that Dr Barton had acted in the way alleged.

A) WITNESS SCHEDULE AND EXPLANATION

B) PATIENT NOTES AND CHONOLOGIES

C) PROFESSOR FORD'S REPORTS

Tom Kark

QEB Hollis Whiteman Chambers

Temple, London EC4Y 9BS 4th June 2009

EVERSHEDS VIEWS	Patient Name	Relative(s)	Contact Form Returned	Rule 6 2002	Class 3 After Police Investigation	Expert Name	Date of Expert Report	Has Dr Barton made a statement	Comments	DATE.	POOR RECORD KEEPING. LACK OF CLEAR RECORDS	INADEQUATE ASSESSMENT OF PATIENT	EXCESSIVE DOSE DIAMORPHINE	SUBCUTANEOUS / SYRINGE DRIVER NOT JUSTIFIED	EXCESSIVE DOSE MIDAZOLAM	OTHER DRUGS EXCESSIVE / INAPPROPRIATE		NATURE OF ADMISSION.
need more?	Eva Page	Son - Mr Bernard Page		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01	No	?	27/2/98 (5) died 3/3/98	LACK OF REASONS.	?	✓	✓	?			LUNG CANCER FOR PALLIATIVE CARE
need [illegible]?	Alicie Wilkie	Daughter - Mrs M Jackson		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01	No	Poss witness: DR LORD	6/8/98 (6) died 21/8/98 *	✓	?	✓	✓	?	HYOSCINE INAPPRO.		OBSERVATION → PLACEMENT DEMENTIA / UTI
*	Gladys Richards	Daughter - Ms Gillian McKenzie	Yes	Yes		Professor G A Ford ✓Professor Brian Livesley "death occured sooner than would have done"	12.12.01 10.07.01	Statement to Police	Poss witnesses: ? MACKENZIE, ? LACK (daughter), DR REID, DR LORD NURSE BREWER	11/8/98 (7) died 21/8/98 *	✓	?	✓	✓	✓	HALOPERIDOL		FOR REHAB FRACTURED FEMUR
concern? ↓ don't [illegible]	Arthur Cunningham	Stepson - Mr Charles Farthing	Yes	Yes	Yes	Dr Andrew Wilcock "others may have allowed [illegible] course" Dr K MUNDY ?? BLACK – only concern [illegible] PROFESSOR FORD.	DRAFT 27.09.05 18.10.01 12.2.01	1 Interview Personal Statement	Poss witnesses: DR LORD, NURSING STAFF	21/9/98 (8) died 26/9/98	✓	✓	✓	? ✓	? ✓			TREATMENT OF SORE + HIGH PROTEIN DIET PROGNOSIS POOR BUT PLACE ON A N/H BLACK SAYS TERMINAL
**.	Robert Wilson	Son - Mr Robert Logan Son - Mr I Wilson		Yes	Yes	Dr Andrew Wilcock Professor R Baker ? DR MARSHALL? Dr K MUNDY – says appropriate Professor FORD BLACK.	DRAFT 21.06.06 DRAFT Feb 06 18.10.01 12.12.01	1 Interview Personal Statement	Poss witnesses: Dr LORD, DR LUZNAT, MRS WILSON? 2nd wife ? NURSE HALLMAN ? NURSES? ? IAN WILSON ? HAMLIN	14/10/98 (9) died 18/10/98	✓	✓	✓	✓	✓	CRAMORPH.		HEART FAILURE + KIDNEY FAILURE FOR PALLIATIVE CARE ?
*	Leslie Pittock	Daughter - Mrs L Wiles			Yes	Dr Andrew Wilcock Dr Andrew Wilcock ?? BLACK.	25.04.05 26.04.05	1 Interview Personal Statement	Poss witness: DR LORD. ? DR TANDY? FOR EVERSHEDS ? NURSE HAMBLIN. ? TANDY CULPABLE	5/1/96 (1) died 24/1/96	✓	✓	✓	✓	?	SERTALINE DISCONT SUDDENLY		FOR PALLIATIVE CARE DEPRESSION CHEST + URINARY INFECTION
* •	Elsie Lavender	Son - Mr A Lavender			Yes	Dr Andrew Wilcock [illegible] ??. BLACK.	01.03.05	1 Interview Personal Statement	Poss witnesses: ? DR TANDY. ? PHYSIO	22/2/96 (2) died 6/3/96	✓	✓	✓	?	✓		UTI + KIDNEYS NO ACTION.	~~FOR PALLIATIVE CARE~~? UTI ? STROKE + FALL SON THOUGHT DOING WELL. BLACK – ? TER[illegible]
↓	Ruby Lake	Daughter - Mrs D Mussell Daughter - Mrs M Woodford Daughter - Mrs Pauline Robinson *	Yes		Yes	Dr Andrew Wilcock Dr Andrew Wilcock ?? BLACK.	DRAFT 10.07.05 re Barton statement → 05.09.05	1 Interview Personal Statement	Poss witness: [Someone from QA.] nursing staff? Dr LORD ?? Physio? HALLMAN.? ? BARRETT – dyin[illegible]. ? daughter	18/8/98 (4) died 21/8/98	✓	✓	✓	✓	✓		FAILED TO ASSESS CHEST PAIN.	FRAIL BUT NOT DET. FRACTURED HIP INDEPENDENT
** •	Enid Spurgin	Nephew - Mr Carl Jewell	Yes		Yes	Dr Andrew Wilcock ?? BLACK. ? REPORT OF REDFERN?	DRAFT 05.03.06	1 Interview Personal Statement	Poss witnesses: SCOTT (CONSULTANT) NEPHEW (MR JEWELL) REID criticised criticised	26/3/99 (10) died 15/4/99	✓	✓	✓	✓	✓		FAILED TO INVEST ? SEPTICAEMIA	~~UNCLEAR IF TERMINAL~~ HIP FRACTURE → INFECTION. ? UTI.
↓ ? don't [illegible]	Elsie Devine	Daughter - Mrs Ann Reeves			Yes	✓Dr Andrew Wilcock Dr C R K Dudley ? BLACK ↑says appropriate	10.12.04 20.03.05	3 Interviews Personal Statement Statement to Police	Poss witnesses: REEVES, DR TAYLOR, DR STEVENS, DR CRANFIELD, DR JAYAWARDENA + DR REID? [* WAS HEALTH AUTHORITY REVIEW. +VE FOR BARTON]	21/10/99 (13) died 21/11/99 (x)	✓	✓	✓	?	✓	FENTANYL TRANS. PATCH. CHLORPROMAZINE		UNCLEAR IF TERMINAL CONFUSION / DEMENSIA. [illegible] AGREE WEAK.
↓	Helena Service	Nephew - Mr Alexander Tuffey	Yes		Yes	Dr Andrew Wilcock BLACK – opiates appropriate ? DR PETCH ? – says appropriate	DRAFT 19.06.06	1 Interview Personal Statement	Poss witnesses: DR ASBIBAL, DR MILLER	3/6/97 (3) died 5/6/97.	✓	✓	✓	✓	✓			UNCLEAR IF DYING. AGREE WEAK.
↓	Sheila Gregory	Granddaughter- Pauline Gregory Granddaughter - Ms T Jackson	Yes		Yes	Dr Andrew Wilcock ? very brief	DRAFT OVERVIEW 22.12.05	1 Interview Personal Statement	Poss witnesses: DR TANDY, DR REID. ← says terminal ↑ not [illegible] GREGORY.	3/9/99 (12) died 21/11/99 (x)	✓	?	✓	✓	✓	CRAMORPH.		FRACTURE HIP + PAIN IN WRIST AGREE WEAK
** •	Geoffrey Packman	Wife - Mrs Betty Packman	Yes		Yes	Dr Andrew Wilcock BLACK MARSHALL	DRAFT 28.03.06	10 Interviews Personal Statement	Poss witnesses: DR TANDY, DR REID ? EVERSHEDS OTHER CULPABILITY. [RAVIDRANE]	23/8/99 (11) died 3/9/99	✓	✓	✓	?	✓	ORAL MORPHINE	TRANSFER FOR GI BLEED?.	FOR REHAB OBESITY / MOBILITY / SWELLING / FALL
	Jean Stevens	Husband - Mr Ernest Stevens	Yes															
	Enda Purnell	Son - Mr Michael Wilson	Yes															

chronological order		Dates of Admission and Death	Contact Form Returned	Rule 6 2002	Class 3 After Police Investigation	Expert Name	Date of Expert Report	
5	Eva Page	27/02/1998 03/03/1998 4 days		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01	opiod analgesai inappropriate not clear why started opiates, poor practise may have contributed to death
6	Alicie Wilkie	06/08/1998 21/08/1998 15 days		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01	opiates not indicated, dose excessive poor practice, potentially hazardous, inappropriate
7	Gladys Richards	11/08/1998 21/08/1998 10 days	Yes	Yes		Professor G A Ford Professor Brian Livesley Professor Black	12.12.01 10.07.01 24.7.05	concerned re record keeping death occurred earlier than it would have done poor record keeping and anticipatory prescription of opioid analgesia (high dose) - drugs be linked to fall
8	Arthur Cunningham	21/09/1998 26/09/1998 5 days	Yes	Yes	Yes	Dr Andrew Wilcock Dr K Mundy Professor Black Professor G A Ford	27.09.05 18.10.01 11.7.05 12.12.01	draft report - excessive dose of diamorphine, lack of adequate assessment no reason for syringe driver unusually high dose no attempt to try less potent drug terminal care managed appropriately poor practice, potentially hazardous, highly inappropriate
9	Robert Wilson	14/10/1998 18/10/1998 10 days		Yes	Yes	Dr Andrew Wilcock Professor R Baker Dr K Mundy Professor G A Ford Professor Black Dr Marshall	21.05.06 Feb-06 18.01.01 12.12.01 19.11.05 28.04.06	diamorphine trebled over 48 hours but ? Involvement of other doctors might have lived if no commenced on opiates Palliative care was APPROPRIATE oramorph/diamorphine/hyosine inappropriate poor documentation; strong opioids written up - negligent, unnecessary and inappropriate in terminal phase - morphine likely to have hastened death
1	Leslie Pittock	05/01/1996 24/01/1996 19 days			Yes	Dr Andrew Wilcock Dr Andrew Wilcock Professor Black	25.04.05 26.04.05 31.1.5	critical of documentation, inadequate assessment, excessive dose, sertraline should not be stopped critical of documentation; higher than usual diamorph; symtomatic approach appropriate
2	Elsie Lavender	22/02/1996 06/03/1996 12 days			Yes	Dr Andrew Wilcock Dr Gillespie Professor Black	01.05.05	lack of proper assessment assessed x-rays cannot comment on most questions asked lack of proper assessment but probably in terminal phase
4	Ruby Lake	18/08/1998 21/08/1998 3 days	Yes		Yes	Dr Andrew Wilcock Dr Andrew Wilcock Professor Black	10.07.05 05.09.05 29.08.05	poor record keeping and inappropriate use of medication poor dox, combination of drugs contributed to death
10	Enid Spurgin	26/03/1999 15/04/1999 20 days	Yes		Yes	Dr Andrew Wilcock Professor Black Dr Redfern	05.03.06	lack of proper assessment/investigation lack of proper assessment; poor records; high dose diamorphine should consider other pain relief further investigation was required; increasing analgesia meant doctors did not consider causes
13	Elsie Devine	21/10/1999 21/11/1999 31 days			Yes	Dr Andrew Wilcock Dr C R K Dudley Professor Black	10.12.04 20.03.05 4.1.5	critical of records and treatment treated APPROPRIATELY in terminal phase of illness critical of documentation; mistaken myeloma, drugs suboptimal
3	Helena Service	03/06/1997 05/06/1997 2 days	Yes		Yes	Dr Andrew Wilcock Professor Black Dr Petch	19.06.06	some difficulty in knowing whether she was dying diamorphine APPROPRIATE although higher than necessary medication and treatement were APPROPRIATE
12	Sheila Gregory	03/09/1999 21/11/1999	Yes		Yes	Dr Andrew Wilcock Professor Black	22.12.05 1.11.05	v brief report: poor record keeping rationale not explained (drugs did not kill her) poor documentation; lack of examination; overall management was ADEQUATE
11	Geoffrey Packman	23/08/1999 03/09/1999 10 days	Yes		Yes	Dr Andrew Wilcock Professor Black Dr Marshall	28.03.06 1.4.05	suboptimal treatment, oral morphine solution inappropriate higher than conventional diamorphine, poor records, lack of examination and assessment suffered a significant GI bleed not clear if he criticises the escalating doses of opiate analgesia

Jean Stevens	Yes					
Enda Purnell	Yes					

chronological order	Patient Name	Dates of Admission and Death	Relative(s)	Contact Form Returned	Rule 6 2002	Class 3 After Police Investigation	Has Dr Barton made a statement	Poor record keeping/lack of recoi	Inadequate assessment of patier	Excess dose of diamorphine	Subcutaneous/syringe driver not	Excessive does of Midazolam	Comments	Eversheds view	FFW view	
5	Eva Page	27/02/1998 03/03/1998 4 days	Son - Mr Bernard Page		Yes		No	x	?	x	x	?	lung cancer for palliative care	?		
6	Alicie Wilkie	06/08/1998 21/08/1998 15 days	Daughter - Mrs M Jackson		Yes		No	x	?	x	x	?	dementia/UTI for observation with a view to placement	?		
7	Gladys Richards	11/08/1998 21/08/1998 10 days	Daughter - Ms Gillian McKenzie	Yes	Yes		Statement to Police	x	?	x	x	x	fracture femur for rehabiliation	*		
8	Arthur Cunningham	21/09/1998 26/09/1998 5 days	Stepson - Mr Charles Farthing	Yes	Yes	Yes	1 Interview Personal Statement	x	x	x	x	x	bed sores/high protein diet prognosis poor but nursing home bed left open	?		
9	Robert Wilson	14/10/1998 18/10/1998 10 days	Son - Mr Robert Logan Son - Mr I Wilson		Yes	Yes	1 Interview Personal Statement	x	x	x	x	x	heart and kidney failure for palliative care	**		
1	Leslie Pittock	05/01/1996 24/01/1996 19 days	Daughter - Mrs L Wiles			Yes	1 Interview Personal Statement	x	x	x	x	?	depression, chest infection and UTI for palliative care	*		
2	Elsie Lavender	22/02/1996 06/03/1996 12 days	Son - Mr A Lavender			Yes	1 Interview Personal Statement	x	x	x	?	x	UTI poss stroke + fall	*		
4	Ruby Lake	18/08/1998 21/08/1998 3 days	Daughter - Mrs D Mussell Daughter - Mrs M Woodford Daughter - Mrs Pauline Robinson	Yes		Yes	1 Interview Personal Statement	x	x	x	x	x	Fractured hip for rehabilitation	no		
10	Enid Spurgin	26/03/1999 15/04/1999 20 days	Nephew - Mr Carl Jewell	Yes		Yes	1 Interview Personal Statement	x	x	x	x	x	Fractured hip (infection? UTI) for rehabilitation	**		
13	Elsie Devine	21/10/1999 21/11/1999 31 days	Daughter - Mrs Ann Reeves			Yes	3 Interviews Personal Statement Statement to Police	x	x	x	?	x	confusion/demensia unclear if terminal	no	weak	
3	Helena Service	03/06/1997 05/06/1997 2 days	Nephew - Mr Alexander Tuffey	Yes		Yes	1 Interview Personal Statement	x	x	x	x	x	unclear if terminal	no	weak	
12	Sheila Gregory	03/09/1999 21/11/1999 79 days	Granddaughter- Pauline Gregory Granddaughter - Ms T Jackson	Yes		Yes	1 Interview Personal Statement	x	?	x	x	x	Fracture Hip + pain in wrist for rehabilitation?	no	weak	
11	Geoffrey Packman	23/08/1999 03/09/1999 10 days	Wife - Mrs Betty Packman	Yes		Yes	10 Interviews Personal Statement	x	x	x	?	x	Obesity/mobility/fall/swelling for rehabilitation	**		

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Evershed's views	Patient Name	Relative(s)	Contact Form Returned	Rule 6 2002	Class 3 After Police Investigation	Expert Name	Date of Expert Report	Has Dr Barton made a statement	Comments	Date	Poor record keeping / lack of clear records	Inadequate assessment of patient	Excessive dose diamorphine	Subcutaneous / syringe driver not justified	Excessive dose midazolam	Other drugs excessive / inappropriate			Nature of admission
need more?	Eva Page	Son - Mr Bernard Page		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01	No	?	27/2/98 (5) died 3/3/98	Lack of reasons	?	✓	✓	?				Lung cancer for palliative care
need more?	Alicie Wilkie	Daughter - Mrs M Jackson		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01	No	Poss witness: Dr Lord	6/8/98 (6) died 21/8/98*	✓	?	✓	✓	?	Hyoscine inappro.			Observation → placement Dementia / UTI
✗	Gladys Richards	Daughter - Ms Gillian McKenzie	Yes	Yes		Professor G A Ford ✓Professor Brian Livesley "death occurred sooner than would have done"	12.12.01 10.07.01	Statement to Police	Poss witnesses: ? Mackenzie, ? Lack (daughter), Dr Reid, Dr Lord Nurse Brewer	11/8/98 (7) died 21/8/98*	✓	?	✓	✓	✓	Haloperidol			For rehab Fractured femur
Crest? ↓ don't ... eggs	Arthur Cunningham	Stepson - Mr Charles Farthing	Yes	Yes	Yes	Dr Andrew Wilcock "overall may have affected the course" Dr K Mundy ?? Black - only concern ... Professor Ford	Draft 27.09.05 18.10.01 12.12.01	1 Interview Personal Statement	Poss witness: Dr Lord, nursing staff	21/9/98 (8) died 26/9/98	✓	✓	✓	? ✓	? ✓				Treatment of sore + high protein diet Prognosis poor but place ... Black says terminal
**	Robert Wilson	Son - Mr Robert Logan Son - Mr I Wilson		Yes	Yes	Dr Andrew Wilcock Professor R Baker ? Dr Marshall? Dr K Mundy - says appropriate Professor Ford Black	Draft 21.05.06 Draft Feb06 18.10.01 12.12.01	1 Interview Personal Statement	Poss witnesses: Dr Lord, Dr Luznat, Mrs Wilson? 2nd wife ? Nurse Hallman ? Nurses? ? Mrs Wilson ? Hamlin	14/10/98 (9) died 18/10/98	✓	✓	✓	✓	✓	Oramorph			Heart failure + kidney failure For palliative care?
*	Leslie Pittock	Daughter - Mrs L Wiles			Yes	Dr Andrew Wilcock Dr Andrew Wilcock ?? Black	25.04.05 26.04.05	1 Interview Personal Statement	Poss witness: Dr Lord, ? Dr Tandy? ? Nurse Hamblin, for bedsores ? Tandy culpable	5/1/96 (1) died 24/1/96	✓	✓	✓	✓	?	Sertraline discont suddenly			For palliative care Depression, chest + urinary infection
*	Elsie Lavender	Son - Mr A Lavender			Yes	Dr Andrew Wilcock Wilcock ?? Black	01.05.05	1 Interview Personal Statement	Poss witness: ? Dr Tandy. ? Physio	22/2/96 (2) died 6/3/96	✓	✓	✓	?	✓		UTI + kidneys no action		~~For palliative care?~~ UTI ? stroke + fall Son thought doing well. Black-
↓	Ruby Lake	Daughter - Mrs D Mussell Daughter - Mrs M Woodford Daughter - Mrs Pauline Robinson *	Yes		Yes	Dr Andrew Wilcock Dr Andrew Wilcock ?? Black	Draft 10.07.05 re → 05.09.05	1 Interview Personal Statement	Poss witness: [Someone from QA] nursing staff? Dr Lord ?? Physio? Hallman? ? Barrett - denum. ? daughter	18/8/98 (4) died 21/8/98	✓	✓	✓	✓	✓		Failed to assess chest pain		Frail but not det. Fractured hip. Independent
**	Enid Spurgin	Nephew - Mr Carl Jewell	Yes		Yes	Dr Andrew Wilcock ?? Black ? Report of Redfern?	Draft 05.03.06	1 Interview Personal Statement	Poss witness: Scott (Consult) Nephew (Mr Jewell) Reid criticised, criticised	26/3/99 (10) died 13/4/99	✓	✓	✓	✓	✓		Failed to invest ? septicaemia		~~Unclear if terminal~~ Hip fracture → infection. ? UTI
↓	Elsie Devine ? don't ... eggs	Daughter - Mrs Ann Reeves			Yes	✓Dr Andrew Wilcock Dr C R K Dudley ? Black ? says appropriate	10.12.04 20.03.05	3 Interviews Personal Statement Statement to Police	Poss witness: Reeves, Dr Taylor, Dr Stevens, Dr Cranfield, Dr Jayawardena + Dr Reid? [* Was Health Authority review. +ve for Barton]	21/10/99 (13) died 21/11/99 (5)	✓	✓	✓	?	✓	Fentanyl trans. patch, Chlorpromazine			Unclear if terminal Confusion / dementia. Acre weak
↓	Helena Service	Nephew - Mr Alexander Tuffey	Yes		Yes	Dr Andrew Wilcock Black - appears appropriate ? Dr Petch ? - says appropriate	Draft 19.06.06	1 Interview Personal Statement	Poss witness: Dr Asbibal, Dr Miller	3/6/97 (3) died 5/6/97	✓	✓	✓	✓	✓				Unclear if dying. Acre weak
↓	Sheila Gregory	Granddaughter- Pauline Gregory * Granddaughter - Ms T Jackson	Yes		Yes	Dr Andrew Wilcock ? very brief	Draft overnight? 22.11.05	1 Interview Personal Statement	Poss witness: Dr Tandy, Dr Reid ← says terminal ↑ witness Gregory	3/9/99 (12) died 21/11/99 (8)	✓	?	✓	✓	✓	Oramorph			Fracture hip + pain in wrist. Acre weak
**	Geoffrey Packman	Wife - Mrs Betty Packman	Yes		Yes	Dr Andrew Wilcock Black Marshall	Draft 28.03.06	10 Interviews Personal Statement	Poss witness: Dr Tandy, Dr Reid ? Evershed: other culpability. [Ravid Rane]	23/8/99 (11) died 3/9/99	✓	✓	✓	?	✓	oral morphine	Transfer for GI bleed?		For rehab Obesity / mobility / swelling / fall
	Jean Stevens	Husband - Mr Ernest Stevens	Yes																
	Enda Purnell	Son - Mr Michael Wilson	Yes																

Patient Name	Relative(s)	Contact Form Returned	Rule 6 2002	Class 3 After Police Investigation	Expert Name	Date of Expert Report
Eva Page no s'ments	Son - Mr Bernard Page		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01
Alicie Wilkie no s'ments	Daughter - Mrs M Jackson		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01
Gladys Richards	Daughter - Ms Gillian McKenzie	Yes	Yes		Professor G A Ford Professor Brian Livesley Dr Black.	12.12.01 10.07.01
Arthur Cunningham	Stepson - Mr Charles Farthing	Yes	Yes	Yes	Dr Andrew Wilcock	27.09.05
Robert Wilson	Son - Mr Robert Logan Son - Mr I Wilson		Yes	Yes	Dr Andrew Wilcock Professor R Baker Dr Jonathan Marshall	21.05.06 Feb-06
Leslie Pittock	Daughter - Mrs L Wiles			Yes	Dr Andrew Wilcock Dr Andrew Wilcock	25.04.05 26.04.05
Elsie Lavender	Son - Mr A Lavender			Yes	Dr Andrew Wilcock	01.05.05
Ruby Lake	Daughter - Mrs D Mussell			Yes	Dr Andrew Wilcock	10.07.05

	Daughter - Mrs M Woodford Daughter - Mrs Pauline Robinson	Yes			Dr Andrew Wilcock	05.09.05
Enid Spurgin	Nephew - Mr Carl Jewell	Yes		Yes	Dr Andrew Wilcock Dr Black Loo Dr Redfearn	05.03.06 CC for SLE
Elsie Devine	Daughter - Mrs Ann Reeves			Yes	Dr Andrew Wilcock Dr C R K Dudley	10.12.04 20.03.05
Helena Service	Nephew - Mr Alexander Tuffey	Yes		Yes	Dr Andrew Wilcock	19.06.06
Sheila Gregory	Granddaughter- Pauline Gregory Granddaughter - Ms T Jackson	Yes		Yes	Dr Andrew Wilcock	22.12.05
Geoffrey Packman	Wife - Mrs Betty Packman	Yes		Yes	Dr Andrew Wilcock	28.03.06
Jean Stevens NO S'MENTS	Husband - Mr Ernest Stevens	Yes				
Enda Purnell	Son - Mr Michael Wilson	Yes				

NO S'MENTS

Has Dr Barton made a statement	Comments
No	
No	
Statement to Police	
1 Interview Personal Statement	
1 Interview Personal Statement	
1 Interview Personal Statement	
1 Interview Personal Statement	
1 Interview	

Personal Statement	
1 Interview Personal Statement	
3 Interviews Personal Statement Statement to Police	
1 Interview Personal Statement	
1 Interview Personal Statement	
10 Interviews Personal Statement	

Patient Name	Relative(s)	Contact Form Returned	Rule 6 2002	Class 3 After Police Investigation	Expert Name	Date of Expert Report	Has Dr Barton made a statement	Comments
Eva Page	Son - Mr Bernard Page		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01	No	
Alicie Wilkie	Daughter - Mrs M Jackson		Yes		Dr K Mundy Professor G A Ford	18.10.01 12.12.01	No	
Gladys Richards	Daughter - Ms Gillian McKenzie	Yes	Yes		Professor G A Ford Professor Brian Livesley	12.12.01 10.07.01	Statement to Police	
Arthur Cunningham	Stepson - Mr Charles Farthing	Yes	Yes	Yes	Dr Andrew Wilcock	27.09.05	1 Interview Personal Statement	
Robert Wilson	Son - Mr Robert Logan Son - Mr I Wilson		Yes	Yes	Dr Andrew Wilcock Professor R Baker	21.05.06 Feb-06	1 Interview Personal Statement	
Leslie Pittock	Daughter - Mrs L Wiles			Yes	Dr Andrew Wilcock Dr Andrew Wilcock	25.04.05 26.04.05	1 Interview Personal Statement	
Elsie Lavender	Son - Mr A Lavender			Yes	Dr Andrew Wilcock	01.05.05	1 Interview Personal Statement	
Ruby Lake	Daughter - Mrs D Mussell Daughter - Mrs M Woodford Daughter - Mrs Pauline Robinson	Yes		Yes	Dr Andrew Wilcock Dr Andrew Wilcock	10.07.05 05.09.05	1 Interview Personal Statement	
Enid Spurgin	Nephew - Mr Carl Jewell	Yes		Yes	Dr Andrew Wilcock	05.03.06	1 Interview Personal Statement	
Elsie Devine	Daughter - Mrs Ann Reeves			Yes	Dr Andrew Wilcock Dr C R K Dudley	10.12.04 20.03.05	3 Interviews Personal Statement Statement to Police	
Helena Service	Nephew - Mr Alexander Tuffey	Yes		Yes	Dr Andrew Wilcock	19.06.06	1 Interview Personal Statement	
Sheila Gregory	Granddaughter- Pauline Gregory Granddaughter - Ms T Jackson	Yes		Yes	Dr Andrew Wilcock	22.12.05	1 Interview Personal Statement	
Geoffrey Packman	Wife - Mrs Betty Packman	Yes		Yes	Dr Andrew Wilcock	28.03.06	10 Interviews Personal Statement	
Jean Stevens	Husband - Mr Ernest Stevens	Yes						
Enda Purnell Edna	Son - Mr Michael Wilson	Yes						

BARTON CASES

ISSUES: Record Keeping; prescribing,

Patient	RULE 6 2002	CLASS 3 AFTER POLICE INVEST.
EVA PAGE son = Bernard Page	✓	* Mundy ⊕ Ford * Mundy ⊕ Ford
ALICE WILKIE Daughter = Mrs Jackson	✓	
GLADYS RICHARDS daughter = GILL MCKENZIE	✓	⊕ Ford Dec 2001, Lawless Jul 2001
ARTHUR CUNNINGHAM stepson MR FARTHING	✓	✓ ⊕ Ford Wilcock Sep 2005 * Mundy
ROBERT WILSON. son of Robert Logan " of. Mr Wilson	✓	✓ * Mundy Oct 2001 ⊕ Ford Wilcock May 2005
PITTOCK daughter = Ms Wilson.		✓ Wilcock April 2005 x2
LAVENDER Son = Mr Lavender		✓ Wilcock. May 2005
LAKE daughter = Mrs Mussell " = Ms Robinson = Mrs Woodford		✓ Wilcock July 2005 + Sept 2007
SPURGEON nephew - Mr Jewell		✓ Wilcock. March 2006
DEVINE daughter = Reeves		✓ Wilcock. Dec 2004 Ridley March 2005
SERVICE nephew - Tuffey.		✓ Wilcock June 2006
GREGORY granddaughter - Ms Gregory		✓ Wilcock Dec 2005
PACKMAN - wife Mrs Packman		✓ Wilcock March 2006

--D GMC happy for us to investigate / see email 11/12/07 + att note

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EDNA PURNELL - son = MR WILSON (not happy re police)

JEAN ~~ERNEST~~ STEPHENS - husband ~~son~~ = ERNEST STEPHENS - (not happy re police)

Field Fisher Waterhouse

Case Report
June 2007

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor:	Tamsin Tomlinson / 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. The police instructed Professor Brian Livesley, Professor Richard Baker and a multidisciplinary team who reported on toxicology, general medicine, palliative care, geriatrics and nursing. 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]. We believe 2 further cases making a total of 15 may require investigation.

Investigations: We have received documents (38 boxes) from Eversheds and have contacted all the family members associated with the 15 cases. We will be shortly contacted the experts who have previously written reports in the Police investigation to find out if they will write modified reports for us. We have also been liaising with the defence and disclosing documents to them as they have requested. 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.

We are liaising with the experts to potentially instruct the same experts and possibly use the same reports for the GMC investigation. We are also in contact with the Police regarding disclosure issues.

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, Stage 1 telephone conference.

Listing time estimate: Our provisional estimate for the hearing is 8 weeks to be held in London as all of the witnesses are on the South Coast. This would probably be in 2008 to enable us to complete our investigation.

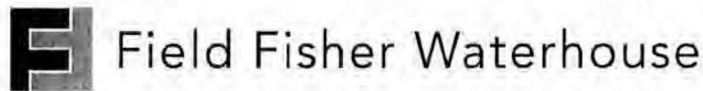
Listed: Not yet listed

Prospects of Success: Medium

Juliette says that [illegible] is [illegible] to start. [illegible]
said not [illegible] 4 [illegible].
Juliette is [illegible] as [illegible] case. This [illegible] an investigation plan.
please [illegible] Sarah/Tom's speak to Juliette.

Speak to RSR [illegible] a helpful contact at NMC for Juliette to speak to.

Are we taking view it is an information case, not [illegible]?



Case Report
November 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: 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.

Recommendation: Confirm expert instructions, production statements from witnesses for their police statements and visits to witnesses as necessary, liaise with Coroner and police.

Listed?

Listing time estimate: 8 weeks. Prof Black is a FTP panellist. Will that not give you problems re allegations of bias/prejudice? [GMC is obtaining CMO's statistical report]

Cant find IIS on file or Mailsite.

r Waterhouse

Case Report
September 2007

	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:	when were we 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

22 OCT 2007
Tamsin Hall

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arrange next month's case Report.

[...] LP, HS, GP and AC [RW and AC together with [...]ule 6 referral letter sent in 2002 after the first po[...]here the patient's relatives have expressed an i[...]

Inv[...] [...] our analysis of the witness statements and transcripts of interview[...] We have provisionally spoken to Professor Black who has indicated [...]ould 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.

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
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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.

As at 2/6/09. since updated

Annex A
General Medical Council and Dr Barton

Witness schedule
(DRAFT 12.5.09)

No.	Day	Surname	First Name	Job/Title	GMC Statement	Full or Read	Comments
Day 1 **8.6.09** **– Argument, Admission and Opening**							
PATIENT WITNESSES							
PT A - PITTOCK							
1	**Day 2** 9.6.09 a.m.	Wiles	Lynda	Daughter	Y	No	NO SUMMONS. WILL READ IF ASKED. RC spoken to witness – very distressed, partially agreed to attend no definite answer (?? witness summons)
2	**9.6.09 a.m.**	**Brigg**	**Michael**	**Doctor**	**N – awaiting production statement**	**F**	**YES**
PT B – LAVENDER							
3	**9.6.09 a.m. (10.30am)**	**Lavender**	**Alan**	**Son**	**Y**	**F**	**YES – 10.30am**
PT C – PAGE							

		NONE OTHER THAN EXPERT		-			
PT D – WILKIE							
4	**Day 3** **10.6.09 a.m.**	**Jackson**	**Marilyn**	**Daughter**	**Y**	**F**	**YES**
PT E – RICHARDS							
5	10.6.09 a.m.	McKenzie	Gill	Daughter	Y		NO.
6	**10.6.09 a.m.**	**O'Brien**	**Lesley**	**Daughter**	**Y**	**F**	**YES**
Pt F – RUBY LAKE							
7	**Day 4** 11.6.09 a.m.	Mussell	Diane	Daughter	Y	F	NO. WILL READ IF ASKED. Not available. out of country
8	**11.6.09 a.m.**	**Robinson**	**Pauline**	**Daughter**	**Y**	**F**	**YES**
9	11.6.09 a.m.	Bindloss	Adele	Nurse	N - None expected	C	NO. WILL READ IF ASKED. Unable to trace - willing to read.
10	11.6.09 p.m.	Coltman	Timothy	Doctor	Y	C	Yes Available. Agreed
Pt K – ELSIE DEVINE							
11	**Day 5** **12.6.09 a.m.**	**Reeves**	**Ann**	**Daughter**	**Y**	**F**	**YES. APPLIC. FOR VID LINK FROM KUALA LUMPAR, MUST BE a.m. AND CALLED BEFORE 14.6.09.**
12	12.6.09 p.m.	Taylor	Joanna	Doctor	Y	F/C	Agreed. Available
13	12.6.09 a.m.	Cranfield	Tanya	Doctor	Y	F	**YES** **Available.**

PT G – ARTHUR CUNNINGHAM							
14							
15	12.6.09 a.m.	Sellwood	Shirley	Friend	Y	F/C	NO. Unwell WILL READ IF ASKED. Witness unwell.
16	12.6.09 p.m.	Gell	Pamela	Nurse	N- awaiting production statement	F/C	Yes
17	**Day 6** **15.6.09 a.m**	**Farthing**	**Charles**	**Step-son**	**Y**	**F**	**YES**
Pt H – ROBERT WILSON							
18	**15.6.09 a.m.**	**Wilson**	**Iain**	**Son**	**N- awaiting revised statement**	**F**	**YES. Witness Summons**
19	15.6.09 a.m.	Wilson	Neil	Son	N - None expected	C	NO Witness in Bahrain, may apply to read – to discuss
20	**15.6.09 a.m. 2pm**	**Kimbley**	**Gillian**	**Wife**	**Y**	**F**	**YES**
20	**Day 7** **16.6.09 p.m.**	**Couchman**	**Margaret**	**NURSE – Pt E - Richards, Pt B- Lavender, Pt E Richards**		**F**	**YES. Witness Summons**
21	16.6.09 a.m.	Luznat	Rosie	Doctor	Y	C	NO. WILL READ IF AGREED Will read by agreement. Out of country until 29th June.
22	**16.6.09 a.m.**	**Peters**	**Ewenda**	**Doctor**	**Y**	**F**	**YES. (WANTED BY DEFENCE)**

Pt I – ENID SPURGIN							
23	16.6.09	Jewel	Carl	Nephew	N-production statement sent – unlikely to be returned.	F/C	UNWILLING. SUMMONS
24	16.6.09	Redfern	Daniel	Ortho Consultant	N- awaiting production statement	F/C	READ IN PART. – Langdale Available. Agreed Can do only 15 or 18 – TK to decide
Pt J – GEOFFREY PACKMAN							
25	**Day 8** **17.6.09 a.m.**	**Packman**	**Betty**	**Wife**	**Y**	**F**	**YES**
26	**17.6.09 a.m.**	**Packman**	**Victoria**	**Daughter**	**Y**	**F**	**YES**
27	**17.6.09 p.m.**	**Dowse**	**Claire**	**SHO**	**N - awaiting production statement**	**C**	**YES**
NOT SITTING THURSDAY 18.6.09							
Pt L – JEAN STEVENS							
28	**Day 9** 19.6.09 a.m.	Stevens	Ernest	Husband	Y	C	NO. WILL READ BY AGREEMENT? Not available. Would read in part if requested.
29	**19.6.09 a.m.**	**Bailey**	**June**	**Daughter**	**Y**	**F**	**No.**

NURSES							
		NAME	**1ST NAME**	**GMC ?**	**Relevant to -**	**FULL OR READ**	**COMMENTS**
30	19.6.09 a.m.	**Beed**	**Philip**	**Y**	**General Evidence and Pt E Gladys Richards**	**F**	**YES**

31	Day 10 22.6.09	Barrett	Lynn	Y	Pt A - Pittock, Pt F - Lake, Pt K - Devine, Pt I – Spurgin	F	YES. WITNESS SUMMONS – Unwell will be sending medical evidence.
32	22.6.09	Douglas	Tina	Y	Pt A Pittock, Pt F – Lake.	F	YES.
33	22.6.09	Florio	Jeanette	N - None expected	Pt H - Wilson, Pt J – Packman	C	Not found
34	Day 11 23.6.09	Giffin	Sylvia	N - None expected	General and Pt E Richards	C	Will agree to read in part (deceased?)
35	23.6.09	Hallman	Shirley	Y	Pt H - Wilson, Pt F - Lake, Pt G - Cunningham, Pt J - Packman	F	YES.
36	Day 12 24.6.09	Ring	Sharon	N - None expected	Pt F - Lake, Pt A - Pittock, Pt – G Cunnigham	C	NO – WILL READ BY AGREEMENT
37	24.6.09	Lloyd	Ingrid	N – None expected	Pt G – Cunningham	F	NO – WILL READ BY AGREEMENT
38	24.6.09	Shaw	Freda	Y	Pt I - Spurgin, Pt H - Wilson, Pt A - Pittock, Pt K - Devine, Pt G - Cunningham	F	YES
39	Day 13 25.6.09	Turnbull	Beverley	N- awaiting FFW statement	Pt J - Packman, Pt F - Lake, Pt G - Cunningham, Pt K - Devine, Pt I - Spurgin,	F	YES
40	25.6.09 2 pm	Tubbritt	Anita	N - awaiting production statement	Pt K - Devine, Pt F - Lake, Pt I - Spurgin, Pt J – Packman	F	YES.
DOCTORS							
41	Day 14 26.6.09	Ravindrane	Arumugam	Y	Pt H - Wilson, Pt J - Packman, Pt K - Devine	F	YES
42	26.6.09 11am	Banks	Victoria	Y	Pt A - Pittock, Pt G - Cunningham	F	YES

CONSULTANTS							
43	**Day 15 29.6.09**	**Tandy**	**Jane**	**Y**	**Pt A - Pittock, Pt J - Packman**	**F**	**YES**
44	**29.6.09 12pm**	**Reid**	**Richard**	**Y**	**Pt K - Devine, Pt E - Richards, Pt I - Spurgin, Pt J - Packman**	**F**	**YES**
45	Day 16 30.06.09	Samuel	Richard	Y			
POLICE							
46		Yates	Christopher			C	To produce interviews of Dr Barton only
47		Quade	Geoffrey			C	A/A

EXPERT							
48	**Day 16 30.6.09 – 7.7.09**	**Ford**	**Gary**	**Y**		**F**	**YES** **Not available on 1.7.09 (Reading Day?)**

WITNESSES (Other than nurses) WHO HAVE MADE GMC STATEMENTS NOT BEING CALLED BY GMC

		Thomas	Elizabeth	Physio	Y	Pt B- Lavender	
		Barrett	David	Doctor	Y	Pt F - Lake	
		Clemow	Ruth	Nurse	Y	Pt H - Wilson	
		Reckless	Ian	Doctor	Y	Pt K - Devine	
		Stevens	Judith	Doctor	Y	Pt K - Devine	
		Reeves	James	Son	Y	Pt K - Devine	
		Watling	Jeffrey	Pharmacist	Y		
		Lord	Althea	Consultant	Y	Pt H - Wilson, Pt F - Lake, Pt A - Pittock, Pt K - Devine, Pt G - Cunningham, Pt E - Richards, Pt B- Lavender, Pt C - Page, Pt D - Wilkie	

NURSES FROM WHOM POLICE AND OR GMC STATEMENTS WERE OBTAINED BUT ARE NOT TO BE CALLED BY THE GMC

		NAME	1ST NAME	GMC ?	Relevant to -	COMMENTS	
		Astridge	Yvonne	N	Pt B- Lavender		
~~29~~	~~Day 11~~ ~~23.6.09~~	~~Ball~~	~~Carol~~	~~Y*~~	~~Left in 1991 – five years before charges but deals with meeting with management where concerns were raised over use of syringe drivers, nothing changed~~	F	~~Efforts being made to obtain this witness (??Witness summons) (let sent 18.05.09 – no response to date)~~
		Barker	Carol	N	Pt K - Devine, Pt H - Wilson, Pt G - Cunningham		
		Bell	Elizabeth	N	Pt K - Devine		
		Broughton	Geraldine	N	Pt B- Lavender		
		Collins	Siobhan	N	Pt H - Wilson, Cunningham, Pt J - Packman, Pt I – Spurgin,		

		Dolan	Christine	N	Pt B- Lavender, Pt G - Cunningham	
		Donne	Sue	N	Left Hospital in 1995	
		Dorrington	Irene	N	Pt K - Devine, Pt B- Lavender, Pt H - Wilson, Pt I - Spurgin,	
		Dunleavy	Joanne	N	Pt K - Devine, Pt F - Lake	
		Edgar	Wendy	N	Pt B- Lavender	
		Evans	Christine	N	Pt K - Devine.	
		Fields	Mary	N	Pt J – Packman	
		Hamblin	Gillian	Y	Pt H - Wilson, Pt A - Pittock, Pt K - Devine, Pt G - Cunningham, Pt I - Spurgin, Pt J - Packman	
		Joice	Christine	N	Pt B- Lavender	
		Joines	Sheelagh	Y	Pt B- Lavender	
		Marjaram	Catherine	N	Pt E - Richards, Pt B- Lavender	
		Martin	Mary	N	Pt A - Pittock, Pt B- Lavender	
		Mears	Elizabeth	N		
		Milner	Sandra	N	Pt H – Wilson	
		Nelson	Susan	N	Pt G - Cunningham, Pt I - Spurgin	
		Rankin	Gill	N	Pt I – Spurgin	
		Rigg	Pamela	N		
		Ryder	Gillian	N		
		Scammel	Antonia	N		
		Spilka	Pauline	N		
		Tyler	Christina	N	Pt B- Lavender	
		Walker	Fiona	Y	Pt B- Lavender, Pt A - Pittock, Pt G - Cunningham, Pt I - Spurgin	
		Wells	Marjorie	N	Pt F - Lake, Pt H - Wilson,	
		Wigfall	Margaret	Y	Pt B- Lavender, Pt K - Devine	
		Wilkins	Patricia		Pt B- Lavender.	
		Woodland	Betty	Y		
		Wright	Fiona	N	Pt K - Devine	

		Edmonson	Michael	N		
		Samuel	Richard	Y		

Case Report
July 2008

Doctors name:	Dr J A Barton
GMC case reference:	2000/2047
GMC case worker:	Code A
Instructed Solicitor and Counsel:	Tamsin Hall/Sarah Ellson/Tom Kark and Rebecca Harris
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
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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 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). In April 2008 we added JS. Counsel has advised that there is not enough evidence to proceed regarding SG, HS and EP.

Investigations: As the Hearing has now been postponed pending the outcome of the Inquest we have informed all relevant parties of this decision. There is a Pre-Inquest Meeting on 14 August 2008, Adele will attend to observe.

We will continue finalising outstanding evidence and serving on the defence and liaising with the witnesses and the Coroner.

Recommendation: Chase remaining outstanding witness statements and disclose. 'After the meeting of 14 August 2008 we hope to have more information about the Inquest and will be in a position to re-list. A further Stage 2 telecon has been scheduled for 15 August accordingly.'

Listing time estimate: 10 – 12 weeks.

Counsel: Tom Kark and Ben Fitzgerald

Listed: Postponed

Prospects of Success: Medium

Now listed 8 June 09 for 55 days

Field Fisher Waterhouse

Case Report
June 2008

Doctors name:	Dr J A Barton
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Recommendation: Chase remaining outstanding witness statements and disclose.

Listing time estimate: 8-10 weeks.

Counsel: Tom Kark and Ben Fitzgerald

Listed: Postponed

Prospects of Success: Medium

FILE COPY

Strictly Private & Confidential

Professor G A Ford
Freeman Hospital
Freeman Road
High Heaton
Newcastle upon Tyne
NE7 7DN

Our ref: ALW/00492-15579/8916193 v1
Your ref:

Adele Watson
Paralegal
Code A

12 December 2008

Dear Professor Ford

General Medical Council - Dr Jane Barton

General Instructions

I write further to your telephone conversations with my colleague, Tamsin Morris, in relation to this matter. Thank you for agreeing to act as an expert on behalf of the General Medical Council. I am pleased to confirm that the General Medical Council have approved your acting as an expert.

As Tamsin has explained we would like to obtain expert evidence from you in this matter in relation to allegations of impairment of fitness to practise to be pursued at the forthcoming Fitness to Practise Panel hearing concerning Dr Barton. In due course, you will be required to attend the General Medical Council to give oral evidence on the basis of your expert report. The case has been given a provisional hearing date of **8 June 2009** for 10 weeks in London. It is likely that you will be required to attend the hearing for approximately two weeks, with additional availability required for you to comment on transcripts and the defence expert before and after your attendance. I estimate your attendance will be in the third/fourth week of the hearing but I hope to be able to give you a better indication in the new year. I note that you are available from 10 June 2009, but will be unavailable on 8-10 July due to a prior commitment.

I propose to start sending you individual instructions on each patient on a weekly basis starting from today, although allowing for the Christmas holiday period, with the timescale of two weeks for each report to be completed. Please could you indicate whether you would be happy with this or if you would prefer an alternative approach.

We also believe a generic report covering appropriate pain management and record keeping issues might be a helpful way of dealing with these issues in one reference document to which your patient specific reports can refer.

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E-mail info@ffw.com **Web** www.ffw.com

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

Background

I do not propose to describe the background of each case in detail to you in this letter of instruction. I will summarise each patient case to you in the individual letters of instruction. Some of the information below will be known to you already, however I hope it is helpful to set out the history of the matter.

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. 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.

Some patients were admitted for palliative care; others were admitted for rehabilitation following hospital admission or for respite care. The circumstances in which patients were admitted are quite wide ranging and there appear to be significant variations as to their prognoses.

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.

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 any concerns you identify about record keeping, proper assessment and treatment and the combination and quantity and method of delivery of medication provided.

The first family to raise concerns were the family of Mrs Gladys Richards who died in 1998 As a result of their complaint, Hampshire Police 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.

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. 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). At this stage I understand the police sought your opinion.

Once further expert evident was obtained in relation to these cases material was forwarded to the General Medical Council (and the Nursing & Midwifery Council and the Commission for Health

Improvement). Hampshire Police then 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.

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.

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. 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.

Your previous involvement

You were previously instructed by Hampshire Police to prepare expert reports on a number of patient cases. I enclose a copy of your previous report dated 12 December 2001 made in relation to Gladys Richards, Arthur Cunningham, Alice Wilkie, Robert Wilson and Eva Page.

I would be grateful if you would confirm that this is the only previous report you prepared and you may want to confirm the information you received in order to prepare this report.

Instructions

We would like you to prepare a report on each of 12 patients for the GMC proceedings. These need to be prepared and disclosed to the defence solicitors as soon as possible. In addition, as mentioned above a generic report may be of considerable assistance.

Patient Reports

Your Expertise

It is not necessary to include your CV at the front of each report. We will use a single copy of your CV to establish your expertise. Your CV will need to address brief details of your own work and experience as a Consultant Physician and Professor of Pharmacology of Old Age and in particular your experience in relation to the management of geriatric patients in a hospital setting. This is to illustrate that you are suitably qualified to comment as an expert in this case.

Please provide a copy of your most recent CV to me as soon as you are able.

Reference Material

In addition to your own experience and expertise I anticipate that the Fitness to Practice Panel will be assisted by the standard guidance and any authoritative material which you consider relevant in this case, bearing in mind the dates of the events in question. If you need any assistance in obtaining documents please let me know. Should you refer to any guidance which was generally available during this time period, please provide a copy as an appendix to your report.

Format

Having reviewed your single report dated 12 December 2001 made in relation to Gladys Richards, Arthur Cunningham, Alice Wilkie, Robert Wilson and Eva Page please note that we will need separate reports for each patient. In addition considering the format for your patient reports you may wish to bear in mind the following suggestions. Please note the emphasis of your comments need to relate to the care and treatment carried out specifically by Dr Barton rather than the medical team as a whole.

1. In your 'Summary' 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.

2. In your 'Summary' 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.

3. For each patient, it would be very helpful if you 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.

4. Wherever a medical note of significance can be attributed to a particular doctor, it should be.

5. Please set out the nature of Dr Barton's responsibility for each patient.

6. 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.

7. Can you 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?

8. Please comment on the appropriateness of prescribing a <u>range</u> 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?

9. Whether you agree or disagree with the draft allegations currently prepared in relation to each patient.

The Panel will need to decide whether Dr Barton's fitness to practise is impaired. This is a judgment which only the Panel can make and you should not therefore specifically comment on this issue.

The Panel will need to consider whether concerns about Dr Barton's conduct are so serious as to raise the question whether she should continue to practise either with restrictions on her registration or at all. To assist the Panel, please indicate in what respects, if any, Dr Barton has fallen short of what would reasonably be expected of a medical practitioner in the circumstances and if he has fallen short, by how much. This should be done by reference to Good Medical Practice, where appropriate. Good Medical Practice states that 'serious or persistent failures to meet the standards in this booklet may put your registration at risk. It is therefore important that you indicate whether any failings which you may identify are serious (or persistent), or not.

If you conclude that the procedures adopted by Dr Barton **do not** fall below of accepted standards of practice you would need only briefly deal with appropriate procedures. However, if you do have criticisms of the procedures adopted by Dr Barton it would be helpful, if in referring to events in question, you could set out what ought to have happened (this is where a generic report may assist)

In terms of evidential issues there may be disparities between the accounts of the witnesses and Dr Barton. Where there is a conflict in the evidence as to what happened you should state for example: "If what Dr Reid says is correct about.... then this would in my view.... However, if Dr Barton, as she claims, did.....then......"

The Panel will determine whose evidence is believed but they will be interested to have your views on each factual scenario. It is particularly significant if you would criticise Dr Barton even on her own account of what happened.

A Generic Report

I suggest a generic report might cover the following issues:

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. (We may be able to assist with the copying of sections of the BNF from the relevant period if you can identify the sections we require.)

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 (again you should let me know if you would like me to obtain any copy documents to which you wish to refer but do not have copies). Please note that the events in question took place between around 1997 to 2000 and Dr Barton should be judged in accordance with the guidance available at that time. In particular you should make reference to Good Medical Practice.

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, if you are able, 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?

Conclusion

If at any time you have questions about the reports which I have asked you to prepare you should not hesitate to contact me. If you require any additional information, please let me know.

We have agreed that you charge £220 per hour for the preparation of reports and phone conferences, and your daily attendance rate is at £1,500 per day.

Please see the patient specific letters of instruction which will set out the date for the return of each report. I would be grateful if you could provide me with the first completed report by **Monday 5 January 2009**.

Many thanks for your kind assistance with this matter.

I look forward to hearing from you.

Yours sincerely

Adele Watson
for **Field Fisher Waterhouse LLP**

Draft (18.02.2008)

DRAFTS FROM TAMSIN

Strictly P

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- will will need to re-format the cut + pasted bit.

18 February 2008

Dear Professor Black

General Medical Council - Dr Jane Barton

General Instructions

I write further to our previous correspondence. Thank you for agreeing to act as an expert on behalf of the General Medical Council in this matter. I am pleased to confirm that the General Medical Council have approved your acting as an expert.

This letter is a general letter of instruction, in which I will set out the terms of your instruction and general points which I would like you to prepare a report on. I will send specific instructions in relation to individual patients under separate cover.

The Fitness to Practise Panel hearing concerning Dr Barton has been listed for a hearing date from **8 September 2008 until 31 October 2008** in **London**. In due course, you will be required to attend the General Medical Council to give oral evidence on the basis of your expert reports. I am unable to confirm the actual dates at present but will do so as soon as I am able. You have confirmed to me that you will be out of the country between 5 September 2008 and 21 September 2008 and we have arranged that you will read transcripts of the hearing on 22 September 2008 and then attend at the GMC from 23 September 2008 in order to give your evidence.

As you are aware, there are a large amount of papers in this case and I will forward these to you as and when necessary under separate cover.

I do, however, enclose with this letter a folder of generic information which I believe will be useful to you at this stage.

1. Rule 6 letter of 11 July 2002

Draft (18.02.2008)

Strictly Private & Confidential

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As you are aware, there are a large amount of papers in this case and I will forward these to you as and when necessary under separate cover.

I do, however, enclose with this letter a folder of generic information which I believe will be useful to you at this stage.

1. Rule 6 letter of 11 July 2002

2. Hampshire Police Summary

3. CHI report

Background

I do not propose to describe the background of each case in detail to you in this letter of instruction. I will summarise each patient case to you in the individual letters of instruction. Some of the information below will be known to you already, however I summarise the position in order that you are clear as to the history of the matter.

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. 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.

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.

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.

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.

The first family to raise concerns were the family of Mrs Gladys Richards who died in 1998 As a result of their complaint, Hampshire Police 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.

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.

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).

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). 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.

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.

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.

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.

To date the GMC have not made their decision as to which patient cases will form part of the final charges against Dr Barton. We will confirm this to you as soon as we are able.

Your previous involvement

You were instructed by Hampshire Police to prepare expert reports on a number of patient cases. I am in possession of reports which you have written as follows:

1. Elsie Devine – 16 April 2005
2. Gladys Richards - 24 July 2005
3. Helena Service – Draft 6 November 2004 and final report 12 June 2006
4. Sheila Gregory – 1 November 2005
5. Arthur Cunningham – 11 July 2005
6. Geoffrey Packman – 30 October 2005 and final report of 20 June 2006
7. Elsie Lavender – 19 March 2005
8. Enid Spurgin – 27 June 2005 and final report 23 November 2005
9. Ruby Lake - 29 August 2005
10. Leslie Pittock – 31 January 2005 and final report 22 April 2005

11. Robert Wilson – 19 November 2005 and final report 21 November 2005

It would appear that you prepared the reports based upon the medical records for each patient, Dr Barton's statements and her job description.

I would be grateful if you would confirm if this is the case and that we are in possession of all of your reports in relation to the above patients. It would also be helpful to have copies of your letters of instruction from the Police if you have retained these.

You have previously indicated to me that you were forwarded copies of the witness statements taken by Hampshire Police in relation to each patient.

Your Report

I would be grateful if you would prepare a generic report covering the following issues:

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?

Your Expertise

Please set out in your report brief details of your own work and experience (you may wish to do this by appending your CV to your report as you have done in your previous reports) and in particular any experience you have in relation to the management of patients with co-morbidities such as Patient A and your experience of using the Vision computer system. This is to illustrate that you are suitably qualified to comment as an expert in this case.

Reference Material

In addition to your own experience and expertise I anticipate that the Fitness to Practice Panel will be assisted by any guidance or authoritative material which you consider relevant in this case.

Please note that the events in question took place between around 1997 to 2000 and Dr Barton should be judged in accordance with the guidance available at that time. In particular you should make reference to Good Medical Practice. Please let me know if you require a copy of these.

If appropriate, please identify and produce any authoritative material which you consider relevant to the issues you are required to provide expert comment on and annex it to your report.

Format

The style and format of your report is essentially a matter for you.

The Panel will need to decide whether Dr Barton's fitness to practise is impaired. This is a judgment which only the Panel can make and you should not therefore specifically comment on this issue.

Conclusion

If at any time you have questions about the issues which I have asked you to consider you should not hesitate to contact me. If you require any additional information, please let me know.

We have agreed that you will charge £200 per hour for writing your report and a daily attendance rate at hearing of £1,200 (which will be billed £600 from you and £600 from the Deanery).

Now that you have some idea of what is involved, I would like to discuss with you further your time estimate for preparing the report and to organise a convenient time with you to have a short telephone conference prior to you drafting your report. **I am required by the GMC to obtain an estimate before you start work on your report.**

I would be grateful if we could work towards having your reports prepared by **14 March 2008.** Please confirm if this date is acceptable to you.

Many thanks for your kind assistance with this matter.

I look forward to hearing from you.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**

Encs

Draft (18.02.2008)

Strictly Private & Confidential

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Code A (Direct Dial)

18 February 2008

Dear Professor Black

General Medical Council - Dr Jane Barton

Please regard this letter as an over-arching explanation of the different letters of instruction and as clarification of the deadlines / work outstanding.

1. General report

    (a) This report is to clarify issues that are common between each patient to clarify matters for the Panel.

    (b) Please do this report after the below reports on the following patients, they are the priority. Please can you complete this report by 14 March 2008.

2. Report on Eva Page

    (a) You have kindly forwarded me the draft of this report already. Please see the letter of instruction regarding format / points to include.

    (b) Please can you complete this report by 3 March 2008

3. Report on Alice Wilkie

    (a) I hope that this issues surrounding the medical records have now been resolved.

    (b) Please can you complete this report by 3 March 2008

4. Preliminary report on Jean Stevens

    (a) This patient does not form part of the charges at present. Please see the letter of

instruction regarding format / points to include.

(b) Please can you complete this report by [ ]

5. Preliminary report on Edna Purnell

(a) This patient does not form part of the charges at present. Please see the letter of instruction regarding format / points to include.

(b) Please can you complete this report by [ ]

6. Supplementary Issues

(a) Counsel has identified a number of areas, in relation to the reports which you have previously prepared, which require further clarification.

(b) Once you have had a chance to consider these in more detail please can you contact me with an estimate of how long you think this will take you.

I would be grateful if you could confirm to me, as soon as possible, if these deadlines present you with any problem. As you are aware from our previous discussions, time is very much against us on this case.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**

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Draft (18.02.2008)

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Tamsin Hall
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18 February 2008

Dear Professor Black

General Medical Council - Dr Jane Barton

Jean Stevens / Edna Purnell

This letter is a letter of instruction which should be read in conjunction with the terms and background set out in the letter marked 'General Instructions' dated [ ].

I would be grateful if you would prepare a preliminary report on the cases of patients Jean Stevens and Edna Purnell.

At present these patients are not included within the charges against Dr Barton and I require a preliminary expert advice as to whether there is evidence that their treatment by Dr Barton was acceptable.

Papers

On 18 January 2008 I sent you the medical records of Mrs Stevens and Mrs Purnell.

Instructions

I would be grateful if you would provide a brief overview in relation to each patient, with your preliminary view as to whether their treatment was acceptable. You may wish to use the following headings as a guideline for your preliminary report:

1. A brief summary of their medical condition

2. Prescription of opioid analgesia

3. Drug chart

4. Pain assessment

5. Medical Records

   (a) Do the medical records adequately set out the reason for the prescription of opiate medication?

6. Drug combination

7. In relation to Edna Purnell, it would appear that Dr Barton did not initially treat her. Please comment on whether Dr Barton was in overall charge of her care and specifically identify which treatment can be attributed to Dr Barton.

Reference Material

In addition to your own experience and expertise I anticipate that the Fitness to Practice Panel will be assisted by any guidance or authoritative material which you consider relevant in this case.

Please note that the events in question took place between around 1997 to 2000 and Dr Barton should be judged in accordance with the guidance available at that time. In particular you should make reference to Good Medical Practice. Please let me know if you require a copy of these.

If appropriate, please identify and produce any authoritative material which you consider relevant to the issues you are required to provide expert comment on and annex it to your report.

Format

The style and format of your report is essentially a matter for you. However please refer to the letter marked 'Supplementary Issues' for guidance and suggestions as to how the report may best assist the Panel.

The Panel will need to decide whether Dr Barton's fitness to practise is impaired. This is a judgment which only the Panel can make and you should not therefore specifically comment on this issue.

Conclusion

If at any time you have questions about the issues which I have asked you to consider you should not hesitate to contact me. If you require any additional information, please let me know.

I would be grateful if we could work towards having your final report on Jean Stevens and Edna Purnell by **[??????]** . Please confirm that this date is acceptable to you.

Many thanks for your kind assistance with this matter.

I look forward to hearing from you.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**

Encs

Draft (18.02.2008)

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18 February 2008

Dear Professor Black

General Medical Council - Dr Jane Barton

Alice Wilkie

This letter is a letter of instruction which should be read in conjunction with the terms and background set out in the letter marked 'General Instructions' dated [ ].

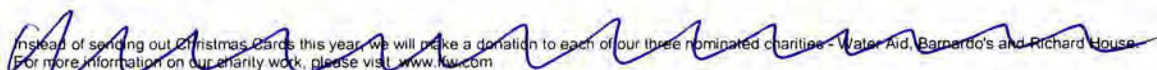
Alice Wilkie was an 81 year old patient who was admitted to the Queen Alexander Hospital on 31 July 1998 following a fall. She was transferred to the Gosport War Memorial Hospital on 6 August 1998. She died on 21 August 1998.

Papers

On 18 January 2008 I sent you two folders of medical records for Alice Wilkie and a folder containing correspondence relating to Mrs Wilkie.

You identified that the medical records were duplicated. My colleague Adele Watson looked into this issue and informed you, via e-mail, that an administration error had been made and the same set have been copied twice. For clarification the first file which is numbered 1-428 is the correct file and the 2nd file is surplus and can be thrown away.

I have now had the chance to inspect the original medical records, currently held by Hampshire Police, and the medical notes relating to the time surrounding her death were indeed missing from the folder.



I have asked the police to do me a definitive copy of the documents in relation to this period and enclose a faxed copy of these records with this letter.

Please telephone me urgently if there remain any issues surrounding these notes that may prevent you from completing your report.

Instructions

I would be grateful if you would focus on the following broad areas within your report.

1. Prescription of opioid analgesia

   (a) 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?

2. Drug chart

3. Pain assessment

   (a) 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?

4. Seeking advice

   (a) Clarify whether expert psychogeriatric advice was sought and/or obtained. Comment on the appropriateness of this course of action.

5. Medical Records

   (a) Do the medical records adequately set out the reason for the prescription of opiate medication?

6. Drug combination

   (a) 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.

Reference Material

In addition to your own experience and expertise I anticipate that the Fitness to Practice Panel will be assisted by any guidance or authoritative material which you consider relevant in this case.

Please note that the events in question took place between around 1997 to 2000 and Dr Barton should be judged in accordance with the guidance available at that time. In particular you should make reference to Good Medical Practice. Please let me know if you require a copy of these.

If appropriate, please identify and produce any authoritative material which you consider relevant to the issues you are required to provide expert comment on and annex it to your report.

Format

The style and format of your report is essentially a matter for you. However please refer to the letter marked 'Supplementary Issues' for guidance and suggestions as to how the report may best assist the Panel.

The Panel will need to decide whether Dr Barton's fitness to practise is impaired. This is a judgment which only the Panel can make and you should not therefore specifically comment on this issue.

Conclusion

If at any time you have questions about the issues which I have asked you to consider you should not hesitate to contact me. If you require any additional information, please let me know.

I would be grateful if we could work towards having your final report on Alice Wilkie prepared by **3 March 2008.** Please confirm that this date is acceptable to you.

Many thanks for your kind assistance with this matter.

I look forward to hearing from you.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**

Encs

Draft (18.02.2008)

Strictly Private & Confidential

Professor David Black
Dean Director
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Tamsin Hall
Assistant Solicitor
Code A (Direct Dial)

18 February 2008

Dear Professor Black

General Medical Council - Dr Jane Barton

Eva Page

This letter is a letter of instruction which should be read in conjunction with the terms and background set out in the letter marked 'General Instructions' dated [ ].

Eva Page was an 88 year old patient who was admitted to the Queen Alexander Hospital on February 1998. She was subsequently admitted into Gosport War Memorial Hospital.

Papers

On 18 January 2008 I sent you the medical records of Eva Page.

Draft report

You have kindly forwarded me your draft report on the treatment of Eva page dated 24 January 2008. Due to the time constraints of this case, as agreed, these instructions are being sent after you have preferred your preliminary draft report.

I would be grateful if you would address the following points within your report.

1. Drug chart

Instead of sending out Christmas Cards this year, we will make a donation to each of our three nominated charities - WaterAid, Barnardo's and Richard House.
For more information on our charity work, please visit www.ffw.com

(a) 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.

2. Pain assessment

(a) 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?

3. Seeking advice

(a) 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.

4. Medical Records

(a) Do the medical records adequately set out the reason for the prescription of opiate medication on Mrs Page's admission to Dryad Ward?

5. Drug combination

(a) 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?

Reference Material

In addition to your own experience and expertise I anticipate that the Fitness to Practice Panel will be assisted by any guidance or authoritative material which you consider relevant in this case.

Please note that the events in question took place between around 1997 to 2000 and Dr Barton should be judged in accordance with the guidance available at that time. In particular you should make reference to Good Medical Practice. Please let me know if you require a copy of these.

If appropriate, please identify and produce any authoritative material which you consider relevant to the issues you are required to provide expert comment on and annex it to your report.

Format

The style and format of your report is essentially a matter for you. However please refer to the letter marked 'Supplementary Issues' for guidance and suggestions as to how the report may best assist the Panel.

The Panel will need to decide whether Dr Barton's fitness to practise is impaired. This is a judgment which only the Panel can make and you should not therefore specifically comment on this issue.

Conclusion

If at any time you have questions about the issues which I have asked you to consider you should not hesitate to contact me. If you require any additional information, please let me know.

I would be grateful if we could work towards having your final report on Eva Page prepared by **3 March 2008.** Please confirm that this date is acceptable to you.

Many thanks for your kind assistance with this matter.

I look forward to hearing from you.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**

Encs

FILE COPY

Strictly Private & Confidential

Professor David Black
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19 February 2008

Dear Professor Black

General Medical Council - Dr Jane Barton

General Instructions

I write further to our previous correspondence. Thank you for agreeing to act as an expert on behalf of the General Medical Council in this matter. I am pleased to confirm that the General Medical Council have approved your acting as an expert.

This letter is a general letter of instruction, in which I will set out the terms of your instruction and general points on which I would like you to prepare a generic report. I will send specific instructions in relation to individual patients under separate cover.

The Fitness to Practise Panel hearing concerning Dr Barton has been listed for a hearing date from **8 September 2008 until 31 October 2008** in **London**. In due course, you will be required to attend the General Medical Council to give oral evidence on the basis of your expert reports. I am unable to confirm the actual dates at present but will do so as soon as I am able. You have confirmed to me that you will be out of the country between 5 September 2008 and 21 September 2008 and we have arranged that you will read transcripts of the hearing on 22 September 2008 and then attend at the GMC from 23 September 2008 in order to give your evidence.

As you are aware, there are a large amount of papers in this case and I will forward these to you as and when necessary under separate cover.

I do, however, enclose with this letter a folder of generic information which I believe will be useful to you at this stage.

1. Rule 6 letter of 11 July 2002

2. Hampshire Police Summary

3. CHI report

Background

I do not propose to describe the background of each case in detail to you in this letter of instruction. I will summarise each patient case to you in the individual letters of instruction. Some of the information below will be known to you already, however I summarise the position in order that you are clear as to the history of the matter.

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. 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.

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.

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.

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 any concerns you identify about record keeping, proper assessment and treatment and the combination and quantity and method of delivery of medication provided.

The first family to raise concerns were the family of Mrs Gladys Richards who died in 1998 As a result of their complaint, Hampshire Police 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.

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.

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).

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). 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.

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.

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. We have copies of reports you prepared in 2005 and 2006 in the course of this investigation.

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.

To date the GMC have not made their decision as to which patient cases will form part of the final charges against Dr Barton. We will confirm this to you as soon as we are able; the decision will be informed by the four new reports we have asked you to prepare.

Your previous involvement

You were previously instructed by Hampshire Police to prepare expert reports on a number of patient cases. I am in possession of reports which you have written as follows:

1. Elsie Devine – 16 April 2005

2. Gladys Richards - 24 July 2005

3. Helena Service – Draft 6 November 2004 and final report 12 June 2006

4. Sheila Gregory – 1 November 2005

5. Arthur Cunningham – 11 July 2005

6. Geoffrey Packman – 30 October 2005 and final report of 20 June 2006

7. Elsie Lavender – 19 March 2005

8. Enid Spurgin – 27 June 2005 and final report 23 November 2005

9. Ruby Lake - 29 August 2005

10. Leslie Pittock – 31 January 2005 and final report 22 April 2005

11. Robert Wilson – 19 November 2005 and final report 21 November 2005

It would appear that you prepared the reports based upon the medical records for each patient, Dr Barton's statements and her job description.

I would be grateful if you would confirm if this is the case and that we are in possession of all of your reports in relation to the above patients. It would also be helpful to have copies of any letters of instruction from the Police if you have retained these.

You have previously indicated to me that you were forwarded copies of the witness statements taken by Hampshire Police in relation to each patient.

I have written to you separately about individual patient reports but our barristers have also asked that you prepare a generic report on a number of issues commons to a number of the cases.

Your Report

I would be grateful if you would prepare a generic report covering the following issues:

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. (We may be able to assist with the copying of sections of the BNF from the relevant period if you can identify the sections we require.)

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 (again you should let me know if you would like me to obtain any copy documents to which you wish to refer but do not have copies). Please note that the events in question took place between around 1997 to 2000 and Dr Barton should be judged in accordance with the guidance available at that time. In particular you should make reference to Good Medical Practice.

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, if you are able, 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?

Your Expertise

It is not necessary to include your CV at the front of each report. We will use a single copy of your CV to establish your expertise. Your CV will need to address brief details of your own work and experience and in particular any experience you have in relation to the management of patients such as those whom Dr Barton treated. This is to illustrate that you are suitably qualified to comment as an expert in this case. It is likely that we will be able to use your previous CV but will check that it is up to date.

Reference Material

In addition to your own experience and expertise I anticipate that the Fitness to Practice Panel will be assisted by any guidance or authoritative material which you consider relevant in this case. I have highlighted guidance we have identified but do please let us know if there is any other relevant materials.

If appropriate, please identify and produce any authoritative material which you consider relevant to the issues you are required to provide expert comment on and annex it to your report.

Format

The style and format of your report is essentially a matter for you.

The Panel will need to decide whether Dr Barton's fitness to practise is impaired. This is a judgment which only the Panel can make and you should not therefore specifically comment on this issue.

Conclusion

If at any time you have questions about the issues which I have asked you to consider you should not hesitate to contact me. If you require any additional information, please let me know.

We have agreed that you will charge £200 per hour for writing your report and a daily attendance rate at hearing of £1,200 (which will be billed £600 from you and £600 from the Deanery).

Now that you have some idea of what is involved, I would like to discuss with you further your time estimate for preparing the reports and to organise a convenient time with you to have a short telephone conference about the work involved. **I am required by the GMC to obtain an estimate for the work on your reports.**

I would be grateful if we could work towards having your reports prepared by **20 March 2008** (I have indicated in my covering letter that in fact some reports are due sooner). Please confirm if this date is acceptable to you.

Many thanks for your kind assistance with this matter.

I look forward to hearing from you.

Yours sincerely

Tamsin Hall
for **Field Fisher Waterhouse LLP**

Encs

GENERAL MEDICAL COUNCIL AND DR. BARTON

(Tape 1)
FILE 2

1. The first document in file is a helpful note giving an overview of the police investigation, including a summary of the expert evidence obtained by the police.

2. Pages 11 and 12 of the note refer to "themes of concerns" noted by the two principal experts, Dr. Wilcock and Dr. Black, when looking at the ten category 3 cases. The themes noted are as follows:

2.1 Failure to take clear, accurate and contemporaneous patient records.

2.2 Lack of adequate assessment of the patient's condition.

2.3 Failure to prescribe only the treatment and drugs that served the patient's needs.

2.4 Failure to consult colleagues, including the following:

2.4.1 Spurgin - Orthopaedic Surgeon, Microbiologist

2.4.2 Packman - General Physician, Gastroenterologist

2.4.3 Service - General Physician, Cardiologist

2.4.4 Lavendar - Haematologist

2.4.5 Gregory - Psychogeriatrician

2.4.6 Pittock - General Physician/Palliative Care Physician

2.4.7 Cunningham - Palliative Care Physician

3. Looking at the above and the relevant editions of Good medical practice - in October 1995 and July 1998 (the latter was in force until 2001), I need to look at the following, in particular:

3.1 Failure to exercise good clinical care, abuse of professional position (subjecting patients to treatment which probably was not in their best interest), possibly inappropriate delegation to those which were not competent to undertake a procedure (particular reference to the use of syringe drivers), possibly signing Death Certificates which Dr. Barton knew or should have known to be false or misleading.

4. With regard to good clinical care, the issues to consider include inadequate assessment of the patient's condition based on the patient's history and clinical

signs, providing or arranging investigations or treatment where necessary, working within the limits of their professional competence, exercising competence when making diagnoses, keeping clear, accurate and contemporaneous records to include details of relevant clinical findings, and any drugs or other treatment prescribed and prescribing only the treatment, drugs, etc. that serve the patient's needs.

5. Note with regard to the guidelines for good medical practice issued in July 1998 - paragraph 13 under the general heading "Maintaining Trust", a doctor must "not allow his/her views about a patient's age to prejudice the treatment which is provided".

6. With regard to paragraph 39 of GMP July 1998, see the following:

   "When you delegate care or treatment, you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient."

7. The police note summarising the overview of the investigation notes, at page 12, that there was little consensus between the two principal experts - Black and Wilcock - as to whether the Category 3 patients were in "irreversible end stage terminal decline". There was also "little consensus between the experts as to whether negligence more than minimally contributed towards the patient's death".

8. Page 13 of the note observes that the medical evidence "did not prove that drugs contributed **substantially** towards the death".

9. The second document in File 2 is a Case Summary prepared by the police. This explains the background to the case and, in particular, concerns raised by nursing staff as long ago as 1991. The concerns related to the excessive use of Diamorphine using syringe drivers. The police summary refers to specific evidence obtained from members of staff. The summary indicates that in 1991, certain members of staff were very concerned about the use of syringe drivers, including the following related practices - putting patients on syringe drivers when they were not in pain, the blanket use of syringe drivers before any other analgesics were tried. The "blanket" prescribing of Diamorphine, the use of Diamorphine to calm patients who were aggressive or noisy rather than in pain. The note refers to a further concern that patient deaths were sometimes hastened unnecessarily.

10. The note refers to a meeting between staff and hospital management on 11 June 1991. The note, and summary, indicates that the management failed to take the

concerns seriously and hints at distress/hostility between vulnerable nurses on one hand and an unresponsive management team on the other.

11. Page 5 of the Case Summary includes a list of nurses from whom the police have taken statements. They all refer to various concerns about the use of syringe drivers and the prescription of medication for use with syringe drivers. **We may need to adduce some of this evidence, even though not directly relevant to these specific patients. We need to check whether any of these nurses were employed between 1996 and 1999, as well as in 1991. They could then give evidence with regard to both the history and possibly some of the individual cases as well.**

12. Page 9 of the note refers to a witness, Jeffrey Watling - the Pharmacy Services Manager for Portsmouth Hospital NHS Trust. **Check his statement, in particular, the exhibit referred to being a handbook covering palliative care. This includes guidance on the clinical management of patients who are dying and includes reference to the use of syringe drivers.**

13. **Page 9 of the note also refers to another witness, Irene Dix, who exhibits to her statement a protocol for prescription and administration of Diamorphine by subcutaneous infusion. The police notes state that this appears to be the earliest protocol regarding the prescribing of Diamorphine by syringe drivers issued by Portsmouth Trust. It is said the guidance is dated "around the end of 1999".**

14. Page 10 of the note refers to a statement from Wendy Jordan, a Personnel Assistant. Her statement includes a job description for the Clinical Assistant post, i.e. a form that would have been applicable to Dr. Barton. The police note includes a summary of the Clinical Assistant's duty which includes responsibility for the day-to-day medical management and responsibility for writing up initial case notes and to ensure that follow-up notes are kept up-to-date and reviewed regularly.

15. Page 11 of the note refers to the report prepared by Professor Baker in 2002. He prepared a statistical analysis of the mortality rates at Gosport Hospital, including an audit and review of the use of opiate drugs. **We need to obtain a copy of the report.**

<u>The first witness statement in the file is Margaret Dorrington:</u>

16. On page 4, she explains the benefits of using a syringe driver - better management of pain control, the patient does not suffer the peaks and troughs of pain encountered with other methods. Syringe drivers are also used when a patient has difficulty in swallowing and cannot therefore take oral medication. She says that syringe drivers were only ever used for patient who were in a lot of pain, i.e., "so much pain that they were nearly losing consciousness". She

says that a doctor had to authorise the use of a syringe driver including the dosage. It was then up to the staff nurse to decide when to commence using it. She says that during the time that she worked at the Redcliffe Annex at the Gosport Hospital, very few patients received medications with a syringe driver.

17. Dorrington goes on to say that in 1994, most of the patients from Redcliffe Ward were to Dryad Ward. The witness describes this as being initially a long-term geriatric ward, but then explains that as some of the patients passed away naturally or were moved to nursing homes, their beds were filled with terminally ill elderly patients. She describes the care for these patients as being "palliative care".

18. On page 4, the witness says the patients' whose health was deteriorating and who were expected to die sooner rather than later, were admitted to Dryad which, on page 5, the witness describes as a "palliative care" ward.

19. On page 5, Dorrington also claims that the patients on Dryad Ward were all suffering from serious conditions and the majority were in a lot of pain. Because of this, she found that the use of syringe drivers was becoming more common. She says she found the staff training "more than adequate". She describes Dryad as being a "very happy ward". She says that Daedelus Ward was not as cheerful due to issues as starving. She claims that Dryad was a happy ward because Sister Hamblin ran it so well. **[Useful background information, but no evidence that is critical of Dr. Barton.]**

<u>Witness statement of Sylvia Giffin:</u>

20. Mentions that Redcliffe Annex was based approximately half a mile from the main hospital site. She describes the unit as about 17 beds "used for the elderly patients who were coming to the end of their lives". She refers to a happy working environment until Nurse Hamblin took over as Sister in the early 1990's. She describes Sister Hamblin has having a "vendetta against people she did not like". She also says that Hamblin encouraged the use of syringe drivers, which were rarely used prior to Hamblin starting work at the Unit. The use of syringe drivers escalated when she started and the witness felt that this was wrong "because it seemed that most patients were going on drivers even when they were not in pain and their use was a matter of course rather than need". It says that the decision to place patients on syringe drivers was entirely down to the doctor responsible for the Ward, i.e., Dr. Barton. The witness says that she got on well with Dr. Barton and felt that she was "a competent doctor". However, she criticises Dr. Barton for authorising the use of syringe drivers on patients as a matter of course. It was open to the nursing staff to use the drivers at their discretion. The witness refers to concerns raised by her and her colleagues concerning the practice and a meeting with management to share their concerns. Refers to one meeting where Dr. Barton said that she felt that she

(Barton) was being accused euthanasia. The witness says that despite the concern expressed at the meeting, the use of syringe drivers continued to increase.

21. Giffin, on page 3 of her statement, says she cannot remember the names of any patients who suffered or died because of syringe drivers, but recalls on one occasion that Dr. Barton asked her advice with regard to a patient who was on Valium. Sister Hamblin wanted to place the patient on a syringe driver. Giffin says that she told Barton that it would be unfair to put the patient on a syringe driver. Dr. Barton agreed to put the patient back on Valium.

22. On page 4 of her statement, Giffin recalls that a check of the Pharmacy revealed that Redcliffe Annex was using more pain killers than other Units. She says that eventually she gave up complaining despite the fact that her concerns had not been addressed.

23. Giffin exhibits to her statement various letters, reports, minutes of meetings relating to the concerns raised in 1991. **[Useful background information. Check to see whether this nurse was involved in the care of any of the ten category 3 patients.]**

24. Iris Goldsmith describes Dr. Barton on page 1 of her statement as being "a first class and very caring doctor".

25. On page 2 of her statement, she says, "I do not think there was any one doctor at the Gosport Hospital who prescribed Diamorphine more than the others". On page 2, she also says:

    "I never had any concerns about any doctor prescribing Diamorphine. As someone with many years experience, in my opinion, these drugs were always given correctly. I was aware that some nurses didn't feel the same way."

26. She also states:

    "I also felt that Diamorphine was only being given as a last resort. Other types of pain management was always tried first."

27. On page 3 of her statement, she refers to concerns raised by other members of staff about the use of Diamorphine/syringe drivers in 1991. She says that she attended the meeting, but says that personally, she does not "have any concerns either about the palliative care, the use of syringe drivers, the prescribing of Diamorphine or Doctor Barton" **[the statement supports Dr. Barton]**.

<u>Statement of Beverley Turnbull:</u>

28. Page 3 refers to Doctor Barton's appointment. "It was around this time that I noticed the use of syringe drivers on the ward". She goes on to say:

"I was extremely concerned because I thought that syringe drivers were being used on patients who had not presented any symptom of pain. All the patients who were prescribed this method of pain relief were under the care of Doctor Barton and it was done on her instruction, but it was the nurses' discretion to administer the drugs."

"I was aware that there were patients on the Ward who did require pain relief and the syringe driver was appropriate, but I was concerned for the number of patients who seemed to be prescribed Diamorphine and strong opiates without first trying weaker analgesics."

29. On page 4 of her statement, Turnbull refers to concerns being raised at the meeting which took place in 1991. She says she kept the minutes and correspondence.

30. She refers to the 1991 meeting as being "very much like them and us".

"The medical staff were on one side and the nursing staff were on the other. The medical staff were sat like a panel. The general tone was that the nursing staff did not know what they were talking about...I felt very vulnerable and that no one was listening to us." **[Check minutes to identify all the doctors who attended the meeting.]**

31. Page 5 of the statement refers to the type of patient being admitted onto Dryad Ward began to change - all patients admitted as a result of Orthopaedic procedures. Thus, there was a need for multi-disciplinary input, e.g. physiotherapy and occupational therapy.

32. The witness exhibits various documents to her statement.

33. On page 7 of her statement, she says that she did not have any concerns about the use of syringe drivers when the Unit moved to Dryad Ward. She says:

"I believe that the syringe drivers were correctly used for the people who needed them. If I remember, the issues seemed to have been resolved." **[Useful background information, but it appears that in the critical period, the witness did not have any concerns about the use of syringe drivers.]**

Statement of Anita Tubbritt:

34. On the second page, she describes a change in medical care at Redcliffe Annex in 1991 - i.e., instead of patients own GP's being responsible for their care, Dr. Barton was appointed as a Clinical Assistant. Barton visited the Ward daily and dealt with all medical matters concerning the patients in the Unit.

35. The witness says that Barton visited the Hospital before her morning GP surgery. Other members of her practice covered for her when she was on leave or away

for any reason. The witness refers to cover being provided by Dr. Peters, Dr. Beasley and Dr. Knapman. Dr. Lord was the Consultant. **[Have statements been obtained by the police from any of the other doctors referred to? What do they have to say about Dr. Barton's use of syringe drivers and prescribing practice?]**

36. The witness says that when Dr. Barton took over the medical side of running the unit "it became better organised and seemed to be better structured".

"I think it was also around this time that syringe drivers were introduced to the Unit. I have no recollection of them being used in the Unit prior to this."

37. On page 3, the witness says that it appeared to her that these syringe drivers became the "preferred method of administering drugs. I certainly noticed them being used more and more". The witness also says that the type of patient admitted to the Ward started to change - "We began admitting people who were far more poorly and who required more nursing than medical intervention. More of our patients required palliative care, by this I mean the patient was made comfortable until his or her death. A patient who required palliative care was expected to die."

38. Witness refers to her main concern being that staff had not been properly trained to use syringe drivers and refers to concerns about this at a staff meeting which followed. **[Is the witness referring to the 1991 meeting (ask)?]**

39. Page 5 of the witness statement indicates that when the Unit moved to the main hospital site and the Redcliffe Annex became Dryad Ward, she didn't have the same concern about syringe drivers. She also says that Dr. Barton appeared to be more accessible. **[The witness seems to be saying that her main concerns about the syringe drivers related to the period around 1991 and that by 1997/98, matters had been resolved. Check to see whether this witness nursed any of the Category 3 patients.]**

<u>The statement of Isobelle Evans:</u>

40. Note that she retired in 1996 and may not, therefore, have been involved in nursing any of the Category 3 patients.

41. On page 2 of the statement, the witness says that syringe drivers were first used in 1991. **Witness says that this was due to some staff attending study days and recommendations that pain relief using this method was more appropriate than alternative pain killing remedies. It therefore seems that Dr. Barton was not responsible for initiating the use of syringe drivers in 1991, although, according to other witnesses, the use of**

syringe drivers appears to have coincided with the commencement of Dr. Barton's role as Clinical Assistant.

42. The witness refers to concerns raised by staff as to the use of syringe drivers. Witness spoke to Dr. Barton and Sister Hamblin in connection with this - "They satisfied me that all usage of the drivers at the Unit was safe and appropriate. I felt that the problem was that the drivers were new and staff did not understand the thinking behind their usage". The Witness says that she arranged training for staff including a lecture by a pain control expert, Steve King.

43. On page 3, the Witness says that at the time she had no concerns about syringe drivers and that, indeed, she instigated their purchase. **[Also note that the statement includes details of use of syringe drivers which, in the police summary, had been referred to as an example of the Witness' ignorance as to how they should be used as the Witness believes that equal amounts of medication should be given orally or by syringe driver, whereas, according to the police note, lower dosages of medication are required when the drug is administered intravenously.]**

44. On page 3 of the statement, the Witness refers to Dr. Barton as an "approachable and capable professional".

45. On page 3 of the statement, the Witness refers to staff being requested to provide examples of misuse of syringe drivers. The Witness says that she did not get a reply. The Witness says that she was still anxious to address the problem and so arranged a meeting which was attended by Dr. Barton and Dr. Logan. Apparently, Dr. Logan answered all concerns over the use of syringe drivers and the prescribing of Diamorphine. **[Have the police taken a statement from Dr. Logan in connection with this?]**

46. The Witness says that no further concerns were raised following the meetings in 1991 until the Witness' retirement in 1996.

47. On page 4 of the statement, the Witness says:

    "My personal opinion is that these problems in 1991 were due to culture changes at the Unit which I helped to impose. These were mainly the use of pain killers and bringing the nursing practices up to date. I was supported in the effort to impose the changes by Gill Hamblin, the Sister in charge of the Unit."

48. The final sentence of the statement says:

    "I can honestly say that I did not do anything incorrectly and I am satisfied that all patients who were placed on syringe drivers were appropriate." **[Interesting background, but query whether this Witness' evidence is reliable/defensive.]**

Statement of Paul Murray - a nurse who was also a full-time Convenor at the Royal College of Nursing

49. The RCN acts as a Trade Union and formulates policy on nursing issues.

50. Page 2 of this statement refers to concerns raised by Nurse Tubbritt in 1991 relating to the use of Diamorphine and syringe drivers.

51. The Witness refers to a meeting in February 1991 when members of staff expressed concern about the inappropriate prescribing of Diamorphine, i.e. concerns that this is being used without any due consideration being given to the use of milder sedatives.

52. Page 3 states that one side effect of Diamorphine is the reduction in the respiratory rate.

    "A patient that is elderly and lying in bed cannot breathe deeply so could therefore suffer with congestion in the lungs leading to hypostatic pneumonia and to combat this, often another drug such as Hyoscine was prescribed."

53. Page 3 refers to visits by Dr. Barton and Dr. Logan who is described as a "Consultant Geriatrician".

54. Page 3 - Witness says that he felt that staff concerned in 1991 were justified however resulting in him sending a letter to Isabelle Evans on 15 February 1991.

55. Page 4 - Refers to Witness attending a meeting with Isabelle Evans when the Witness represented Sylvia Giffin. Concerns about the use of syringe drivers were raised at the meeting. Following the meeting, a notice was put up to notify staff that a meeting would be arranged where they could voice any concerns without fear of reprisals by disciplinary action.

56. Pages 4/5 - the Witness refers to a meeting of staff on 11 July 1991 where the staff re-iterated their concerns. The Witness did not attend this meeting, but minutes of the meeting are exhibited to the Witness' statement.

57. Page 5 refers to training received by staff as a result of their concerns. Notwithstanding the training, the perception of the Witness was the concerns were not being addressed properly and the Witness was also concerned by the fact that Management had asked staff to lodge formal allegations in support of their position. The Witness felt that the Management had failed to manage the situation properly.

58. Page 7 of the statement, the Witness says that the concerns raised were serious enough to warrant the introduction of a policy on the use of Diamorphine - "To my knowledge, such a policy was not made as a result of my request".

59. The Witness refers to the fact that Gosport was "quite an isolated hospital" and that the Redcliffe Annex was even more isolated as it was situated about a mile from the Hospital.

60. The Witness says, on page 7, that by the middle of 1992 correspondence with the staff ceased so the Witness assumed that the matter had been resolved to the satisfaction of both parties. The Witness therefore had no further dealings with staff about the subject of Diamorphine and syringe drivers. **[Check minutes of meetings to see how the concerns were raised and, in particular, how Dr. Barton responded to the concerns.]**

Statement of Geraldine Whitney - Senior Lecturer in respect of Community and Child Health Studies at the University of Portsmouth:

61. The Witness was involved with dealing with the concerns raised by staff in 1991. Witness prepared a report which is exhibited to this statement which records the concerns. On page 4 of the statement, the Witness states that she circulated a copy of her report to her staff members, but as she didn't hear from any of these people again, she concluded that the problems had been addressed. **[Read copy of the report contained in the exhibits bundle.]**

Statement of Jane Parvin (second statement in the file - witness was a Personnel Director employed by the Fareham and Gosport Primary Care Trust):

62. The second statement deals with disclosure by nurses in 2002 of concerns which they raised in 1991. **[The police had re-activated their investigation into the death of Gladys Richards in April 2000, the CHI had issued a report in May 2000 and Professor Baker had been commissioned to prepare a statistical an analysis of deaths.]** The Witness' statement indicates that nobody in the senior management seemed to have been aware of the concerns expressed in 1991. **[There are a number of statements in this section of the file obtained by police from various individuals involved in the management of the Trust concerning the events of 16 September 2002. A meeting had been called on that date to discuss how the Trust would manage and co-ordinate the media and other communications surrounding Professor Baker's audit. On the same day, Managers were presented with documents from staff members, recording the staff's concerns relating to the use of Diamorphine and syringe drivers in 1991. The statements from Managers refer to shock and surprise on discovering that concerns had been made at that time.]**

Statement of Betty Woodland:

63. The Witness was a Senior Staff Nurse at Gosport Hospital and a steward of the Royal College of Nursing. Had no direct involvement in this case other than attending the September 2002 meeting referred to above. However, on the

fourth page of her statement, she says that she had contact with Dr. Barton on a regular basis.

"I have always found her to be very accommodating and very nice to the patients I have seen her with. I have always found her to be approachable, humorous, friendly, and very professional."

64. Witness also describes Dr. Lord as being "one of the most professional Consultants I have ever worked with. I have always found her to be extremely knowledgeable and friendly. She is extremely caring to both her patients and her staff."

Statement from Margaret Wigfall - State enrolled nurse who worked at Gosport Hospital from 1981 to at least October 2002:

65. Confirms that she had concerns about the use of syringe drivers and the meetings were called to deal with these concerns. The use of syringe drivers made the witness "uncomfortable". The Witness felt they were used too often - rather than being used to control pain, they were used on patients who were approaching death and suffering from anxiety and distress.

"My concerns were increased because it appeared that an awful lot of patients that died were on syringe drivers."

66. However on page 4 of the statement, the Witness expresses a view that Dr. Barton and the nursing staff always acted in the best interest of the patients.

"Just because I was concerned about the syringe drivers does not necessarily mean that the use was wrong.

Finally, I never directly discussed my concerns with Dr. Barton."

Statement from Mary Ryder - Nurse who worked at Gosport for about 15 months from May 1990 (also worked previously at the Hospital for two years from 1985):

67. Confirms that syringe drivers were in use when she returned to work at the Hospital in May 1990. She felt uncomfortable using them due to a lack of training. On the first page, she claims that there is nothing which made her think that certain doctors were prescribing Diamorphine more than others.

68. On page 2, she says that patients were not commenced on syringe drivers without first having been prescribed other forms of analgesic.

"I can only remember very ill people being put on syringe drivers. People on syringe drivers with Diamorphine were not expected to live that long. They were prescribed the driver to manage their pain prior to death."

69. Witness says that she found Doctor Barton to be approachable and very professional and caring towards the patients and other staff.

Statement of Susan Rigg - worked at Gosport between 1993 and 2003, including a spell on the Radcliffe Annex NB: Dryad Ward

70. Describes the general patient care on the wards as "very good". However, she said that the needs and demands of patients changed and more acute patients were taken on. She feels that the medical cover did not reflect the changes in the type of patient. She referred to an increasing work load. On page 1, she refers to the practice of prescribing a variable dose of medication for use in syringe drivers thus placing responsibility onto the nurse to decide the actual dose. She had concerns that not all nurses were sufficiently trained in regard to the use of Diamorphine, the implication being that too much responsibility was placed on certain members of staff using syringe drivers/Diamorphine.

"At no time do I think there was any intention to harm, but I do feel there was a lack of education."

Witness - Elizabeth Ball - worked as a nurse at Gosport between July 1990 and October 1991

71. Describes the general patient care as "excellent". Praises the Sister, Gill Hamblin. Expresses concern with regard to the use of syringe drivers and Diamorphine. Refers to the practice of Doctor Barton issuing prescriptions for the use Diamorphine to the Sister over the telephone. Telephone prescriptions were supposed to be followed up. The Witness says that follow-up visits did not seem to happen.

72. On page 2, the Witness says that patients were being put on to Diamorphine inappropriately - i.e., without considering other types of analgesic relief. The Witness also says that with hindsight, she felt that Doctor Barton was "overly trusting" of Sister Hamblin **[interesting comment, but surely it ignores the fact that Doctor Barton was responsible for determining by proper assessment whether or not it was appropriate to start a patient syringe driver/Diamorphine]**.

73. Witness refers to Sister Hamblin showing great care for the patients, although the Witness pleads that Hamblin was obsessed about these types of patients and had an "unhealthy interest in the death process".

74. On pages 2 and 3, the Witness refers to specific cases of concern - where patients were given syringe drivers for "no reason at all", i.e. they were not ill or in pain.

Witness - Code A - Nursing Auxillary Nurse worked at Gosport from June 1991 to August 1991 as Nursing Auxillary

75. Refers to an elderly patient called Marjorie who was given Diamorphine even though she was not in pain. Within a couple of days, she had died. The Witness discussed this with one of the nurses - Nurse Ball, who expressed concern about the use of Diamorphine (not only in Marjorie's case, but in the case of other patients as well).

Witness - Sue Donne - worked as a nurse at Gosport from April/May 1991.

76. Shortly after she started work, she became aware of staff concerns over the use of syringe drivers. Drivers had been recently introduced. Attended the meetings between July and December 1991 with Management when concerns were aired.

77. Witness says that after the meetings in 1991, and until the witness left the Hospital in 1995, the issue regarding syringe drivers was not raised again.

78. On page 3 of the statement, the Witness deals with some of the points raised in Ms. Whitney's report (referred to earlier). Comment on the criticism that patients were "written up" to have syringe drivers before they required it, the Witness says this happened if a patient's condition was expected to deteriorate. SIV syringe driver could be used if required.

79. Witness describes criticism of Doctors Barton and Logan as "unfounded".

"Both were approachable and capable professionals. Doctor Barton was especially approachable and happy to receive input from staff."

Witness - Elizabeth Martin - worked as a Staff Nurse at Gosport from 1987/88

80. On page 2, expresses some concerns about syringe drivers and Diamorphine - certain patients were put on syringe drivers where there were no indications that they needed it. Witness cannot remember the patients' names. The Witness refers to the meeting (1991?) when staff concerns were raised.

81. On page 4 of the statement, the Witness describes Doctor Barton as "pleasant and approachable".

Statement of Shirley Hallmann - Senior Staff Nurse at Gosport from January 1998.

82. She was supposed to be Ms Hamblin's Deputy, but was given very little responsibility.

83. Page 1 of statement - Witness impressed with the level of patient care. "The patients were well cared for, they were always clean, including hair and nails. The Ward was clean and nurses gave great attention to making sure the patients ate properly. This was due to the way Gill Hamblin ran the Ward. She was an excellent nurse..."

84. Page 2 - the Witness had not been at the Hospital very long when she began to have concerns about the use of syringe drivers - in particular, the fact that drivers were used too early before other methods of pain control had been tried.

85. Page 2 - Nurse says that Doctor Barton authorised the use of a syringe driver "as and when it was required". Witness says that Barton is the only doctor that she has known to do this. It meant that authority was in place and the decision whether to use the driver or not was down to the trained nurses. In reality, this meant Ms. Hamblin. The Witness says that Hamblin and Doctor Barton were very close. Barton was very trusting of Hamblin. Barton did not question Hamblin's views.

86. Page 3 - Witness is unable to recall any names of patients who were placed on syringe drivers. **[Check to see whether this witness was involved in the care of any of the Category 3 patients.]**

87. Page 3 - Witness describes a deterioration in her professional relationship with Ms. Hamblin. Says that Doctor Barton "remained civil and kept a very professional attitude".

88. Pages 3 and 4 - Witness involves a strange conversation with Doctor Barton. Witness apologises to Barton because she believes she has upset Barton, but is not aware of the reason for this.

89. Witness - "I believe I upset you and I am sorry if I have".

    Barton - "It's not that, but you just don't understand what we do here".

    Witness says that she took this to mean that Doctor Barton was referring to the use of syringe drivers.

90. Page 4 - Witness made a complaint of harassment against Hamblin and Barton. Witness has the documents relating to the complaint process. The upshot was that the Witness left the Hospital on a lower grade. **[Witness' date of departure from Gosport not clear from statement.]**

91. Page 4 - This says, "In my opinion, the patients at Gosport were put on syringe drivers too early and on too high a dose of either Diamorphine or Medazolam".

92. Page 4 - Witness refers to the practice of Doctor Barton and Sister Hamblin of putting patients on syringe drivers. "Both of them believe that they were doing the best for each and every patient. I do not believe that they ever intended to harm or kill any patients."

93. "In my opinion, Doctor Barton was responsible for the high dosages given to patients. Her actions were ill thought out and could have led to the premature death of a patient."

94. Witness left Gosport in September 2000. **[*Consider taking a more detailed statement from this Witness as she appears to have been working on the Ward in 1998/1999 and may be able to give relevant evidence with regard to the Category 3 patients.]**

Second Statement of Sandra Hallman

95. Refers to misgivings of other staff members - Freda Shaw, Lynne Barratt and Sharon Ring and Barbara Robinson. **[Check to see whether these witnesses have given statements to the police. If not, we are going to need to trace them and interview them.]**

96. Page 4/5 - The Witness refers to the patient notes of Mr. Cunningham. Some of Mr. Cunningham's notes are signed by the Witness. Mr. Cunningham's general condition is described on page 5. Page 5 also refers to the use of a syringe driver. The extract from the patient's notes referred to on page 5 indicates that the use of a syringe driver in this case was necessary - see note of conversation with Mr. Cunningham's relative - "Mr. Cunningham was on a small dosage, which he needed".

97. Page 6 - Further reference to the patient's note which again indicate that the use of a syringe driver was necessary for pain relief.

"It may be that Mr. Cunningham could not take Oramorth for any reason and that was why the syringe driver was put in place." **[The Witness does not, therefore, appear to be in a position to give any clear evidence regarding Mr. Cunningham.]**

Witness - Tina Douglas - worked as a nurse at Gosport from 1993 - 2003

98. **[Witness was present at the relevant period re treatment of Category 3 cases. Possible candidate for interview/more detailed statement.]**

99. Witness says that at Gosport, syringe drivers seemed to be used more frequently than other hospitals. Witness said that although the use of syringe drivers was more frequent, their concerns were with specific patients as opposed to general use. Witness did not get on with Sister Hamblin. Hamblin and Barton enjoyed a close working relationship. Drugs were prescribed to patients more or less on their arrival thus passing responsibility on to the nurse as to when the patient should be started on the drugs.

100. "At no stage did I ever witness or feel that any member of staff did anything to harm a patient."

Pauline Spilka - worked from mid 1995 to February 1999

101. **[May be able to give detailed evidence in relation to the Category 3 cases in 1996, 1997 and 1998 - she left in February 1999 before the first of the Category 3 cases in that year occurred.]**

102. On page 1, Witness refers to the specific case of Gladys Richards and remembers the case because the staff were wary of one of her daughters who was known to complain.

"Due to this, I recall Mrs. Richards being nursed rather better than the norm."

103. Page 1 refers to an internal inquiry following a complaint by one of the daughters. **[Has the Trust provided details of the investigation into the complaint?]**

104. The Witness does not give a great deal of detail in relation to Mrs. Richards **[worth taking a statement from?]**

105. Page 2 - The Witness refers to "indiscriminate use of syringe drivers" as being her "main concern".

106. "It appeared to me then and more so now that euthanasia was practiced by the nursing staff."

107. Page 2 refers to the role of the Ward Manager. The Witness identifies two people, Sheila Joins who retired and was replaced by Philip Beed. **[Check to see whether police have taken statements from either of these witnesses.]**

108. Page 2 - Witness says that patients were usually admitted by the Clinical Assistant (presumably Barton) or, if she was not available, then occasionally Doctor Lord. On admission, a Care Plan for each patient would be drawn up.

109. Pages 2/3 - The Witness refers to the practice of authorising the use of a syringe driver when patients were admitted.

"This enabled any member of the nursing staff to set up a syringe driver without any further reference to the Doctor."

110. Page 3 - The Witness refers to the "regime" on the Ward. She describes nurses making a decision as to whether a syringe driver should be used; in which case, the nurse would seek approval from another trained nurse. Presumably, this happened when Barton had already authorised use of the syringe driver, but the timing as to the commencement of the use of the device was left to the nurses. The Witness referred to disagreements between nurses, usually resolved by referring the matter to a more senior nurse. **[*This is an important point because it illustrates that whilst Barton facilitated the use of the syringe drivers, the decision to commence the use of them was left with the**

nurses. Presumably the nurses also had the discretion as to the ~~drug~~ drugs to be used within the parameters authorised by Doctor Barton. I can therefore see why it would be more difficult to prove that in doing this, Doctor Barton intended to kill or hasten the death of a particular patient. It does, however, raise issues as to whether or not authorisation in any particular case was or was not appropriate and whether or not it was appropriate to delegate decisions as to when the syringe driver should be used and how much medication should be used.]

111. Pages 4/5 - Witness refers to the case of Mr. Brickwood - the Witness seems to be saying that there was no need for this patient to be placed on a syringe driver. The decision to do so was made as he remained unconscious until he died.

Witness - Dorothy Forfar

112. Witness was an Auxiliary Nurse at Gosport between 1976 and 1994 **[i.e., before any of the Category 3 cases]**. Thinks that syringe drivers were being used too soon on some patients and some patients were put on them "just because they moaned and groaned". She says there are other nurses who shared her concerns.

Witness - Susan Corless

113. Witness an Auxiliary Nurse between 1978 and 1992 **[again, before the Category 3 cases]**. On occasions, she had concerns about the use of syringe drivers, "I didn't understand why some stroke patients, who didn't appear to be in pain, were put on them".

"When patients were put on syringe drivers, they were not taken off of them until they died. In my opinion, the use of a syringe driver shortened the patient's life."

Also expresses the view that Diamorphine was used inappropriately, i.e., given to patients who didn't require "that level of pain relief".

114. On page 4 of her statement, she says that Dr. Barton did not spend much time with the patients.

Witness - Margaret Brennan

115. The Witness worked as an Auxiliary Nurse between 1963 and 1995. She had concerns about the use of syringe drivers and the fact that they were used "so quickly", i.e., other types of pain relief were not tried first.

116. Describes Dr. Barton as "a very nice lady - who appeared to be very friendly. I know that she wrote the patients up for Diamorphine and syringe drivers".

117. Pages 2 and 3 says that after she retired, her mother was admitted to Daedalus Ward in June 1997. She suffered from arthritis and had suffered strokes, but was admitted to treat a bed sore. The Witness visited her mother daily. She was telephoned by Philip Beed. He sought permission from the Witness to use a syringe driver on her mother. The Witness told him that, in her opinion, her mother was not in need of Diamorphine and she refused. Subsequently, she did agree to the use of a syringe driver, but Diamorphine was not used. Later, the Witness consented to Morphine being used by syringe driver after a discussion with Dr. Lord. The Witness discussed the matter with Dr. Lord because she could see that her mother was in pain.

Witness - Joyce Tee

118. The Witness worked as a Nursing Auxiliary from October 1971 to March 1991 **[i.e., before the Category 3 cases, but note that she is typical of many witnesses who say they had concerns about the use of syringe drivers.]**

Witness - Jane Basson

119. The Witness worked as a nurse between June 1999 and January 2002 **[this therefore falls partly within the period covered by the Category 3 cases]**. Describes general patient care as "very good". Said that she has no concerns about the use of syringe drivers or the drugs used in them, but says there were no labels on the syringe drivers to say what medicine was in the syringe drivers. She said that the issue of labels was brought up at a Ward Meeting which resulted in labels being put on the drivers. Worked nights so had little contact with doctors, however, describes meeting Dr. Barton who she found to be "a very good and caring doctor".

120. **[THE ISSUE OF PATIENT/RELATIVE CONSENT BEFORE SYRINGE DRIVERS ARE USED DOES NOT SEEM TO FEATURE IN ANY OF THE STATEMENTS. CHECK GUIDANCE TO SEE WHETHER CONSENT WAS REQUIRED.]**

121. The Witness was an experienced RGN Nurse before she was employed at Gosport Hospital. From 1 November 1999 to 31 October 2000, she worked as a Senior Staff Nurse on a one-year contract. She worked on Daedalus Ward. She describes the standard of patient care as "unacceptable".

122. On page 2, she says that drug charts were either not filled in or not filled in correctly.

123. On page 3, she says that pain management was totally inadequate. "The dosage for Diamorphine was rarely changed and consideration was not given to the patient's build up of tolerance to morphine. I am very experienced in pain control due to my previous places of employment and consider that the doctors

were reluctant to prescribe the necessary dosage in order to control some very painful conditions in very elderly patients." **[The inference here is that syringe drivers and Diamorphine were underused!]**

[This Witness started after the last Category 3 patient died.]

Witness - Sheelagh Joines

124. The Witness worked at Gosport between 1979 and 1997, including a period on Daedalus Ward. Refers to Dr. Barton making early morning visits to review patients (page 2). Describes Dr. Barton as "One of the best doctors I have worked with. She is a very caring lady and someone I would describe as compassionate, she is a fair lady and someone who valued the opinion of her staff. She is still my GP and someone that I trust and respect highly".

125. On page 2 - final paragraph - refers to consent of the patient's family before using a syringe driver.

"With regard to the very ill patients for whom there was no further treatment who were in pain or distress, I would inform the family that the use of a syringe driver would lead to a peaceful, dignified death. The use of syringe driver did not accelerate the process of dying. In the four years I was at Daedalus **[it is not clear exactly which period this relates to]**, the Witness says that only one family declined to give consent.

126. Page 3 - The Witness says that some patients suffered from pain for a period prior to being seen by Dr. Barton (for example, when they were seen by some of Dr. Barton's partners who the Witness says did not know the patient's history and were therefore unwilling to prescribe analgesic drugs).

127. On the second paragraph on page 2, the Witness describes an agreement between Dr. Lord, Dr. Barton and the Witness to the effect that Dr. Barton would prescribe medication prior to it being required.

"This was done in case a patient deteriorated and needed the drugs that had been prescribed."

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

129. "At no time did Dr. Barton and I ever disagree about the use of the syringe drivers. I have never had any concern about the use of syringe drivers or the drugs given under the direction of Dr. Barton.

130. On page 4, the Witness says she left Gosport in January 1997. **[IMPORTANT WITNESS. STRONGLY SUPPORTS DR. BARTON. DOES NOT APPEAR TO HAVE BEEN QUESTIONED BY THE POLICE CONCERNING THE CATEGORY 3 CASES.]**

Witness - Julie Fletcher

131. The Witness gives some expert evidence concerning the drug Nozina, a drug used for pain relief, distress and agitation. **[Not sure why the police obtained this evidence - were they investigating the possibility that this should have been used as an alternative to Diamorphine?]**

Witness - Jane Carter

132. Jane Carter's statement produces medical records for 60 patients, i.e., the medical records from the Hospital.

133. **[A number of other witness statements producing other medical records, admission books, etc.]**

Witness - Jeffrey Watling

134. Mr. Watling is a Pharmacy Services Manager at Portsmouth NHS Trust. Amongst various exhibits referred to in his statement is a handbook relating to Palliative Care and Guidance on the Clinical Management of Patients who are Dying. Exhibit "JJW/7" **[important exhibit - check that it is in the documents provided to us]**.

Witness - Irene Dix

135. Irene Dix's statement of 8 December 2004 refers to a protocol for prescription and administration of Diamorphine by subcutaneous infusion **[important document - check that it is included in our papers]**.

Statement from Yvonne Farmer

136. Statement from Yvonne Farmer seeks to date the protocol for prescription and administration of Diamorphine. Says she found it at the bottom of a file. The earliest paper work in the file being dated January 2001. **[We need to check to see whether the date for the protocol has actually been determined.]**

Witness - William Cairns

137. William Cairns' statement describes the procedure for certifying cause of death. A Death Certificate must be signed by a doctor who has (1) Seen a patient within 14 days prior to death, and (2) Has viewed the body after death. If both criteria are met, the medical practitioner can certify the cause of death.

138. If there are doubts over the cause of death, then the matter has to be referred to the Coroner.

139. In the case of a burial, completion of a Death Certificate by a medical practitioner is sufficient. In the case of a cremation, a further certificate is required which needs to be completed by two medical practitioners. The second practitioner must have viewed the body of the deceased and both practitioners must certify that they know of no reasonable cause to suspect that the deceased died either a "violent, unnatural, or sudden death". **[Check to see whether any of the ten Category 3 cases were cremation cases - in which case, there should be a Death Certificate signed by a second GP. If this is the case, have the police interviewed the second GP re cause of death and did the second GP have any suspicions concerning the cause of death.]**

140. **[Various witnesses exhibit cause of death and Death Certificates relating to the various Category 3 patients - check to make sure they are on the exhibit files and also check to see whether a second doctor certified death in any of the cases.]**

Witness - Paule(?) Ripley

141. Paule(?) Ripley's statement describes a visit by a husband to the Gosport Hospital in April 2000. He suffered from arthritis and gout at the time and was in some pain. It appears, from what the Witness says in her statement, that her husband received an analgesic overdose whilst at the Gosport Hospital. He later recovered from this and the statement bundle includes two statements from him. However, the statements simply say that he cannot recollect anything about the time he spent in the Hospital. **[There is no mention of Dr. Barton in the statement and it is not clear whether or not she prescribed the use of a syringe driver/use of Diamorphine for this patient.]**

Witness - Professor Baker

142. The statement of Professor Baker refers to the report that he prepared on the instructions of Sir Liam Donaldson. The statement includes details from the terms of reference on page 2. On page 5, Professor Baker says he reviewed a total of 81 medical records in which Dr. Barton certified death which he says represents about 10% of all deaths certified by Dr. Barton. He says that he can be reasonably confident that the general findings in his report reflect what would be found if all records had been reviewed.

143. He states that his report includes concerns about aspects of care at the Gosport 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, had sufficiently recovered to be discharged from hospital eventually. An attitude or culture of limited hope and expectations of recovery appear 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.**" **[We need to see a copy of Professor Baker's report.]**

The foregoing is a summary of all the statements in the first generic file of police evidence. Note the following:

144. There is very little direct evidence relating to the ten Category 3 cases. Check to see in the relevant patient files whether the police took statements from staff members in respect of these cases.

145. The statements do not contain a great deal of detail concerning Dr. Barton's role or the amount of time that she spent at the Hospital.

146. A significant number of witnesses believe that Dr. Barton was a caring doctor.

147. It is not clear what role, if any, Dr. Barton had in the treatment of a patient once she had given authority to the nurses to use a syringe driver.

148. Note from the police summary that of the 92 cases that the key clinical team looked at, 78 failed to meet professional negligence required to conduct a full criminal investigation. **Check to see if we can find out how many of the 92 cases were deemed to be Category 1, i.e., where the experts considered that optimal care had been given.**

(Tape 2)

FILE 3

149. This contains various exhibits which are referred to in statements obtained by the police and included in File Number 2. Most of the exhibits relate to the concerns expressed by nursing staff in 1991 about the use of syringe drivers/Diamorphine and the discovery by Senior Management in September 2002 that concerns had been raised by nursing staff in 1991.

150. Key documents in File Number 2 include the following:

150.1 Tab 9 - notes of meeting held on 17 December 1991 **[note that Dr. Barton was present at the meeting - the note is therefore evidence that Dr. Barton was aware of staff concerns following a staff meeting on 11 July 1991.]**

150.2 Also in Tab 9 is a copy of Geraldine Witney's report of 31 October 1991 which records continuing concerns by staff concerning the use of syringe drivers/Diamorphine - see paragraph 1 in the Conclusion.

"The staff are concerned that Diamorphine is being used indiscriminately even though they reported their concerns to their Manager on 11 July 1991."

150.3 Tab 12 includes a note of a meeting which took place on 11 July 1991.

150.4 Tab 12 also includes a copy of Isobel Evans' Memorandum to Staff dated 7 November 1991. Note that the memo was copied, inter alia, to Dr. Barton. **[Is this the memo which a number of staff members, in their witness statements, complained of because they were being requested in the memorandum to provide names of any patients that they felt had been dealt with inappropriately. The Staff Union Representative, in particular, took exception to this. See previous notes.]**

150.5 **[In the overall presentation of the GMC's case, we need to consider how much evidence relating to the 1991 concerns need to be included. I think we need to interview and take further statements from at least some of the witnesses as the very strong representations made by staff in 1991 will be an important aspect of this case. Dr. Barton's future conduct appears to have disregarded these concerns. It also appears that the Patient Care Manager - Isobel Evans - in particular, has been criticised by the way that she dealt with the concerns. It would appear that there was a failure to properly address the concerns at that time.]**

<u>FILE 4</u>

151. The first document in the bundle is a copy of the Palliative Care Handbook - Fourth Edition issued by the Portsmouth NHS Trust. **[The date of publication is not evident. Check with the Trust to make sure that we have the correct edition(s) to cover the period between 1996 and 1999 - the period relating to the ten Category 3 cases)**.

152. On page 3, in the Introduction, "palliative care" is defined as the "active total care of patients and their families, usually when there disease is no longer responsive to potentially curative treatment, although it may be applicable earlier in the illness". The definition includes providing relief from pain and other symptoms. The aim of palliative care is to aim to achieve the highest possible quality of life for patients and families.

153. The Handbook is stated to contain the guidelines to help "GPs, community nurses and hospital staff as well as specialist palliative care teams".

154. On page 4, under the heading "General Principals of Symptom Management", the following is set out:

accurate and full assessment is essential for a diagnosis and treatment. **[Did Barton follow this in each of the 10 cases?]**;

the practice nurse's attention is drawn to the importance of non-physical factors which are often mixed together with physical symptoms. The Guide states that when symptoms are difficult to control, there may be more than one cause. The Guidelines state that the practice nurse should use appropriate therapies to maintain best possible quality of life. Practitioners are urged to be careful to ensure that drug side effects do not become worse than the original problem. A further principal is that the practice nurse must exercise sensitive explanation and include the patient and the carers in decision making. The practitioner is urged to consider referral to a palliative care specialist if there is a problem which does not respond as expected or in complex situations which may benefit from specialist expertise.

155. Page 5 of the Guidelines deal with the issue of pain. Under the heading "Diagnosis", the Guide states:

"There is no easy way of measuring pain in a clinical situation; as such, it is generally held that pain is what the patient says it is".

156. Also, on page 5, under the heading "Assessment", the Practice Nurse required to identify the site, severity, duration, timing and any aggravating factors.

157. Page 6 includes details of "the analgesic ladder". The Guide states that it is essential to "use an analgesic which is appropriate to the severity of the pain". There are three steps in the analgesic ladder: Step 1 - (the use of non-opioids); Step 2 - (the use of weak opioids); and, Step 3 - (the use of strong opioids).

158. Page 5 includes Diamorphine in the list of strong opioids. The maximum recommended concentration is 250mg/ml.

159. Page 9 includes a table showing opioid equivalent, i.e, a list of opioids which are equivalent to an oral dose of morphine of 30mg. Subcutaneous Diamorphine equivalent is listed at 10mg.

160. Page 10 sets out guidelines for the management of specific pain, i.e., bone pain, abdominal pain, neuropathic pain, rectal pain, muscle pain.

161. On page 17, Diamorphine is recommended to deal with "constant aching abdominal pain".

162. Page 25 deals with the use of syringe drivers and the following indications are listed: severe nausea/vomiting, dysphagia, severe oral tumours, sores or infection, in the case of profoundly weak, unconscious or heavily sedated patients or poor absorption of oral medication.

163. Page 26 of the Guidelines lists the various drugs used in syringe drivers. This includes Diamorphine, the recommended dose being 10mg - 1g over 24 hours. **[This appears to be a very general broad-ranging indication. There is no further guidance as to how practitioners should determine the correct dose. The Guidance does say that Diamorphine is preferred to morphine for subcutaneous use due to its greater solubility. Cross reference is made to the section on Opioid Equivalents on page 9 of the Guidance (see above note)].**

164. The document at Tab 1 is a copy of a protocol for the prescription and the administration of Diamorphine by subcutaneous infusion. The date of issue is not apparent on the document. There are some manuscript amendments, some of which are illegible. The protocol appears to be aimed at nurses to give them guidance to control pain such as on weekends and Bank Holidays and medical cover is provided on an emergency call-out basis.

165. Under the heading "Dosage", a rather vague indication is given as follows:

"Guidance from the Palliative Care Service indicates that if pain has not been controlled in the previous 24 hours by "Xmg" of Diamorphine, then up to double the dose should be administered the following day, i.e., up to 2 times "Xmg" should be given".

It is not clear whether the reference to "Xmg" relates to an indication of dose already provided by a practitioner, i.e., it is possible a nurse is being told in the Guidance that it is permissible to double a previously authorised dose if the pain has not been controlled in the previous 24 hours.

166. On the 4th page of the protocol, under the heading "Information for Patients and Relatives", the Guidance makes clear that patients must be told that an infusion of Diamorphine is being started and that the dose will be adjusted to allow them to be as comfortable as possible without being unduly sedated. **[The indication given by witness statements from nurses is that many of the patients were sedated which would appear contrary to the Guidelines.]** In cases where patients are not capable of understanding an explanation concerning the use of Diamorphine, the Guidance requires nurses to communicate with their next-of-kin. If a relative expresses concern about the use of Diamorphine, the Guidelines require the medical staff to be informed and medical staff to make every effort to discuss the use of Diamorphine with the patient's next-of-kin.

[This raises the whole issue of consent; specifically, whether or not Dr. Barton and/or nurses on her behalf obtained the necessary consent either from the patients themselves or from their next-of-kin.]

167. Tabs 6-23 are the Cause of Death/Death Certificates for the ten Category 3 cases. The majority are certified by Dr. Barton, the exceptions being Tab 16 (Robert Wilson certified by E. J. Peters) and Tab 23 (Arthur Cunningham certified by J. R. Kenroy, the Coroner for Portsmouth).

168. Tab 24 is a copy of job descriptions for the post of Clinical Assistant at Gosport. The following points are noted, in particular:

The Clinical Assistant is accountable to the Consultant Physicians in Geriatric Medicine - the Consultants are stated to be Dr. Wilkins and Dr. Grunstein, at that date. **[Have the police taken statements from them and any other consultants who work with Dr. Barton?]**

169. The job summary includes the following:

"This is a new post of five sessions a week worked flexibly to provide a 24-hour medical cover to the long-stay patients in Gosport. The patients are slow-stream or slow-stream rehabilitation, but holiday relief and shared care patients are admitted. An important aspect of this role is for the post holder to be seen not only as a medical adviser, but as a friend and counsellor to the patients, relatives and staff."

170. The duties include visiting the Hospital on a regular basis and to be on call as necessary, to ensure that all new patients are seen promptly after admission, to be responsible for writing up the initial case notes and to ensure that the follow-up notes are kept up to date and reviewed regularly, to take part in the weekly consultant rounds. **[Did this happen and did the consultants raise any concerns?]**

171. The duties also include responsibility for the day-to-day medical management of the patient. This includes prescribing drugs as required "**under the care of the consultants and physicians in Geriatric Medicine**". **[This raises the question as to what extent consultants were required to review the prescriptions issued by Dr. Barton.]**

172. Item 13 in the list of duties requires the Clinical Assistant to be responsible for liaison with the GPs with whom the patient is registered and other clinicians and agencies as necessary.

FILE 5

173. Tab 1 contains documents which appear to relate to Dr. Barton's application to become the Clinical Assistant of Gosport Hospital. The first document is a letter from a Consultant Physician, Dr. Grunstein, dated 19 April 1991. It is addressed "To Whom It May Concern". The letter simply confirms that Dr. Barton attended the Department of Geriatric Medicine for 10 half-day sessions between 27 and 31 November 1989.

"During this time, Dr. Barton attended clinical sessions, studied service management and preventative medicine for acute, rehabilitation and long-stay patients, together with Geriatric Clinic communities." **[This does not amount to a reference from Dr. Grunstein. Check with police to see whether Dr. Grunstein or anyone else provided a reference on Dr. Barton's behalf.]**

174. The Tab also includes a job application form signed by Dr. Barton and dated 17 March 1988 **[as this pre-dates Dr. Grunstein's letter, it is reasonably clear that Dr. Grunstein's letter was not intended to support the application. Therefore, query the reason for Dr. Grunstein's letter.]**

175. The application form shows that Dr. Barton was educated at Oxford University and attended Oxford University Medical School. From the time she qualified in 1974 up until the date of the application, 1988, she worked as a General Practitioner.

176. The job application states Dr. Barton was regarded as a pleasure to extend care to the elderly which she and her co-partners and General Practitioners give to the community. In making application, she mentioned at the time that she was working a minimum full-time period of 20 hours per week and therefore regarded herself as being "ideally placed to offer continuity of care and my partners have agreed to share the on-call cover".

177. The application form contains two referees, Dr. Gray and Dr. Britten, the latter described as a Consultant Psychiatrist.

178. Tab 2 is a letter from Dr. Logan to S. King dated 18 July 1991. This appears to have been prompted by the concerns expressed by nurses at that time concerning the use of syringe drivers and Diamorphine. The letter seems to support the practices which were giving rise for the concern. **[Check to see whether Dr. Logan give a statement to the police.]**

179. Tab 3 is a note of a meeting which took place on 17 December 1991 (the meeting referred to previously in these notes). It appears from the exhibit sheet that the note was prepared by Dr. Logan, although this needs to be checked.

180. The first paragraph refers to the concerns raised by the staff thus "putting undue strain on Jane, in particular". **[Reference to Dr. Barton. Did Dr. Logan believe that Dr. Barton was being unfairly criticised?]**

181. The note goes on to say that Dr. Logan was asked to talk in general terms about the use of opiates in the long-stay ward. The note records that he expressed a view that it was often very difficult to know what was best for very frail, elderly patients who couldn't clearly express their symptoms and that one could only do one's best in interpreting them. The note goes on to state:

"I felt that when there was any question that the patients had pain then they should be given the benefit of analgesia. Unfortunately, there were no really useful middle range drugs between Codeine and Dihydro-Codeine and Diamorphine. I also explained that, besides their pain relieving properties, Diamorphine and Morphine have very useful psychological effects producing some psychological detachment and euphoria which can do much for a patient's tranquillity. I said that it was, however, vital for us to make sure that there were not more simple reasons for the patient's pain or distress...Having established that and being content that the patient was distressed and probably in pain, then one should not hesitate to use opiate analgesia if necessary. Obviously, the oral route is the best if the patient can manage it, but if not, as is often the case, injections or subcutaneous infusion were perfectly acceptable."

182. In the final paragraph of his note, Dr. Logan records that it was agreed that when opiates were given, there was no need for a patient to be rendered totally unconscious. "Far from it, the aim was to keep the patient comfortable, but as awake as possible."

183. The note also records that if the staff should have any future misgivings, it was vital that these be discussed first with Dr. Barton or Sister Hamblin. **[Reminder to check to see whether Dr. Logan has provided a statement to police.]**

184. Amongst the documents in Tab 4 is a copy of a Medicines Policy issued by Portsmouth NHS Trust in January 2002. It contains various references which touch upon the issues raised in this case. **[We need to contact the Trust and obtain a copy of the relevant policy which was current in the period 1996/1999.]**

185. The following sections in the January 2002 version which indicate that an earlier version may exist in this case are as follows:

Section 2.2 on page 6 - deals with the responsibilities of the prescriber, i.e. deciding the drug, dose, route, rate of administration and appropriate duration of treatment.

186. Page 9, paragraph g - deals with the frequency of administration. This includes "when required", the abbreviation of this being "prn".

187. Page 10, sub paragraph f - deals with "when required" prescriptions. These should include the dose and if the dose is a range, guidance on how to choose

which dose should be given if possible. Directions should also be given for frequency and maximum daily dose.

188. Page 12 - section 2.5.1 - deals with prescribing of controlled drugs by community nurses. The Guidance provides that the nurse must have a written direction from a Medical Practitioner stating the name of the drug, dosage and frequency and method of administration.

189. Page 51 - section 12.6 - provides that each doctor is responsible for prescribing appropriately within this policy.

190. Tab 6 - copy Guideline dealing with confirmation of death. The date of the policy is stated to be May 1998 and the review date is May 1999. It states that it is the responsibility of doctor to confirm death. However, in small hospitals without resident doctors, a qualified nurse who is competent to do so may verify death. **[May be relevant in this case. Check to see whether in any particular cases, Dr. Barton gave instructions to nurses in a patient's notes, passing responsibility on to the nurses to confirm death.]**

191. Tab 8 includes a letter from the Portsmouth and South East Hampshire Health Authority to Dr. Barton dated 24 April 1988. The letter confirms the offer of appointment as Clinical Assistant - stated to be for a period of 1 year commencing on 1 May 1988.

192. The penultimate paragraph on the first page refers to annual leave entitlement of six weeks. **[Check to see whether the police interviewed doctors who covered for Dr. Barton during her holidays.]**

193. **See previous note relating to Dr. Barton's job description.**

194. Tab 10 includes the Portsmouth Health Care Drug and Therapy Guideline 1998. In the fourth paragraph of the Introduction, there is reference to this being the Second Edition. **[Ask the Trust for a copy of the First Edition and/or the editions which were used in 1996/1997.]**

195. At the end of the Index, there is reference to guidelines available elsewhere, including a policy for control and administration of medicines which are stated to be in the "Policy and Procedures Manual". **[Obtain copy of the Policy and Procedures Manual if not in the bundle provided by the police.]**

196. Pages 114 and sequence deal with calculation of drug dosages **[check to see whether in each of the ten Category 3 cases, there is any evidence of a calculation having been made by Dr. Barton or whether it was a standard direction to nurses to administer Diamorphine by syringe driver.]**

197. Page 135 and sequence sets out the policy for prescription writing - see, in particular, page 136, subparagraph "f" - frequency of administration. In the case of preparations to be taken "as required", the minimum dose intervals should be specified.

198. Page 137 - Section 4.2 - deals with in-patient prescriptions. In subparagraph "d", it states that the drug allergies and sensitivity section should be completed. In subparagraph f, the times for administration for regular and once-only drug therapy are to be stipulated.

199. Page 138 - Section 4.3 - deals with medicines administered at nurses' discretion. Note that sub-paragraph "b" states that prescriptions should be in the "only once" section of the prescription chart. **[Does this mean that nurses have no discretion to administer medicine if medication is to be taken more than once?]**

200. Tabs 11-36 (i.e., all the remaining documents in the file) - contain further copies of Death Certificates and coroner's documentation relating to the Category 10 patients. **[NB: the following tabbed documents 24, 26, 28, 29, 30, 31, 32, 34 and 35. These are Medical Certificates for the ten Category 3 patients. On each Certificate, there is a cause of death section and opposite that, there is another section which the doctor is required to complete to deal with the approximate interval between the onset of the illness and death. Most of these Certificates have been signed by Dr. Barton (there are two which are signed by other doctors) and in the majority of the cases, at least two or three days elapsed before the onset of illness and death. Check to make sure that this is covered by the experts. Did Dr. Barton continue to prescribe Diamorphine in these periods? Should she have been prescribing different medication to deal with the onset of the illness in question, e.g., bronchopneumonia.]**

201. **[Also note that on each Certificate, the name of the consultant responsible for the patient is also recorded at the foot of the page. The name of the consultant recorded in each case is either Dr. Lord, Dr. Reid, or Dr. Tarby(?).]**

FILE 6

202. The first document in the file is a letter dated 14 September 2006 sent by the Investigating Officer to the CPS. Various documents are forwarded with the letter the majority of which seem to be found in Files 6 and 7. However, the first set of documents referred to in the letter - additional witness evidence relating to 26 generic statements and attached summary does not appear to be copied into either File 6 or 7. Also, the generic case summary included in File No. 2 refers to a total of 60 witness statements in the "Generic" category. **[*Check**

with the police to make sure that the 26 statements referred to in the 14 September 2006 letter have been provided.]

203. One of the documents sent with the 14 September 2006 letter is a draft report dated 4 September 2006 prepared by Dr. Wilcock, expert in palliative care.

204. Dr. Wilcock's instructions were to identify themes arising in the standard of care relating to the ten Category 3 patients. He refers to previous reports that he has prepared in respect of each of the ten patients on various dates between December 2004 and July 2006.

205. In his 4 September 2006 report, he identifies a number of themes (failings) and identified the specific patients whose lack of care falls within each of the themes/failings identified.

206. The themes identified are as follows:

206.1 Failing to keep clear patient records (he splits this between the time of transfer to Gosport Hospital and secondly, whilst at Gosport Hospital).

206.2 Failing to adequately assess the patient's condition (again he distinguishes between the failure to do this on transfer to Gosport Hospital and whilst at Gosport Hospital).

206.3 Failure to prescribe only the treatment, drugs or appliances that serve patients' needs.

206.4 Failure to consult colleagues.

206.5 The patients' prognosis, i.e., he says in each of the ten cases whether it was unlikely, difficult to judge or likely, that a particular patient was entering a natural irreversible terminal decline when they died. Three patients are categorised in the "unlikely" category - Spurgin, Packman and Lavender.

207. **[The report is helpful because the various headings/themes, with the exception of the patients' prognosis are taken directly from the Good Medical Practice Guide October 1995. Whilst the report identifies cases falling within each category, this is very much a summary of reports. There is no detail to support his findings, although in each case he refers to his earlier report in respect of each specific patient and it is possible that the earlier report in each cases provides the necessary detail to support his conclusions.]**

208. **One feature of Dr. Wilcock's September 2006 report, he uses language which has not made entirely clear whether on the balance of probability there has been a failure to comply with the principals of good medical practice. For example, on page 6, under the heading "Failure to**

Prescribe", he says that the use of oral Morphine was "difficult to justify". Later in the report, he refers us to doses of Diamorphine which were "likely to be excessive" (page 7). In the last paragraph on page 7, he refers to a "potential lack of appropriate medical care". At the top of page 8, he refers to the discontinuance of "potentially beneficial drugs".

209. ***Check to see whether this was Dr. Wilcock's final report. It needs to be read in conjunction with the individual reports which he prepared in respect of the individual patients. It is possible that this report with further information will form the basis of the charges in the GMC case.**

210. The next document in the file is a report prepared by Professor McQuay, from the Pain Relief Unit at the Churchill Hospital in Oxford.

211. On page 2, the "normal" dose for acute pain relief is stated to be 10mg Morphine or 5mg Diamorphine. Also on page 2, the expert states that respiratory depression is minimal when appropriate regular doses of opioid are given to patients in chronic pain. The opposite appears to be the case when opioids are given to patients who are not in chronic pain. **[*This is very important in the context of this case because if patients were being prescribed Diamorphine in circumstances when they were not suffering pain, it is possible that the consequences would include respiratory depression and/or death.]**

212. On page 3, the second paragraph, the expert states:

"The clinical message is that opioids need to be titrated against pain. Excessive doses, doses bigger than needed to relieve pain or doses given where there is no pain, will cause respiratory depression." In the same paragraph, the experts says that to provide best care, the titration of drug, the size of doses and timing of doses all need to be well organised.

213. On page 3, final paragraph, the expert states that in cases of chronic pain, opioids are usually given by mouth. The dose is worked out by titration over a period of days.

214. On page 4, there is reference to the "analgesic ladder" for cancer pain management. The expert explains that the "ladder" is used widely in palliative care. The "ladder" is the pathway for treating pain using increasing strengths of analgesia, as represented by further steps or rungs up the ladder.

215. In the second paragraph of page 4, Morphine is stated to be the standard "strong" opioid. It is available as both normal-release and slow-release formulations. The usual slow-release formulations provide enough morphine to relieve pain for 12 hours. It is usually administered orally.

216. If a patient cannot swallow or, for some reason, has an intolerance, alternative ways of administering medication are available - including subcutaneous injection.

217. In the 4th paragraph on page 5, the standard adult dose by injection is 10mg of Morphine or 5mg of Diamorphine, repeated 4 hourly, as necessary. **[*Check to see what doses were used in each of the Category 3 cases.]**

218. In the 6th paragraph on page 5, the expert refers to a practice over 30 years to treat severe cancer pain with oral Morphine then switch to subcutaneous injection usually by a syringe driver if the patient can no longer swallow.

219. In the final paragraph of page 5, the expert says that there is a very small group of terminal cancer patients, say 5%, who would need doses as big as 100mg. **[The expert does not say over what period that this should be administered.]**

220. In the 3rd paragraph of page 7, the expert says that the older a person is, on average, the greater the effect of a given dose of opioids.

221. On page 10, the expert states that the aim of using strong opioids in palliative care is to relieve pain.

"There is no quality evidence to show that effective pain relief shortens life. Opioid doses titrated well against the report of pain should not depress respiration and should not shorten life." **[*Is there any evidence that each of the Category 3 patients was well titrated and not suffer depressed respiration?]**

222. The next document in the file is a schedule with a list of the ten Category 3 cases. **[*This is a very helpful document that details the individual care plans, analgesics, date of admission to Gosport, summary of assessment on admission, summary of care plan, details of analgesics prescribed, date that use of syringe driver commenced, total number of days in the Gosport Hospital, total number of days on the syringe driver and the date and cause of death.]**

223. The first thing to notice that the most of the patients listed on the schedule were only on a syringe driver a matter of days before they died. Some do not seem to have been prescribed Diamorphine. The following are listed as having been prescribed Diamorphine; Lake, Wilson, Service, Cunningham and Gregory. **[* In each of these cases the prescription was for 20-200mgs of Diamorphine to be administered subcutaneously in a period of 24 hours - in the case of Service there was an earlier prescription for Diamorphine with a dose of 5-10mg to be administered by IV injection "as required".*]**

224. On page 5 of Professor McQuay's report referred to above there is reference of a standard adult dose of 5mg repeated every 4 hours. This equates to a daily dose of 30mg. However the prescription range referred to in the schedule goes up to as much as 200mg every 24 hours. Professor McQuay says that only a very small number of terminal cancer patients, say 5% would need doses as big as 100mg or bigger. **[*Do we need Professor McQuay to consider each individual case?].**

225. The next set of documents in the bundle is a case summary that supplement the summary provided by the Police in file 2. **[*It appears that this is the summary referred to in the letter at the beginning of the file dated 14 September 2006, although the summary refers to 30 witness statements rather than 26 as stated in the letter. We need to copy all the relevant witness statements and put them in the same file. In some cases witnesses have provided more than 1 statement. The statements need to be grouped together so that all statements relating to specific witnesses can be found in one place.]**

Witness statement of Agnes Howard

226. Healthcare support worker (not a trained nurse) worked at Gosport from 1973 to August 2002. Worked nights and therefore had little contact with Dr Barton. Is not involved in using syringe drivers. Says that other types of pain management were normally used prior to syringe drivers. Expresses an opinion that patients who were placed on syringe drivers were dying and needed help to control the pain. **[Witness generally supports Dr Barton but queried whether the witness is in a position to give any useful evidence in this case].**

Witness statement of Esther Williams

227. Worked as a nurse at Gosport for a period up to June 1991 - says that whilst she worked at the unit she was satisfied that syringe drivers were used correctly. Also says that the position to use a syringe driver was up to Dr Barton and they were not used in every case.

Statement of John Grunstein

228. Between 1971 and 1992 he was a Consultant Physician in Geriatric Medicine at Gosport Hospital. He had shared responsibility for the continuing care wards in Gosport.

229. He refers to Dr Barton's application to become a Clinical Assistant in March 1988.

230. The witness describes Dr Barton as an experienced doctor "I remember her as being very good. She enjoyed the work and her heart seemed to be in it. She had a liking for these very frail elderly patients".

231. Witness says that Dr Barton attended ward rounds, Outpatient Department and day hospital sessions in order to get hands on training. The training period would have covered most aspects of elderly care but the witness believes that the training could not be described as "in depth".

232. The witness says that Dr Barton also attended a training programme for care of the elderly - a series of lectures covering most aspects of elderly medicine, including palliative care. Witness believes that Dr Barton would have heard about the "analgesic ladder".

233. Witness attended ward rounds with Dr Barton. This would include a review of new patients, assessing those patients with problems.

234. **[*Witness says it was his responsibility to offer advice on the best management of patients including investigation, diagnosis and treatment. This would include advice on drug dosages. He says that he would expect his advice to be followed as ULTIMATE RESPONSIBILITY FOR PATIENT CARE (RESTED) WITH THE CONSULTANT. However he says that Dr Barton's post required her to exercise a "considerable degree of autonomy." Witness says that admissions to all elderly medicine continuing care wards - long stay wards - were authorised by a Consultant in elderly medicine.]**

235. On the 4th page of his statement the witness says that the bulk of patients transferred to Gosport were considered "too incapacitated to be cared for in registered nursing home" and that "palliative care (care of the dying) was a significant part of the work."

236. Witness says that the survival time of new admissions was short - on average less than a month.

237. ***With regard to the rumours in respect of Dr Barton the witness' response is as follows:-**

"To say that I was incredulous is to understate my position".

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

238. ***This is an important witness although he left Gosport in 1991 and will therefore not be able to give evidence of what happened between 1996 and 1999. It is interesting to note that he confirmed that ultimate responsibility for patient care rested with the Consultant, not the Clinical Assistant. In looking at the ten Category 3 cases we need to look carefully at the role/involvement of the Consultant who worked with Dr Barton.**

Witness Statement of Dr Logan

239. Consultant Geriatrician at Gosport from 1991 to 1992/1993. Was involved in dealing with staff concerns in July/September 1991 although appears to have little recollection of these events.

240. Page 2 says that he conducted ward rounds once a fortnight but was available for consultation between ward rounds.

241. On page 3 he says that for patients that were dying the aim was to provide the best possible palliative care and that in certain cases best palliative care required the use of syringe drivers.

242. Page 4 says that in 1991 as far as he can recollect there were no policies or set procedures with regard to the dosage of Diamorphine.

243. Page 5 - his recollection is that in 1991 patient care was of a "high quality".

244. Page 6 says that during the period in which he was a Consultant working at at the Redclyffe Annex, he had "full confidence in Dr Barton's clinical ability".

245. Dr Logan's second statement - page 2 - witness says that during ward rounds he discussed the patient, does not recall having any serious disagreement about the medical management of patients.

246. Page 2 - refers to training given to Dr Barton by Dr Grumstein prior to starting as a Clinical Assistant. Says that Barton was an experienced doctor prior to undertaking the dose - Barton had 20 years experience before becoming an Assistant. "This meant she as very experienced for this role".

247. Page 2 - witness does not recall Dr Barton ever expressing concerns about her workload "nothing I saw on the ward with Dr Barton ever caused me concerns with regards to her workload".

248. Page 3 - witness says that in the early 1990s a significant proportion of the patients at the Redclyffe Annex were frail and coming to the end of their lives.

Witness statement of Sharon Ring

249. She started work at Gosport in September 1991 in the Redclyffe Annex. Also worked on the Dryad ward from September 1997 to October 1998 [* **This witness was working on Dryad ward for part of the period that we are concerned with, but no specific reference is made in her statement to any of the ten Category 3 patients. Her statement gives some general details about the use of syringe drivers, writing up of notes and ward rounds. She says that ward rounds were generally completed between**

7.30 and 8am. No reference in statement to concerns about the use of syringe drivers].

<u>**Witness Statement of Shirley Hallmann**</u>

250. **From memory this witness gave at least one other statement to the Police - check file 2.** Statement in this particular file does not deal directly with the issue of syringe drivers/Diamorphine. Instead, for reasons which are not apparent, witness was asked to provide details about various types of equipment on the Dryad Ward, which does not have any obvious connection with the issues arising in this case.

<u>**Witness Statement of Barbara Robinson**</u>

251. Became the Service Manager for Gosport Elderly Services in 1996 and worked at Gosport until 2000. Describes general level of nursing care as "excellent". On page 2 of her statement there is reference to two complaints (date not specified) on behalf of Gladys Richards and a Mr Wilson. Witness was not involved in the investigation of the complaints. Says that as a result of the investigations, other staff did not come forward to voice concerns.

252. Page 3 - says that Shirley Hallmann and Gill Hamblin did not get on. Ms Hallmann was difficult to manage - critical of colleagues.

253. Also on page 3 witness refers to Dr Barton - visited the hospital at 7.30am between Monday and Friday. Attended on other occasions if required at the request of staff. Describes Barton as being "very attentive to patient needs" and then "excellent doctor". Says that Barton was held in high regard by staff, patients, other GPs and the local community.

<u>**Witness statement of Chris Donohoe**</u>

254. Refers to various documents concerning Dr Barton's appointment as Clinical Assistant. I have already seen these documents in other bundles. **However in the statement he confirms that Dr Barton was employed at Gosport between 1 May 1988 and 30 June 2000.**

255. *** An important point to note with regard to the date that Dr Barton finished at Gosport is that she left more than 2 years after the first Police investigation, relating to Gladys Richards. The reinvestigation of Gladys Richards' case took place in April 2000 and the CHI report was published in May 2000. Therefore she remained in post for a considerable period after the first Police investigation. Check whether she was suspended from duties during this period.**

Witness statement of Leng Wee

256. Consultant in palliative medicine based in Oxford. Between April 1995 and July 2003 he visited Gosport Hospital in various roles - Locum Consultant, Consultant and then Senior Lecturer in Palliative Medicine. Page 4 of his statement says that in 1998 he developed an outreach programme in palliative care for the primary care teams in Fareham and Gosport.

257. Page 4 - he says that he attended Gosport Hospital on many occasions to provide information and advice on palliative care and the use of syringe drivers. He does not recall specific dates. He does not mention Dr Barton.

258. On page 5, with regard to syringe drivers he gave advice on when to use them, when it was not appropriate to use them and what drugs could be used with syringe drivers. ***On page 5 he expresses to use an initial dose of 100mgs of Diamorphine would not be appropriate, nor would 50mgs be appropriate in one dose.**

259. On page 5 she records general discussions with staff at Gosport concerning the use of syringe drivers. He was asked "how do we know if we are giving too much or not enough?". He says that a higher dose given would be a judgement call and down to the experience as well as the amount of pain that the patient was suffering and the analgesic history of the patient. **[*It may be worth re-interviewing this witness to obtain more detail of his visits to Gosport and in particular, whether he had any contact with Dr Barton].**

Witness statement of Valerie Vardon

260. Provides a statement, the purpose of which appears to identify a date on which the protocol for prescription of Diamorphine was first noted. Witness refers to a letter of 12 February 2000 enclosing a copy of the protocol. **[*Copy of the protocol has already been seen as checked to see whether the copy of the protocol was shown to Dr Barton when she was interviewed].**

(Tape 3)

261. In tab 1 there is a note prepared by the Police which summarises some additional evidence obtained by the Police relating to the deaths of Elsie Devine, Arthur Cunningham and Ruby Lake. The additional evidence referred to in respect of each of these patients can be found at tabs 1, 3 and 5 of file 6 respectively. **[*I NEED TO REVERT TO THESE STATEMENTS AFTER I HAVE COMPLETED THE READING IN THE INDIVIDUAL FILES RELATING TO THESE PATIENTS. QUERY WHY THE POLICE OBTAINED ADDITIONAL EVIDENCE IN RESPECT OF THESE THREE PATIENTS - ACCORDING TO DC STEPHENSON, THESE THREE CASES ARE NOT CONSIDERED TO BE THE STRONGEST CASES].**

262. Tab 6 is a transcript of the Police's interview with Dr Barton on 23 March 2006. On page 4 it states that the interview will be concentrating on the patient Ruby Lake (note that by the date of the interview the Police had obtained various expert reports from Dr Wilcock. Check to see whether reports had also been obtained from Dr Black. Dr Wilcock's report in respect of Ruby Lake was prepared on 23 August 2005).

263. Note on page 2 that Dr Barton was represented by a Solicitor, Ian Barker. Note also that at this point Dr Barton was not under arrest - she attended the Police interview on a voluntary basis.

264. On page 4 the Police Officer interviewing Dr Barton explained that this particular investigation started in September 2002 and concerns allegations of unlawful killing of a number of patients at the Gosport Hospital during 1990 and 2000 - the Officer explains that no decision had been made as to whether an offence or any offence had been committed, but the offence range being investigated runs from potential murder down to assault.

265. On page 4 the Officer explains that the questions will fall under particular headings which concern specific topics.

266. At the top of page 5 the Solicitor intervenes to say that he has advised Dr Barton that she should not make any comments.

267. Page 6 - refers to a Police interview with Dr Barton "last year" and there was reference to the initial statement which Dr Barton attended at that interview **[therefore this interview appears to be one of the "challenge interviews" mentioned by DC Stephenson when I met him recently, ie, interviews during which various questions were put to Dr Barton but she declined to answer].**

268. On page 6 the Officer mentions his first "topic", ie, "clerking" ie, the process whereby the patient's needs and treatment are identified and suitable care plans are put in place.

269. On page 7 the Officer refers to a relevant section of the Good Medical Practice Guide which deals with adequate assessment of a patient's condition based on the history and symptoms. He also refers to the duty to keep clear accurate and contemporaneous patient records including a record of any drugs or other treatments prescribed.

270. On page 8 Dr Barton is asked how often she visited patients, but as in respect of all questions asked of her, she declined to comment.

271. On page 10 she is asked how long she spent with each patient. She is also asked whether she conferred with the Sister on the ward or a Senior Nurse.

272. On page 11 she is asked how long it took her to examine, assess and write up the patient's records.

273. On page 11 the Officer refers to information previously provided as follows: a daily routine which involved working at her surgery between 9 and 11/11.30am.

274. On page 11 she is asked if on arrival at the hospital she was presented with a list of patients she needed to see and if there was a list, how that list was generated.

275. On page 13 the Officer refers to page 77 of Mrs Lake's medical note and an entry dated 18 August 1988. The Officer asked Dr Barton whether the entry is in her handwriting. Dr Barton does not comment.

276. Page 14 - the Officer refers to the note of 18 August 1988 and the reference to "continuing care". Dr Barton is asked what continuing care is.

277. Page 17 - she is asked what notes were available to her when she was transferred from the Haslar Hospital.

278. Page 19 - the Officer asks whether at the time of admission Dr Barton had formed the opinion that Mrs Lake was in the terminal phase of her life.

279. Page 19 - the Officer refers to the entry by Dr Barton and the note - "I am happy for my staff to confirm death". On page 20 she is asked if it is her normal practice to write this on the notes on the time of admission and she is asked for the reason for doing this.

280. On page 20 the Officer highlights an apparent contradiction in the notes which refer on one hand to "gentle rehabilitation" and the reference to staff confirming death on the other.

281. Page 20 - the Officer moves onto the second topic being the initial assessment of the patient and what Dr Barton considers to be the fundamental purpose of the initial assessment.

282. On page 23 she is asked what sort of examination would have taken place on an initial assessment of a patient.

283. On page 24 she is asked if she made a medical care plan for Mrs Lake.

284. On page 30, referring to the medical notes, the Officer observes some of the notes referred to the patient's previous medical history. He asks Dr Barton about the evidence for the history **[presumably the Officer is trying to determine how Dr Barton obtained evidence of the previous history - either with reference to some notes which were transferred from the Haslar Hospital or possibly taking a history from the patient herself]**.

285. Page 33 - the Officer refers to the next "topic", ie care plans, ie, to monitor and review the patient's progress. Dr Barton is asked about the purpose of a care plan and whether she was directly involved in the process of establishing a care plan.

286. On page 5 of her second interview, Dr Barton is asked why the physiotherapy which the patient received at the Haslar Hospital did not continue at Gosport.

287. On pages 5/6, the Officer makes the point that in the notes the patient is supposed to be receiving "gentle rehabilitation" and yet there is no plans for the Physiotherapists to be involved.

288. Page 7 - indicates that the Officers had not been able to find a care plan for this patient. The questions are therefore directed at trying to establish how the nurses were to properly treat Mrs Lake if there was no treatment or care plan.

289. Page 8 - refers to Mrs Lake's chest pain. Dr Barton is asked whether she has had any training relating to cardiology. On page 9 Dr Barton is asked whether she examined Mrs Lake after she complained of chest pain. The Officer also asks her whether if she did examine the patient, why she did not make a record of the pain assessment.

290. On page 11 the Officer asked why morphine was considered necessary when the patient had previously been taking paracetomol and codeine.

291. Page 13 - deals with the doctor's duty to keep clear and contemporaneous medical records in accordance with the principles set out within the Good Medical Practice Guide.

292. Page 13 - at the foot of the page refers to page 30 of the Good Medical Practice where a decision to withhold life prolonging treatment should be recorded to make clear the decision making process.

293. Page 15 - the Officer points out that no mention is made in Mrs Lake's records of her being in pain.

294. Page 16 - the Officer refers to a note from the Haslar Hospital which indicates that she receive 1 dose of Diamorphine whilst she was at that hospital. **[Clearly someone other than Dr Barton therefore felt that Diamorphine was appropriate albeit for a single dose. Check to see whether any evidence has been obtained by the Police from doctors at the Haslar Hospital prior to the transfer of the patient to Gosport]**.

295. Page 17 - the Officer asks why there isn't an entry in the Gosport records to explain why Mrs Lake was prescribed Diamorphine.

296. Page 18 - deals with the next topic which is work rounds. Dr Barton is asked how she conducted her ward rounds and the purpose of ward rounds in the care and treatment of a patient. She is asked as to the frequency of her rounds. At the foot pf page 18 there is reference to Dr Barton having previously stated that she attended the hospital at least every morning between 7.30 and 9am.

297. On page 20 she is asked if a ward round involved seeing each patient or, possibly, a discussion with staff about the patient. She is asked how often the Consultant conducted a ward round. On page 21 she is asked whether she attended the Consultant's rounds.

298. Page 23 - refers to Dr Barton's job description as a Clinical Assistant and the fact that responsibility for the ward rounds is mentioned.

299. Page 24 - she is asked whether she has any concerns relating to the support received from Consultants. She is asked if she had any concerns about Consultants.

300. On page 25 she is asked which Consultant was responsible for Mrs Lake's care.

301. ***WE NEED TO DETERMINE THE CONSULTANT'S INVOLVED IN EACH PATIENT'S CARE, AND WHETHER THERE IS ANY INDICATION OF THE CONSULTANT REVIEWING THE TREATMENT/DRUGS PRESCRIBED BY DR BARTON.**

302. Page 26 refers to the Consultant being Dr Lord, but the only reference to Dr Lord seeing Ruby Lake is an entry in her records in the early part of 1998.

303. On page 27 the Officer asks whether Dr Barton ever discussed Mrs Lake with Dr Lord.

304. On page 27 the Officer observes that Mrs Lake was only at Gosport for 3 days. He asked whether if it was possible that there was not enough time for her to be seen by Consultants. **[CHECK THE VERY USEFUL SCHEDULE IN THE PREVIOUS GENERIC FILE WHICH INCLUDES DETAILS OF HOW MANY DAYS EACH PATIENT SPENT IN THE HOSPITAL AFTER ADMISSION BEFORE THEY DIED. IT MAYBE THAT SOME WERE NOT THERE LONG ENOUGH TO BE SEEN BY A CONSULTANT. HOWEVER AT LEAST SOME WOULD HAVE BEEN THERE OVER A FAIRLY LENGTHY PERIOD AND WOULD ALMOST CERTAINLY HAVE BEEN SEEN BY CONSULTANTS].**

305. On page 3 of the transcript of the third interview, going over to the fourth page, there is reference to a statement prepared by Dr Barton - "the very first statement which was a generic statement". **[*CHECK THAT WE HAVE ALL OF DR BARTON'S STATEMENTS WITH THE GENERIC STATEMENT AND THE PATIENT SPECIFIC STATEMENTS].**

306. Page 4 deals with the next topic being pharmacy - specifically the prescription and the administration of controlled drugs. Dr Barton was asked how she kept up to date in her knowledge in this area. She is asked if she had any training.

307. Page 11 - she is referred to a previous statement in which she referred to a "proactive prescribing policy". She is asked about this.

308. Page 18 again refers to a previous statement by Dr Barton. She is asked where the section of this statement which deals with the prescription on a wide range of doses. Her statement says that in this case she would expect a nurse to contact her when the administration of the drug was about to start to confirm the dosage. The Officer asks whether this is was is meant by "telephone prescribing".

309. Page 21 - she is asked why in this case drugs are being prescribed but not administered.

310. Page 21 - she is asked why a syringe driver was used in Mrs Lake's case.

311. Page 23 - she is asked whether Mrs Lake was incapable for taking oral medicine.

312. Page 25 - she is asked why there is no entry on the medical records to indicate why the use of a syringe driver was considered necessary.

313. Page 30 - it is put to Dr Barton that because she authorised administration of subcutaneous medicine there must have been a dramatic change in the patient's condition. This being the case she is asked why she did not write this up in the patient's note.

314. Pages 31/32 - the Officer points out that there is no date on the prescription for Diamorphine. He asks Dr Barton when she wrote the prescription.

Fourth Police interview

315. Page 8 - refers to the Wessex protocols for prescribing drugs. **[Check to make sure we have got details of this protocol]**.

316. Page 11 - with regard to the prescription of Diamorphine, the Officer points out that the range prescribed was from 20 to 200mgs. He asked Dr Barton how she would have stopped the nurse from issuing the full 200mgs. She is asked what checks are put in place to prevent an overdose.

317. Page 15 - reference is made to the prescription of Hyacine in a range from 200-800mgs. The Officer points out that when it was first administered it was started at 400mgs. Dr Barton is asked why this was the case. She is also asked why there is no record of the patient being started at this dose.

318. Page 16 - Dr Barton is asked why there is no record of ongoing assessment in the medical notes to explain the increase in dose of Diamorphine from 20 to 60mgs over a three day period.

319. Page 17 - she is asked whether she preferred decisions on the treatment of the patient to a Consultant. **[We need to identify the Consultant who checked it].**

320. Page 20 - the Officer points out that on the day of her admission to Gosport, and entry in the patient's note is made permitting the nursing staff to confirm death. She is asked if the patient was in the terminal phase of her life when she was admitted.

Fifth Police interview

321. Page 3 - refers to the next topic, being death certificates.

322. Page 4 - refers to a medical certificate and a separate document being the cause of death records.

323. On page 6 she is asked why there is no reference on the medical notes to the cause of death stated in the death certificate - bronchopneumonia **[*WHERE A PATIENT'S DEATH HAS BEEN CAUSED BY A CONDITION SUCH AS BRONCHOPNEUMONIA, HAVE THE POLICE TRIED TO DETERMINE WHEN THE CONDITION FIRST AROSE AND WHAT, IF ANY, TREATMENT FOR THE CONDITION PRIOR TO DEATH].**

324. On page 7 she is asked whether the patient was suffering from bronchopneumonia on the date of her admission. She died within 3 days of being admitted.

325. On page 7 she is asked for evidence that the patient actually died from bronchopneumonia **[what evidence would one normally expect from this condition, if any?].**

326. Page 8 - she is asked whether she was happy with the level of supervision which she received. Reference is also made to a previous statement when she described the role of Clinical Assistant as a "training post". She is asked whether she is happy with the level of training she received.

327. On page 11 she is asked who has ultimate responsibility for the patient - the Clinical Assistant or the Consultant.

328. On page 12 she is asked whether there is any reason why she was not able to consult Dr Lord with regard to the treatment/diagnosis/prognosis for this patient? **[*HAS DR LORD PROVIDED A STATEMENT?].**

329. Page 14 quotes from a previous statement by Dr Barton which indicates that by 1998 she considered that many of her patients were profoundly dependent and demands on her time and the nursing staff were considerable. There is reference to the following quote:

"I was in affect left with the choice of attending to my patients and making notes as best I could or making more detailed notes about those I did see but potentially neglecting other patients." **[*AN ADMISSION THAT DR BARTON FAILED TO KEEP PROPER NOTES?]**

330. Page 19 - refers to Mrs Lake receiving an injection of Diarmorphine of 2 ½mgs at the Haslar Hospital. She had been admitted with a broken leg.

331. Page 20 indicates that Mrs Lake was seen by a number of doctors on or about 12 August 1998 - not long before she died. These included Dr Lord, Surgeon Dr Farquarson-Robert **[have statements been taken from these two doctors?]**. There is reference to a note from one doctor describing Mrs Lake's condition as being "alert and well over the last two days".

332. Page 21 - referring to some records, the Officer notes that Mrs Lake had a number of problems. The Officer refers to a note by Dr Lord stating "it was difficult to know how much Mrs Lake would improve". **[*AGAIN IT IS VERY IMPORTANT THAT WE OBTAIN A STATEMENT FROM DR LORD IF THE POLICE HAVE NOT ALREADY DONE SO]**.

333. Page 24 - the Officer refers to Dr Barton's statement where Dr Barton refers to a lack of adequate documentation or to recollect anything about this particular patient.

334. Page 30 - the Officer makes reference to the fact that within her written statement, Dr Barton claims that she did not make a Barthel assessment for Mrs Lake. The officer takes this as being an admission that Dr Barton didn't discuss the patient on her admission.

Sixth Police interview

335. On page 2 there is reference to a discrepancy to the recording to the Barthel score. In her statement Dr Barton refers to a score of 6 whereas the nurses record it as given a score of 9. These scores are out of a possible 20. The lower the score the more dependent the patient is deemed to be. It is put to Dr Barton that she failed to properly examine the patient; alternatively she failed to record her assessment.

336. **[*ASSUMING THAT DR BARTON DOES NOT MAKE AN APPLICATION TO STRIKE OUT THE CASE ON THE GROUNDS OF DELAY, IT IS POSSIBLE THAT GIVEN HER AGE - APPROXIMATELY 59 - SHE WOULD DECIDE NOT**

TO DEFEND THE GMC PROCEEDINGS. SHE DIDN'T ANSWER QUESTIONS IN INTERVIEW WITH THE POLICE, PRESUMABLY ON THE BASIS THAT SHE MAY SELF INCRIMINATE HERSELF. THE POLICE HAVE DECIDED NOT TOP PROSECUTE. IF SHE GOES BEFORE THE GMC AND DECIDES TO ANSWER DETAILED ALLEGATIONS RELATING TO THE CLIENT SHE MAY FEEL THAT SHE RISKS SELF-INCRIMINATING HERSELF THUS EXPOSING THE POSSIBILITY OF A NEW POLICE INVESTIGATION/CHARGES].

337. On page 8 the Officer puts to Dr Barton that there is no mention of bronchopneumonia in the doctor's assessment of the patient and yet the death certificate records that she'd suffered from that condition for 3 days, ie, logically she must have been suffering from bronchopneumonia on her admission.

338. Page 9 - the Officer puts to Dr Barton the fact that at the Haslar Hospital, the patient was prescribed paracetomol whereas as soon as she was admitted to Gosport, she was prescribed Oramorph for pain relief. On page 10 it is put to Dr Barton that this prescription required occurred on the same day that she was transferred from the Haslar Hospital. Dr Barton is asked what happened in the interim to justify the prescription.

339. Page 12 - refers to a note recorded on 18 August. These describe a patient suffering anxiety and distress and the fact that doses of Oramorph end up having little affect.

340. On page 30 the Officer asks whether it was appropriate to prescribe morphine for anxiety **(as opposed to a patient who is in pain)**.

341. ***PAGE 14 - THE OFFICER MAKES FURTHER REFERENCES TO DR BARTON'S PREVIOUS (WRITTEN) STATEMENT. CHECK TO SEE WHETHER THE EXPERT WITNESSES HAVE CONSIDERED DR BARTON'S STATEMENT AND COMMENTED UPON THE REASONS/JUSTIFICATION GIVEN WITH REGARD TO PRESCRIBING PRACTICE.**

342. Page 15 - the Officer challenges Dr Barton on a comment in her written statement to the affect that Tamazepan might have made Mrs Lake's heart failure worse. The officer asks why, if this was the case, Dr Barton prescribe Tamazepan when Mrs Lake was transferred to Gosport.

343. Page 17 - the Officer refers to this action in Dr Barton's written statement where she complains of excessive pressure of work. The Officer refers to the admissions book around the period which Mrs Lake was admitted and put it to Dr Barton that within that period only 3 other people including Mrs Lake were admitted within a 9 day period. Dr Barton is asked whether that was a particularly busy time. She is also asked whether all the beds were full. **[Do the Police have records of the number of people on the ward at the time that the ten Category 3 patients stayed at the hospital?].**

344. Page 17 - the Officer quotes from Dr Barton's statement where she seeks to justify the prescription for Diamorphine.

345. Page 18 - the Officer asks why Diamorpine was prescribed when no mention had been made of the patient being in pain. Dr Barton's statement refers to pain from a fractured hip and ulcers on her legs. The Officer puts it to Dr Barton that the physiotherapy notes for 17 August say that Mrs Lake was mobilising with a zimmer frame and was managing well with no mention of pain. The Officer put to Dr Barton that if there had been pain would it not have been most apparent during weight baring or movement.

346. Page 19 - Dr Barton is asked why she prescribed Diamorphine in the range of 20-200mgs and why she didn't prescribe a smaller dose.

347. Page 26 - she is asked whether she had an arrangement with Sister Hamblin where discretion was given to the Sister to commence the use of syringe drivers and Diamorphine when she deemed it suitable.

Seventh Police interview

348. On page 4 she is asked why she didn't seek to determine the underlying causes of Mrs Lake's chest pain in view of the fact that it was known that she had heart problems.

349. Page 6 - she is asked why she prescribed opiates if she believed that Mrs Lake was suffering from heart problems.

350. Page 6 - she was also asked how she knew that Mrs Lake's condition was deteriorating.

351. Page 7 - reference is made to the fact that Mrs Lake had a peaceful night but notwithstanding as Diamorphine and Medazalan were increased. She is asked to explain this.

352. Page 8 - further reference to Dr Barton's statement and her admission in paragraph 38 of that statement that the increase in the dose of Diamorphine was made without her knowledge.

353. Page 11 - she is asked why she recorded the cause of death as bronchopneumonia when she considered that congestive cardiac failure was a significant factor in Mrs Lake's death.

354. Pages 13/14 - she is asked why she could not refer Mrs Lake's death to the Coroner - either because of the fall which caused her broken hip or the surgery within the previous 3 weeks . **[Is the failure to inform the Coroner a further failure to comply with Good Medical Practice?]**

355. Page 16 - it is put to Dr Barton that she had an opportunity to see Mrs Lake on 9 occasions during the three days that she was in hospital - ie, on each day in the morning, at lunchtime and in the evening **[it therefore appears that Dr Barton's attendance was not restricted to morning rounds]**. It is put to her that if she attended on 3 occasions on each day there was no need for "proactive prescribing". **[ie, giving the nurses a discretion to increase the dosage of medication]**.

356. Page 17 - she is asked if anyone attempted to treat the underlying causes of Mrs Lake's heart condition.

FILE 7

357. This contains transcripts of Police interviews with Dr Reid.

358. The interviews all seem to have taken place on the same day - 4 July 2006.

359. The first document on the file is a Police note summarising each of the interviews. The note in respect of interview tape 1 (one of the tapes which is missing) indicates that Dr Reid had a dual role from March 1998. He was Medical Director based at Queen Alexandra Hospital. He was also a Consultant with responsibility for a number of wards including Dryad ward at Gosport. **(From March 1998 and possibly 1999 - part of the period that we're concerned with - he was therefore acting as Consultant but presumably, working with Dr Barton. This appears to overlap at least partly with Dr Lord who according to file 6 tab 6 was Consultant in August 1998).**

Before Tab 1

360. **This is the first of the transcripts of the Police's interview with Dr Reid, i.e. an interview which started at 09.21 and concluded at 10.00 on 4 July 2006.**

TAB 1

361. Page 2 - Dr Reid is represented by Mr Childs of Radcliffe's Westminster Office.

362. Page 38 confirms that Dr Reid attended the interview voluntarily. He had not been arrested. He is however, cautioned.

363. Page 6 - Interviewing Officer explains that the Police investigations started in September 2002 and has been running for the best part of four years. Investigations concerns allegations of unlawful killing of a number of patients at the Gosport Hospital between 1990 and 2000.

364. Page 7 - The Officer explains that the purpose of the interview is to obtain details about Dr Reid, his qualifications, training and polices and procedures at the Gosport Hospital during the period that he worked there.

365. Page 8 - He says that he qualified as a Doctor in 1974.

366. On pages 9-11 he gives details of his experience.

367. On page 10 he says that he became a consultant in geriatric medicine at Southampton General Hospital in August 1982 and remained there until March 1998.

368. On page 11 he says that in April 1998 he was appointed as a consultant in geriatric medicine at the Portsmouth Healthcare Trust, where he was also Director of Medicine.

369. On page 12, Reid says that in some ways general practice and the practice of geriatrics are similar - they are both broad based.

370. On page 14 Reid says (in 1998?) Portsmouth Healthcare Trust ran all the community hospitals, i.e. Havant, War Memorial Hospital, Petersfield and Gosport.

371. On page 15 Reid says that in 2002 Portsmouth Healthcare Trust was dissolved and split into three organisation - Portsmouth City Primary Care Trust, Fareham & Gosport Primary Care Trust and East Hampshire Primary Care Trus.

372. On page 15 Reid describes the facilities within the elderly medicine department which included beds at the following hospitals; St Christopher's Hospital in Fareham (which no longer exists); The Gosport War Memorial Hospital, St Mary's Hospital and Queen Alexandra Hospital.

373. On pages 17-18 Reid says that there was a clinical assistant at Petersfield Hospital doing the same sort of work that Dr Barton did at Gosport. He indicates that there were two GPs from the same practice working as clinical assistants at St Christopher's Hospital.

374. On page 35 Reid confirms that in 1998 his time was split 50-50 between working as medical director and working as a consultant doing clinical work. He says he worked after Ann Ward at Queen Alexandra Hospital and did an outpatient clinic at the same hospital. He thinks that he did a session in the Dolphin Day Hospital at Gosport.

375. Page 38 refers to an earlier statement which he prepared for the police (**Check to see whether we have a copy of this**).

376. Page 36 confirms that he had responsibility for Dryad Ward for about a year (1998/1999?). He also covered for Dr Lord on Daedalus Ward.

377. On page 2 there is reference to Dr Reid working in Dryad ward from 1999 onwards **(this seems to contradict the summary note provided by the Police referred to above. We need to see the first transcript to make sense of this. If Dr Reid was only there from 1999 onwards, his involvement relates only to the following patients: Packman, Spurgin, Gregory and Devine. If he was responsible for Dryad ward in 1998 as well the following additional patients may fall under his responsibility: Wilson, Cunningham and Lake).**

378. Page 2 - he describes Dryad ward as a ward for "continuing care". The patients were all over 65 years old, frail and suffering from "multiple medical problems".

379. On page 3 Reid says that Barton did the routine day to day care. Reid refers to Dr Lord who was "usually around" but would not be involved in ward rounds **(clarify Dr Lord's role).**

380. Page 5 - Reid says that no Locums were brought in whilst he was on holiday - annual leave 6 weeks a year.

381. Page 6 - Reid did ward rounds at Queen Alexandra Hospital at least twice a week -an acute elderly care ward.

382. Page 7 - Reid did ward rounds on Dryad ward once a week, on Monday afternoon. Has no recollection of ever doing a ward round on Daedalus Ward.

383. Page 10 - says that Dr Barton came in every morning at about 7.30 and invariably came in the afternoon as well.

384. Page 10 - says that Dr Lord did her ward rounds on Monday afternoon "so Dr Barton would sort of join us on alternate weeks". **(It is not clear what the witness is saying with regard to Dr Barton working with Dr Reid and Dr Lord. Seems to be saying here that Dr Barton saw Dr Lord on alternate Monday afternoon. Requires clarification).**

385. Page 11 - says he worked at least 60 hours a week. The workload was "very heavy".

386. Page 12 - witness says that Dr Jarrett was the Head of Elderly Medicine **(notwithstanding that Dr Reid himself was Director of Medicine - Jarrett was Lead Consultant in terms of administration).**

387. Page 13 - describing the structure of the department, Reid confirms that next in line to Consultants in terms of seniority were the Senior Registrars and then

Registrars **(*Were there any Senior Registrars/Registrars working with Dr Barton?)**

388. Page 14 - Reid appears to be saying that Consultants were responsible for the Registrars working with them.

389. Page 14 - Reid draws a distinction between a Registrar and a Clinical Assistant, the latter being a "career post" as opposed to a doctor who is undergoing training. Clinical Assistants worked in hospitals in secondary care, outpatient clinics - in departments where there was a Consultant.

390. Page 15 - reads that some Clinical Assistants had experience which was not that far off the experience of a Consultant. Other Clinical Assistants were GPs who had less experience.

391. Page 16 - Reid says that although the permission is not clear, most people would regard Clinical Assistants as being under the supervision of a Consultant. **[*Important point which raises the question as to the level of supervision given and the degree of responsibility afforded to Clinical Assistants].**

392. Page 19 - Reid says that on Ann Ward he worked in a team which included a Registrar or a Senior Registrar and a pre-registration House Officer (the latter being an inexperienced doctor in their first job after completing medical school).

393. Page 20 - no team as it was operating at Gosport, ie there were no House Officers, Registrars or Senior Registrars - just Dr Barton. This happened by "evolution".

394. Page 21 - Reid explains that there were no junior doctors working in Gosport because Consultants only attended once a week. Queen Alexandra Hospital Consultants would have been there most of the time and therefore presumably in a much better position to train the junior doctors.

395. Page 22 - Reid says that most patients (presumably means elderly patients) were admitted in the first instance to Queen Alexandra Hospital. Some would be fit enough to go home and others needed a period of rehabilitation. The latter category would go to places like Gosport.

396. Page 22 - it is not clear but Reid seems to be saying that although some patients were referred to Gosport for rehabilitation, it was understood that they were never going to get better. **[This needs to be clarified]**.

397. Page 22 - Reid says that in 1999 he would have been responsible for 19 patients at Ann Ward and 20 patients on Dryad Ward at Gosport.

398. Pages 23-24 - Reid did a walk round on Monday which was a busy period. On the weekends there was not the same level of medical cover and so it was often, it encounter problems on a Monday. On Monday morning he did a ward round at Ann Ward at the Queen Alexandra Hospital and in the afternoon he went to Gosport Hospital.

399. Page 24 - says he did a "days hospital session" at Gosport. Seems unclear as to when this was - "it might have been a Thursday morning" **[*therefore seems that Reid was at Gosport on Monday afternoon and Thursday morning each week, although this is not entirely clear from the transcript]**

400. Page 25 - Reid explains that Ann Ward was busier than Dryad - patients came in with heart attacks for example, and after a few days of treatment they would get better and be sent home. There was a higher turnover of patients.

401. Page 26 - "it was only after people had been in the Queen Alexandra Hospital and not appearing to make progress that they would go to somewhere like Gosport".

402. Page 26 - when asked about his job description - Reid says broadly that this was to "provide care to patients". Accepted he probably has a formal job description somewhat. On page 27 he says his job description probably would have been provided in 1998 when he was appointed.

403. Pages 28/29 - Reid gives details of his ward round at QA. Spent about 12 minutes on average per patient but the length of time spent depended on how many new patients there were and some patients were more complex to deal with than the others. On average it took 4 hours to complete a ward round.

404. Page 30 - completed ward round at QA at about 1pm, got to Gosport at about 2pm. Finished at Gosport between 4.30 and 5pm.

405. Pages 31-32 - Reid appears to be saying that it took longer to prepare notes of patients at QA because they were more "medically sick".

406. Page 33 - Reid dealing with ward rounds at Gosport - Reid says that Barton was there "usually every other week". **[*It seems odd that Dr Reid did not do his weekly round at Gosport at a time when Dr Barton was present which was presumably every other week because Dr Barton worked mainly in the mornings and Dr Reid did his ward rounds on Monday afternoons. This needs to be checked.]**

407. Page 33 - when asked to describe the Clinical Assistant's role Reid refers to writing up notes, summarising the patient's problem and the reasons for their admission and (on page 34) generally, attending to medical needs on an as required basis.

408. Page 34 - Reid expected the Clinical Assistant to prepare treatment plans for rehabilitation or continuing care.

409. Page 34 - Reid is asked what support is given to the Clinical Assistant - indicates that if Barton could ask questions during the ward round, alternatively telephone Dr Reid if she wanted to discuss something. Reid says that he did not have regular appraisals with Barton.

410. Pages 35/26 - says that his responsibilities included sitting on a large number of committees, mainly in his capacity as Medical Director.

411. Page 37 - Reid says that in practice a third of his time was spent on clinical matters and about two thirds of his time was spent on Medical Director duties.

412. Page 38 - in clarifying the roles of the various wards at Gosport Reid says that in 1998/1999 the role of Daedalus was rehabilitation and the role of Dryad was continuing care and assessment for continuing care. **[*This is quite important, we need to clarify which ward Barton worked on and whether she was mainly responsible for people requiring rehabilitation on one hand or continuing care on the other. The latter presumably would include palliative care]**. Reid confirms that some clinical assistance would be on a par with Consultants, although this would be exceptional. Most doctors could be Clinical Assistants and suitability for the post would be determined partly by their experience. So for example, Clinical Assistants who were GPs could work in a Dermatology clinic or in an ENT clinic but ideally you would look to employ Clinical Assistants with some experience in the area of medicine that they were going to be engaged in. If a GP didn't have specific experience in a particular area, that would not however debar them because GPs may generally have skills required by examining older people as part of their general practice.

TAB 2 (continuation of interview with Dr Reid)

413. Page 2 - Reid sees Clinical Assistants as relieving Consultants of the burden of some of the work which they would otherwise have to do by delegating "simple straightforward" work.

414. Page 3 - Reid expected Barton to provide a 24 hour cover for the wards, see new patients that came in an attend to any problems.

415. Page 5 - Reid says that Barton went beyond the role that was expected of her - she usually came in twice a day and didn't wait to be called. So she was "quite proactive in her approach".

416. Page 6 - says that Barton and Dr Lord worked very closely together for a long time. **[*Lord must therefore be an important witness - check to see that Police have taken a statement]**.

417. Page 6 - Reid says that because Barton knew Lord better than she knew Reid, she was more likely to speak to Lord. **[Is he simply being defensive? What Reid appears to be saying in his evidence is whilst he was Dr Barton's line manager, in practice Barton worked more closely with the other Consultant, Dr Lord].**

418. Page 7 - Reid says that to the best of his knowledge Barton saw new patients. On page 8 he cannot recollect any problems with Dr Barton. **[* How closely did he supervise her duties. Did he for example, review her care plans and prescriptions with her - perhaps this is dealt with later on in the interviews].**

419. Page 8 - Reid says that Barton had the day to day responsibility for medical management of the patient.

420. Page 9 - Barton was responsible for writing up case notes.

"I felt that at any time there was an important.... change in a patient's condition that was recorded". **[*THIS IS AN IMPORTANT POINT. HOW DOES HE KNOW THAT IMPORTANT DECISIONS WERE RECORDED? DID HE REVIEW THE NOTES WITH BARTON?].**

421. Page 10 - Reid says he might have done the occasional death certificate, if Barton was holiday or not immediately available. He may also have done the occasional cremation certificate. However Barton did most of this.

422. Page 10 - with regard to the amount of contact that Reid had with Barton he says that his timetable and Dr Lord's timetable coincided and Barton "could not be in two places at once". **[*It therefore appears that Lord and Barton also did regular ward rounds together and if this is correct Lord becomes an important witness. What hasn't come out of the interview notes is whether Lord and Reid had separate responsibilities for Dryad an Daedalus wards.].**

423. Page 11 - Reid says that the nurses thought that they were very well supported by Barton. If they had a problem they rang Dr Barton and she sorted it out.

424. Page 12 - Reid confirms that Barton prescribed drugs. He thinks, but he is not sure that she took part in case conferences. If she didn't take part he does not see that as a problem because he says that there was no need for them both to be at the conferences.

425. He says that a case conference would have involved a senior member of the nursing staff, Occupational Therapist and Physiotherapist to discuss the patients and the patients' plans. **[If Reid is correct in his recollection that Barton did not attend case conferences frequently, Reid must have been relying**

on the medical records as well as the views of the other staff members. ie Barton's medical records/notes of prescriptions etc].

426. Page 13 - Reid is not sure whether there were regular case conferences on Dryad - this ward focussed on nursing/medical care whereas Daedalus dealt with rehabilitation which involved input from Physiotherapists and Occupational Therapists **[*Again it is not entirely clear whether Barton's involvement was limited to one ward or whether she had responsibility for both wards].**

427. Page 13 - going through the job description Reid is asked about requirement to provide advice and professional support. Reid confirms that Barton gave this to the nursing staff and that he was happy with the support which the staff received from Barton.

428. Page 14 - Reid confirms that Barton advised and counselled relatives. This is based on his discussions with nursing staff.

429. Page 15 - when questioned further about recording important changes in patient's condition, Reid confirms that Barton did this. For example, if the patient developed heart failure or a chest infection. If the patient simply had a headache he wouldn't expect that to be recorded.

430. Page 16 - with regard to noting changes in prescription, Reid says that any marked changes in prescriptions would usually be a consequence of a change in a patient's condition, so he would expect such changes to be noted. **[*This is important because it appears from the Police's interview with Barton that she admits not keeping adequate notes due to pressure of work. Did Reid review the notes to make sure that they were kept up to date?].**

431. Page 17 - Reid confirms that it would be good practice to note any change in medication both in drug charts and the patient's medical notes.

432. Page 18 - Reid confirms that he would expect the drug charts and patient's medical notes to cross refer in terms of detail relating to the patient's condition and the drugs prescribed.

433. Page 20 - Reid acknowledges that running a busy general practice and providing 24 hour cover for a hospital place doctors under "additional sort of strains".

434. Pages 20/21 - Reid acknowledges that the Consultant working with Barton would be responsible for ensuring that she completed her duties satisfactorily.

435. Page 22 - Reid confirms that to the best of his recollection Barton was putting in extra hours.

436. Page 24 - Reid confirms that Barton is responsible to him for patients on Dryad Ward **[ie the continuing care ward. What isn't clear however is whether Barton was also responsible to Dr Lord for patients on Daedalus ward]**.

437. Page 24 - Reid confirms that there were 20 patients on Dryad Ward and that the ward was "invariably full".

438. Pages 24/25 - there was a higher turnover on Daedalus Ward because they had a higher turnover of patients ie at some stage it was expected that patients on Daedalus Ward would be fit enough to go home and not spend the rest of their life in hospital.

439. Pages 25/26 - Reid says that he believes that Barton spent more time on Daedalus Ward than Dryad Ward. On Dryad the patients would be relatively more stable.

440. Page 26 - Reid confirms that at the beginning of 1999 Daedalus dealt with rehabilitation patients and Dryad dealt with continuing care patients.

441. Page 26 - Reid confirms that rehabilitation wards deal with patients who have potential to improve and be released from hospital. Continuing care wards deal with patients who were very frail - very dependent patients - where there is no prospect of them getting any better.

442. Page 28 - Reid is asked about he palliative care. He says that on a continuing care ward a number of patients are going to die (by inference he seems to be saying that some of them will therefore require palliative care).

443. Page 28 - he is asked what he understands palliative care to mean. He says relieving symptoms of people who are distressed in someway, eg, because of a general cancer or severe/untreatable heart failure - people whose life expectancy is limited.

444. Page 29 - he says palliative care is primary about symptom control and people who have an illness that is likely to be terminal, but may not be terminal at that point.

445. Pages 29/30 - Reid recalls that Charles Ward at Queen Alexandra Hospital was a palliative care ward. Some of the patients there would go home but most of them ended their life in that particular ward.

446. Page 31 - Reid explains that palliative care is not necessarily limited to a palliative care ward. He says that certain patients may be too ill to be moved to a palliative care ward.

447. Page 32 - Reid confirms that not everyone on Dryad Ward who is suffering from an illness or disease would necessarily be receiving palliative care. **[*I am still**

not clear as to the distinction between palliative care and continuing care given that patients receiving continuing care are effectively expected to die in hospital].

448. Pages 32 and 33 - Reid confirms that the standard of nursing and medical care on Dryad Ward was very good - "I'd no concerns about the medical care".

449. Page 35 - Reid is asked about transferring patients for emergency treatment. Reid refers to a decision having to be made - if it was felt right that a patient should be treated actively, they would be transferred back to Queen Alexandra Hospital. On the other hand if a patient was not likely to recover or was too ill to be transferred the most important consideration was a palliation of the symptoms.

450. Pages 35/36 - Reid says the sort of decision which usually made by Dr Barton would be a matter for her clinical judgement **[*this is an important point. Reid seems to be saying that he had no responsibility in making decisions of this sought, which were left to Dr Barton. This seems odd. He appears to be absolving himself completely of the responsibility of dealing with patients who required palliative care.]**.

451. Page 36 - he is asked whether there are any guidance or protocols regarding palliative care. He says there were none that he was aware of.

452. Page 37 - he is asked whether there is any ongoing training in respect of the prescription of drugs. He says that there is no specific training and doctors were expected to be competent to prescribe. He is asked whether prescribing is one of his responsibilities. He confirms that it is.

453. Page 37 - he says that there were lots of courses available to cover topics such as palliative care.

454. Page 38 - Reid says that during the period that he had responsibility for Dryad Ward **(1999?)** that all the places in Dryad Ward were taken up. The ward started to run with empty beds. ie, there were not enough patients coming through with continuing care problems to fill the beds.

455. Pages 38/39 - as a result of spare capacity at Dryad, a decision was made to utilise the capacity by transferring patients from Queen Alexandra Hospital, ie, patients who "might get back on their feet, but it really doesn't look very likely". Therefore describes pressure from the Queen Alexandra Hospital to fill beds in the community hospital.

456. Page 39 - Reid says in an ideal world these sort of patients probably should have gone to Daedalus Ward.

457. Page 39 - the result of all this was the patient turnover on Dryad Ward increased. This is because some of the patients who came in did in fact get better and went home.

458. Page 40 Reid also says that some patients came to Dryad Ward for respite care, ie, they spent a couple of weeks in hospital and then went home, possibly to return later. He said that this was happening when he first started as a Consultant on Dryad Ward.

459. Page 41 - Reid confirms that as turnover increased, so did the amount of work he was required to do.

460. ***It is interesting that there should be more capacity in Dryad Ward. Could this be something to do with an increase in the mortality rate as a consequence of Dr Barton's prescribing practice? In his interview, Dr Reid is not pressed as to the underlying reason for the extra capacity. It also raises the interesting question as to whether the change in the type of patients referred to Dryad caused Dr Barton to review her treatment of patients ie, did she draw any distinction between a patient requiring continuing care or being the type of patient who had historically been referred to the Dryad Ward, and somebody who was admitted with the possibility that they could be rehabilitated and sent home at a later stage?**

461. Page 41 - Reid says that in addition to his Monday ward rounds it was not uncommon for him to spend Wednesday evenings at Dryad Ward to speak to the patient's relatives. He also indicates that on occasions he would pop in on an ad-hoc basis to see someone that he was concerned about.

(Tape 4)

FILE 7

Tab 3

462. Page 2 - Dr. Reid confirms that on a ward round, he would grab the "notes trolley", which contains all the patients' records.

463. Page 3 - He confirmed that he looked at the medical notes and the prescription chart and then, if appropriate, make decisions about management of care, i.e., continue treatment or make a change. Decisions would be confirmed in the medical records. **[*Note that on page 2, he says he did the ward rounds with the senior nurse on duty on the ward rounds when Dr. Barton was not present. Dr. Barton attended ward rounds with the consultant every other week.]**

464. Page 3 - Reid refers to a Senior Registrar being present - Dr. Ravindrain. On page 4, Reid thinks that he did ward rounds too.

465. On page 4 - The Senior Registrar's role seems to be that of observer during the ward rounds. It does not appear that the Senior Registrar had any further involvement in the wards.

466. Page 4 - Reid is asked why entries are made by him in the patients' notes during a ward round. Reid says this is to enable people to know what is happening and hope they make the right decisions and support decision making. **[*Did Reid not notice during ward rounds that Barton was authorising the use of syringe drivers and prescribing a wide band of dosages for Diamorphine?]**

467. Paragraph 5 - Reid is asked about pain management. He refers to the role of the nurses and the exercise of their discretion in dealing with pain. If a patient complained of a headache, the nurses were able to give Paracetamol and, in "extreme cases" they would call a doctor.

468. Page 5 - Dr. Reid is asked about the Wessex Protocols. He confirms that these guidelines are for palliative care. **[CHECK TO MAKE SURE THAT COPY OF WESSEX PROCOTOL IS INCLUDED IN THE PAPERS PROVIDED BY THE POLICE - ON PAGE 6, EXHIBIT REFERENCE NUMBER FOR THE PALLIATIVE CARE HANDBOOK IS CSY/HF/3.]**

469. Page 6 - Dr. Reid confirms that the Guidelines deal with, inter alia, the management of pain, distress and agitation.

470. Page 6 - Reid says he wasn't aware of the existence of the Wessex Protocols in 1999. **[Check when the Guidelines first came into use.]** - Reid says, on page 7, that he didn't become aware of the Guidelines until 2001.

471. On page 8 - Reid confirmed that he first became aware of the Wessex Guidelines in 2001 and was not aware of any guidelines before then.

472. Page 8 - Reid indicates that the Guidelines may have existed before 1999, although he was not aware of them at that time. He says he is not an expert in palliative care.

473. Page 9 - Reid describes the analgesic ladder - 3 steps to pain control because one starts at the lowest level of analgesia and only move to the next level if that doesn't work, then only move to the top level when the second level does not work. **[*******He claims that he had not heard of the analgesic ladder in 1999. We therefore need to check when the analgesic ladder was first introduced. Check with the experts.]**

474. Page 9 - By way of clarification, Reid says that although he had not heard of the analgesic ladder in 1999, in practice, pain was controlled at that time in accordance with the procedure set out in the analgesic ladder.

475. Page 10 - By way of clarification, Reid says that you would not always apply the analgesic ladder. He gives the example of someone with a broken hip. You would not start by giving the patient Paracetamol. In other words, it is up to the doctor to make a judgment as to where to start.

476. Page 12 - Reid is asked how a patient's level of pain is assessed. He says the patient is asked to give an indication on a scale of 1-10. He also refers to "non-verbal clues" such as someone rolling around in agony, clutching their stomach, and by making deductions from clinical observations.

477. Page 12 - Reid confirms the assessment of pain can be "quite subjective".

478. Page 13 - He says if the patient is confused, the level of pain may be difficult to establish. If a patient is compos mentis, it is relatively easy.

479. Page 13 - He has referred to a copy of Portsmouth Health Care Trust policy for the assessment and management of pain. On page 14, he expresses a belief that the policy was developed as a result of the police investigation into the complaints from relatives at Gosport. **[Presumably, therefore, the Guidelines were not in existence in the period we are concerned with - 1996-1999.]**

480. Page 15 - Reid has referred to a section of the Guidelines which deals with pain assessment methods. Reid says that he is quite sure that these assessment methods were not in use when he worked on the Dryad Ward.

481. Page 15 - Reid confirms that if a patient was complaining of pain, that fact would be recorded in the patient's records. On page a16, he clarifies this by saying that if a patient developed "sufficient new pain", then one would expect that to be recorded. He compares this with someone with say, arthritis, who complains of pain every half an hour, 2 or 3 times a day. The fact of a number of complaints being made about the same matter would not be recorded every time the patient made a complaint.

482. Page 18 - Reid is not aware that there were any policies in place at Dryad Ward regarding the prescribing of strong opiate analgesic.

483. Page 19 - Reid is asked about commencing a treatment by prescribing Diamorphine. He confirms that the initial responsibility for the patient rests with the doctor who issues the prescription, but acknowledges that it is ultimately it is the consultant who is in charge of the patient. He also acknowledges that he reviewed patient notes during ward rounds. **[*This is a key point. Before the**

event, must Reid bear responsibility for the syringe drivers and prescriptions for Diamorphine issued by Dr. Barton?] Is this something covered by the experts in their reports. Has Reid been interviewed with reference to each of the ten Category 3 patients?]

484. Pages 19-20 - Reid says that it is unlikely that he would have received any communications from Barton between ward rounds unless Dr. Barton or a member of the nursing staff had been particularly concerned about a patient. **[We therefore have a possibility that the patient was admitted, seen by Dr. Barton, prescribed Diamorphine, but died before Dr. Reid had a chance to see the patient or review the patient's notes.]**

485. Page 21 - Reid indicates that most patients were admitted to Dryad Ward from Queen Alexandra Hospital of St. Mary's.

486. Page 21 - Reid is asked whether the patients' notes accompany the patients on transfer. He indicates that the notes would often not accompany the patient or some of the notes would be missing - a "huge problem". On page 22, he confirms this was certainly happening in 1999.

487. Page 23 - Reid is asked how long it would take for missing notes to turn up - "sometimes never, sometimes the following day".

488. Pages 24-25 - Reid is asked how he would have admitted a patient to Dryad Ward without the patient's notes. He indicates that he rarely, if ever, admitted patients. However, he says that it is Dr. Barton who has been admitting the patient without any notes. The nursing staff would either contact the ward to make enquiry about the missing notes. Dr. Barton might also seek to make contact with a junior doctor responsible for the patient's care before the patient was transferred.

489. Page 27 - Reid says that in 1999, every nurse would have a basic knowledge of palliative care. Those nurses who had worked in a palliative care environment would have more knowledge than others, but all nurses would have basic knowledge. They would know, for example, if Paracetamol was not relieving pain and something stronger was needed and if that didn't work, something stronger again would be needed.

490. Page 28 - Reid confirms that nurses were allowed to administer subcutaneous procedures.

491. Page 34 - Reid is referred to exhibit GJQ/HF/7 "Operation Policy, Dryad Ward Continuing Care" dated February 1995. Reid does not remember ever seeing it. **[Check to see that this document has been provided to us by the police.]**

492. Page 39 - The officer refers to exhibit CSY/HF/6 which appears to include some pro forma clinical records. **[Again, we need to check that we have these.]** Reid is asked what he would expect to see in the clinical records - he says these would include admission notes and regular updates.

493. Page 40 - Reid confirms that observation charts were kept up to date by the nurses.

494. Pages 40/42 reconfirms that prescription charts were his responsibility and Dr. Barton's responsibility.

495. On page 42 - Reid says that subcutaneous prescriptions would have been written up by the doctor.

496. On page 43 - Reid confirms that all patients would be issued with an observation chart when they were admitted. A further chart would be used if there were concerns about a patient's fluid intake or if a patient was being started for treatment for heart failure.

497. Page 44 - Reid refers to the "first few complaints" which resulted in the Trust conducting a review. Reid chaired the Medicines and Prescribing Committee of the Trust. It was decided that the Trust needed a pain management policy. This would include appropriate documentation by nurses to assist in pain management.

498. Page 45 - Reid refers to a statement which he has made in respect of Mrs. Gregory, one of the Category 3 patients. **[Check to see whether Dr. Reid has been interviewed in respect of all ten Category 3 patients.]** In his statement concerning Mrs. Gregory, he recalls speaking to Barton on one occasion because he had observed a large dose range and had sought an explanation. She had told him that her partners were being unhelpful at attending the Hospital in her absence and he accepted her explanation. He also says that he honestly did not have any concerns about Barton's management of pain other than having that one discussion. **[*Check all his statements and the remaining transcripts of interviews - did the police probe Dr. Reid concerning Dr. Barton's pain management of the ten Category 3 patient?]**

Tab 4

499. This is a duplicate of the interview in Tab 3 - I have drafted an e-mail to go to D. C. Stevenson to ask him to provide a copy of the missing transcript.

Tab 5

500. Reid is asked how his own work was supervised. He says that his work was not supervised in that consultants' work generally was not supervised at that time. However, on page 6, he says that when he joined the Trust, the set up an appraisal system for a consultant. He had an appraisal with Dr. Jarrett sometime during 1999, but he would not describe that as "supervision".

501. Page 10 - He confirms that there was no system to appraise Dr. Barton.

502. Page 11 - Reid says that if Barton or any clinical assistant had a problem either with regard to patients or the organisation of the Hospital, she could have spoken to Dr. Reid or, if the concerns related to Dr. Lord's patients, to Dr. Lord. If Dr. Barton had had very serious concerns about either of Dr. Lord or Dr. Reid, she could, in theory, have gone to the Chief Executive of the Trust or Hospital Manager, Barbara Robinson. The latter would have dealt with non-medical issues.

503. Page 12, Reid is asked whether there was any structure to the supervision with regard to Barton's work. He says there was no formal supervision, but confirmed that he was responsible for her work with patients. **[*Again an admission that he is responsible for Dr. Barton's work. He said, earlier in his interview, that on ward rounds, he was required to check the patients' notes, including the notes relating to prescriptions issued to the patients. It appears that he was working with Dr. Barton in 1999 - possibly in 1998 as well - when at least four of the Category 3 patients were at the Hospital. There must be an argument therefore that if Barton has prescribed inappropriately and/or the standard of clinical care has been deficient, he should bear some responsibility as well.]**

504. Page 12 - Part of his responsibility in practice meant reviewing patients on his ward rounds. This amounted to his supervision of Dr. Barton.

505. Page 16 - Reid confirms that whilst he was away on holiday, Barton would do ward rounds on her own.

506. Page 18 - Reid says that if he was concerned about what Dr. Barton was doing or vice versa, they could question each other.

507. Page 19 - He says that if nurses had been unhappy about a prescription, they could query it with Dr. Barton, or if Dr. Reid had issued the prescription, they could speak to him about it. He has no recollection of any nurse questioning a prescription. He refers again to there being one occasion when he spoke to Dr. Barton about a prescription. He thinks it related to Diamorphine where she had prescribed a wide dosage range. Dr. Barton had told him that she had done this because her partners were not good at coming out to cover for her.

508. Page 20 - Reid is asked about treatment plans. He says these had emerged during the course of the ward rounds. If it was something important, he would almost certainly tell the nurses to write it into the medical notes.

509. Reid is asked about syringe drivers. On pages 23/24, he says that at the time there were two types of syringe driver in use, each using a different type of measurement for the dosages. He said that this was confusing and dangerous so after the complaints on those, steps were taken to standardise the process. This resulted in the use of one instead of two syringe drivers throughout the whole of the PCT.

510. Page 25 - He confirms that only Dr. Barton or himself could make a decision to use a syringe driver. The nursing staff could make suggestions for a syringe driver to be used, but only the doctors could prescribe its use. If a nurse made a suggestion to use a syringe driver, they would also have to provide some justification.

511. Page 27 - Reid is asked about the use of Diamorphine syringe drivers - in particular, increasing the dose. Reid says that now the Guidance is much clearer. He says he would look at the total dose someone had received in the previous 24 hours and probably increase that by 50%. So, for example, if someone had 40mg one day in total and that had not controlled the pain, what one would usually do is increase it to 60mgs. This would be administered in 10mg doses every 4 hours.

512. Page 28 - Reid goes on to explain that if having increased the dosage to 60mg and the pain still was not being controlled, the following day, it would be permissible to increase by a further 50%, plus another half of 90 up to a total maximum of 135mgs. **[Compare this with the expert evidence referred to previously in the notes. These doses seem very high compared with the expert evidence.]**

513. Page 28 - Reid explains that the dosage information referred to above applies currently. He says that there wasn't the same degree of knowledge in 1999 **[*Check the experts' view on this. Also check that the experts, in expressing their opinions are applying guidelines which were in place in the relevant period 1996/1999.]**

514. Page 29 - He is asked about converting oral Morphine to Diamorphine. He says one would look at the British National Formulary to make the appropriate conversion.

515. Page 32 - When questioned with regard to the factors which apply in prescribing opiates, Reid refers to the guidance, but also indicates that the appropriate position is based partly on the practitioner's judgment of the degree of pain and what will be required to alleviate it.

516. Page 33 - Reid acknowledges that the level of dose may vary according to the size of the patient - possibly different dosages for a very large person and a small frail elderly person.

517. Pages 35/36 - Reid is asked about recording these syringe drivers. He says that one would normally expect these syringe drivers to be recorded, because the following example where it may not be necessary to make a record: if, for example, someone is receiving oral Diamorphine, but is starting to become drowsy, and instead, someone decides to inject the medication instead, then someone might not record the fact that they had switched from an oral prescription to a syringe driver prescription because it does not amount to a significant change.

518. Page 38 - Reid refers to the "as required" section of the prescription forms. This is where a prescription is written up and the medication can be given according to the patient's need.

Tab 6

519. Page 4 - Further reference is made to the prescribing form. **Note the reference to a review date. When reviewing the expert evidence, make sure that the issue of reviewing prescriptions (with the possible lack of a review) is dealt with; i.e., did Dr. Barton review the prescriptions for Diamorphine?**

520. Pages 8 and 9 - Reid is asked about Barton's prescribing practices, in particular, her "prescribing drugs proactively". He refers again to the one patient he recalls where she had prescribed 20 to 80mg to a patient who was in pain. However, apart from this, Reid does not remember if the same was done with other patients until the police presented him with details of some other cases. **[*What other cases have the police looked at with Dr. Reid? Have there been any other interviews/witness statements - check with P. C. Stevenson.]**

521. Page 9 - Reid does not remember Barton writing up Morphine or Diamorphine for patients who were not in any pain.

522. He is asked when he first noticed Dr. Barton writing up "variable doses" (i.e., a range of doses, for example, 20 to 80mgs). He is not sure when he first noticed this, but it was early on during his time at the Hospital.

523. Pages 9/10 - He is asked about the difference between a variable dose and proactive prescribing. He understands proactive prescribing to be prescribing in the absence of any pain, i.e., in anticipation that pain may, in the future, require the medication to be administered. He describes variable doses as those which are given to a patient who is in pain, where a discretion is given to the nurses as

to how much the dose should be. He says he has not seen any policy or guidance as to how large the variants can be.

524. Page 11 - Reid says Barton did not need his authority to issue a proactive prescription - it was her decision to prescribe in the absence of pain, although he says that with regard to prescribing opiates, this was not good or acceptable practice. **[*Clearly, Dr. Reid therefore feels that prescribing opiates in anticipation of pain was inappropriate. However, it begs the question as to why, during his ward rounds, he failed to pick this up.]**

525. Page 13 - He is asked in more detail about the prescribing variable doses. He indicates that small variations would be acceptable, i.e., 20 to 40 mg, but expresses the view that 20 to 200mg was not acceptable practice.

526. Page 13 - He is asked how one could ensure that a nurse started at the lower end of the range instead at starting at the higher end of dose. He says that one would rely on the nurses' discretion and common sense and makes the point that two nurses would have to check the prescription.

527. On page 14, he is asked whether the type of illness would have any bearing on prescribing opiates. He says that so far as possible, he would avoid prescribing opiates to patients with chronic bronchitis. Opiates can cause respiratory depression (shallow breathing). He says he would try to avoid prescribing in these circumstances and would certainly be more cautious in the level of dose employed. **[*THIS IS IMPORTANT BECAUSE THE DEATH CERTIFICATES FOR SOME OF THE PATIENTS REFERRED TO BRONCHOPNEUMONIA AS BEING THE CAUSE OF DEATH. CHECK TO MAKE SURE THE EXPERTS HAVE CONSIDERED THE CAUSE OF DEATH WHEN CONSIDERING THE APPROPRIATENESS OR OTHERWISE OF THE MEDICATION WHICH WAS PRESCRIBED.]**

528. Page 15 - Barton never consulted him about prescribing Diamorphine for people who are not in pain.

529. Page 17 - Reid confirms that until the Police enquiry, he was unaware that Barton had been prescribing "proactively". This is the first time that he had heard of proactive prescribing.

530. Pages 18 & 19 - Reid is referred to the protocol for prescription and administration of Diamorphine by subcutaneous infusion. He can't say when this dates from.

531. Page 20 - the Police Officer seems to be saying that the policy was prepared by Val Vardon an Associate Specialist, Queen Alexandra Hospital. However the Police are not sure when the guidance was introduced. The period 1998-2000 is mentioned. **[Page 21 refers to some handwritten amendments on the**

document. Check but I think this document is included in one of the generic files].

532. Page 21 - contrary to what was stated on the previous page, Val Vardon may not have introduced the guidance. She may have been the person whose manuscript and notes appear on the copy of the guidance in the Police's possession.

533. Page 22 - Reid has no recollection of seeing the protocol.

534. Page 23 - Reid confirms that he did not draw up the protocol and does not recall seeing it.

535. Page 24 - Reid is asked in what circumstances a nurse could verify death. He said a nurse could do this if the death was expected. By way of clarification, on page 25, he says that somebody who is clearly dying and dies during the night, when a doctor was not around, it was permissible for the Night Nurse to verify death. The doctor would then certify the death in the morning.

536. Page 27 - Reid says that his responsibilities did not include supervising Dr Barton's duties to complete death certificates.

537. Pages 27/28 - Reid says he never saw any death certificate and did not query any cause of death.

538. Page 29- Reid confirms that where a cause of death is uncertain it has to be reported to the Coroner. The interviewing officer refers Reid to a document entitled "Department of Medicine for Elderly People, Essential info for medical staff" this includes a list of 16 circumstances where a death has to be referred to a Coroner.

539. Page 33 - Reid confirms that he did not complete death certificates or medical certificates. He did complete 2 or 3 cremation forms.

540. Page 33 - by way of clarification he says he may on one occasion have certified a death in Dr Barton's absence. However he does not give any further details.

541. Page 35 - he is asked about the difference between a death certificate and a medical certificate of cause of death. Reid thinks they are the same thing. The officer points out they are two different forms.

Tab 7

542. Page 3 - Reid is asked who would make a decision as to the type of care a patient would receive on their admission, ie whether or not they would receive palliative care. In response Reid says that Dr Barton would form a view and that he (Reid) would form a view himself.

543. Page 4 - Reid confirms that patients being transferred to Dryad would be referred by a Consultant with instructions - for example, "transfer to Gosport for rehabilitation or for further assessment". Dr Barton would then see the patient. Reid is asked whether Barton was able to change the type of care to that outlined by the referring doctor. Reid says that would happen only if circumstances change eg, if the patient was sent for rehabilitation but has suffered a very significant deterioration in their condition. He confirms this didn't happen very often.

544. Page 5 - Reid confirms that palliative care differs from rehabilitation and continuing care. Reid confirms that the principle aim in palliative care is to relieve symptoms. He describes the patient, for example, who might referred for rehabilitation. They develop heart failure with the possibility that they may die. It might be appropriate to prescribe Morphine and treat the heart failure. They may then recover and be referred back to a rehabilitation plan.

545. Page 6 - Reid is asked whether palliative care equates to terminal illness. Reid says that terminally ill people can receive palliative care but patients do not necessarily have to be terminally ill to receive such care. For example someone may have a potentially life threatening illness but recover. Also for example, a certain type of cancer patient may not be dying, although it is known that in two or three years time they will probably die. They may receive some treatment in hospital in respect of their pain but then be released. It could be said that they received palliative care but they are not terminally ill. **[This is a difficult area but I think palliative care is all about relieving symptoms without a possibility for a cure. It can sometimes apply to terminally ill patients but patients who are not terminally ill may also receive palliative care].**

546. Page 7 - Reid is asked about the content of the patient's medical notes. He would expect their to be a brief resume in respect of the patients condition on transfer or an admission to hospital plus a management plan. He would not expect a detailed history for patients being transferred to Gosport because they were being transferred from another hospital and most patients would be stable.

547. Page 8 - he confirms that the management plan is the same as a care plan.

548. Pages 8 and 9 - there is a distinction between a medical care plan and a nursing care plan.

549. Page 10 - Reid confirms that a record of the care plan is made in the notes. This enables anyone else coming along to determine the plan as a guide to future treatment.

550. Reid is asked whether Barton "accepted" patients onto the ward. **[Were the Police inferring that there was some sort of selection process?].** Reid responds by saying that patients were transferred from a list so Barton was

given the option to take or reject a patient. However she could make representation that she felt that a patient was sick and would be more appropriate to treat the patient at the Queen Alexandra Hospital. **[*This is a difficult area as well. The Dryad Ward dealt with continuing care patients. My understanding is that these are the patients who are relatively stable but nevertheless needed to stay in hospital to be looked after and were not fit to go home or return to a nursing home. There was an expectation that they would remain there for the rest of their life. They would not necessarily be terminally ill. In comparison Daedalus Ward dealt with patients requiring rehabilitation. I understand this to mean that they may have been admitted with a particular illness or problem which was treatable and the expectation was that they would leave hospital and either go back home or be sent to a nursing home when they were fit enough.]**

551. Page 12 - Reid confirms that Dr Barton was responsible for the initial "clerking" of the patient (I understand this to mean the initial assessment of the patient). Dr Reid would not see the patient until his Monday afternoon ward round.

552. Page 13 - Reid confirms that he and Dr Barton had joint responsibility of the patients.

553. Page 13 - he is asked whether there are any policies in place for completion of medical notes. There were none that he is aware of.

554. Page 14 - he is asked about his own standard of record keeping. He recorded what he considered to be the important information and the notes would reflect what he had actually done with the patient. On page 15 he gives an example - if a patient had a chest infection he would usually write that down following an examination and then record the prescription for antibiotics.

555. Page 15 - He is asked whether he was satisfied with the standard of record keeping. He describes Dr Barton's notes as "brief" but they did actually record significant changes in either the patient's condition or significant changes in the management plan. **[*One of the deficient areas outlined by Dr Wilcock in his expert's report concerns Dr Barton's poor record keeping.]**

556. Page 17/18 - Reid confirms that Dr Barton recorded most of the important changes in her patients. She was very busy and may not have recorded relatively minor points for example, a urine infection.

557. Page 18 - Reid confirms that there were no occasions when he raised the subject of record keeping.

558. Page 19 - He confirms that he was never in a position where due to poor records he was unable to understand how a patient had been treated/cared for.

559. Page 19 - he is asked what information he would expect Dr Barton to record when admitting a new patient. He would expect her to write down the main diagnosis eg, stroke/heart failure and a management plan as a result of the initial assessment. He would expect her to have looked at the patient's medical records. He would have expected her to look at the patient to ensure the patient was stable and that the pulse, blood pressure and temperature were all ok. If a patient was unwell in any way he would have expected her to examine the patient or to have recorded the findings and to state what she was going to do about it.

560. Pages 20/21 - he is asked whether there are any problems with Dr Barton's partners when covering for Dr Barton. Dr Reid cannot recall any specific problems. Some nurses reported that some of the partners were reluctant to attend but he was never given any specific example of this happening.

561. Page 22 - Reid is asked whether Barton ever raised any concerns regarding the pressures of her job. Reid recalls a conversation in early 2000 when she was experiencing problems with the level of medical cover. She felt that this was not adequate. The reason was that because empty beds were appearing on Dryad Ward different types of patients were being transferred to fill the beds. ie, rehabilitation patients rather than patients requiring continuing care. He says this happened over a few months. On page 23 he says that by early 2000 it had become clear that this was a permanent state of affairs. By then, in Reid's opinion, a fulltime Clinical Assistant was required. Shortly after this she resigned.

562. Page 24 - Reid says that Barton gave years of "very valuable service to the War Memorial Hospital". **[This change in the type of patient, which caused Dr Barton to consider her position, appeared after the period that we are looking at - 1996/1999. QUERY WHETHER IN THE 90+ CASES WHICH THE POLICE REVIEWED, ANY RELATED TO 2000. WE NEED TO CONSIDER WHAT, IN PRACTICAL TERMS, DR BARTON DID ON DRYAD WARD. IT IS REASONABLY CLEAR THAT BETWEEN 1996 AND 1999 IT WAS A WARD WHICH DEALT MAINLY IF NOT SOLELY WITH PATIENTS WHO REQUIRED CONTINUING CARE. IF THESE PATIENTS WERE RELATIVELY STABLE, WHAT SORT OF TREATMENT DID THEY REQUIRE AND HOW BUSY WAS DR BARTON?]**

563. Page 25 - Reid says that a fulltime staff grade doctor was appointed in June 2000 (presumably after Barton's resignation). Reid says that Barton may have mentioned her concerns to Dr Lord.

564. Page 25 - Reid is asked how Barton conducted her ward round. He understands that she came onto the wards every morning. She asked whether there were any problems and saw any patients who had any problems. She'd come again in

the afternoon and see any new patients. She would also review patients she had seen in the morning and have a look at any patients the nursing staff wanted her to see.

565. Page 25 - he says

"What I'm not clear about, because I haven't asked her, is when I was away, did she do a ward round in the same round that I did" **[No details were provided to explain this comment].**

566. Page 26 - Reid describes Dr Barton's daily routine - this involved attending the hospital between 7.30 and about 9am. She would return at about midday to taken in new patients. Reid thinks she also came around mid afternoon and before she did an evening surgery. He also thinks that she may have come to the hospital after her evening surgery as well.

567. Page 27 - Reid is asked about "telephone prescribing". He refers to this as "verbal orders" ie a nurse describing a problem to a doctor over the telephone. The doctor making a diagnosis and then suggests a treatment. He is reasonably sure that there was a policy in respect of this but cannot recall the detail, in terms of what was required to be written on the prescription chart.

568. Page 29 - Reid is asked why it would be necessary for a doctor to prescribe a range of drugs when there is a policy in force which permitted a doctor to prescribe over a telephone, as part of an out of hours service. Reid says that a verbal order would usually be for a new problem - variable dose is used to manage an existing problem.

569. Page 30 - Reid seems to be suggesting that Dr Barton could be telephoned in circumstances where an "as required dose" for pain had not been written. Eg, a prescription for 400mgs (a specific amount) had been written up. A nurse could call Dr Barton out of hours to say that the patient was in a lot of pain and asked if she could give the patient another 2.5 - 5mgs. Reid seems to think that this was permissible and that the variation in the dosage should have been written up in the notes the following morning.

570. Page 30 - Reid also seems to be saying that if a doctor had prescribed a dosage range he would have expected Dr Barton to speak to the nursing staff to explain it rather than simply writing up the prescription in the notes.

571. Page 31 - Reid is asked what he would expect a Clinical Assistant to record in the patient's medical notes when the patient is "clerked" (ie, I think this refers to the initial assessment of the patient on admission). Reid refers to diagnosis, any diagnosis problems and a treatment plan.

572. Page 32 - Reid says that after the initial assessment, notes should be made if there is a change in someone's condition or a new prescription.

573. Page 32 - Reid is asked about the amount of detail he would expect in the notes. Reid states that this depends on the nature of the problem and gives some examples. If a patient was switched over to a syringe driver he would expect a short note to say that the patient was in constant pain and a direction to start using the syringe driver. On the other hand if someone had developed heart failure he would expect more detail - patient complaining of shortness of breath, no chest pain, pulse rate, blood pressure etc.

Tab 8

574. Page 1 - Reid is asked whether Dr Barton kept her note in line with GMC guidelines. On page 2 Reid looks at the guidelines and then expresses a view that Barton did not keep her notes "to the letter". He didn't discuss her note keeping with her because (1) she felt she was a senior GP and she'd have know the importance of good note keeping and (2) it is Reid's impression that when there had been a significant change in a patient's condition Barton did actually record that fact. Reid goes on to say that he knew that Barton was under pressure for her time and did not want to add to the burden by insisting that "every sort of encounter of a patient" should be documented.

575. Pages 2/3 - he was asked how he was able to follow Barton's treatment regime with reference to her notes. He said if it wasn't clear from the notes he could ask the nursing staff. He did not recollect there being a problem.

576. Page 3 - Reid is asked about "an issue" which Barton allegedly raised with some of the hospital management in 1998 ie a year before Reid started at the hospital. He is asked whether he heard anything about this when he started. He says this is the first time that he has heard about it.

577. Reid confirms that it would have been acceptable for Barton to prescribe a range of drugs as part of her out of hours service. **[I assume this is reference to issuing telephone instructions to nurses]**.

578. Pages 4/5 - Reid is again asked about Barton's standard of note keeping. Reid refers to 4 sets of notes which he has been shown by the Police **[It is not clear which sets of notes he has been shown - check this with DC Stephenson]**.

579. Most of the interview in tab 8 concerns Reid's knowledge of a protocol relating to prescriptions. The Police exhibit reference number is GJQ/HF/39. The Police show Reid some exchange of correspondence relating to the protocol which indicate that he was instrumental in developing the protocol. It appears that his recollection of this is not very clear although he seems to recall that in his

capacity as Medical Director and in response to complaints made on behalf of the relatives of Gladys Richards and Mrs Devine, and against the background of Shipman, a decision had been made to develop a policy for the management of pain, including the use of Diamorphine given by subcutaneous infusion.

580. Pages 14 and 15 refer to the Gladys Richards complaint. He says he didn't handle the complaint but he picked up the gist of the complaint and the concern relating to the prescribing of Diamorphine. He therefore felt that it was important that the hospital should develop a policy and protocol.

581. On page 15 he also refers to the case of Elsie Devine. He says she died in late November (1999?) and that in the early part of 2000 he was to deal with the complaint arising from her death. He met her daughter, Mrs Reeves, in March 2000. He also says that he saw a prescription for Mrs Devine which had a concern about, ie, there had been a switch from Fentanyl to Diamorphine and he says he would have been more prudent in the dosage, ie by prescribing 20-30mgs rather than up to 40mgs as prescribed by Dr Barton.

582. Page 18 - he is asked if he was aware of any other problems of a similar nature within the Trust. He says he was not aware of any other problems.

(Tape 5)

FILE 12

Enid Spurgin

583. ***Check to make sure that we have a copy of the clinical team assessment for this patient.**

584. The first document in the file is a summary of evidence prepared by the Police. Page 5 is missing and I have asked the Police for a copy.

TAB 1

585. First document is a further copy of the Police investigation overview, and behind that, still in tab 1 is a further summary of evidence prepared in respect of Mrs Spurgin's case.

TAB 2

586. This is a copy of a draft report prepared by Dr Wilcock, expert in palliative medicine. It is dated 5 March 2006.

587. On pages 6 and 7 there is a list of documentation considered by the expert. This includes at item 6 a copy of the palliative care handbook guidelines, also known

as the "Wessex Protocols" **[Check that we have a copy of this in our papers].**

588. Item 7 is a list of policies provided by the Portsmouth NHS Trust, including the following: Control of Administration of Medicines by Nursing Staff Policy January 1997; Prescription Writing Policy, July 2000; Policy for Assessment and Management of Pain, May 2001; Compendium of Drug Therapy Guidelines - Adult Patients, 1998; Draft Protocol for Prescription Administration of Diamorphine by Subcutaneous Infusion, December 1999; and Medicines Audit carried out by the Trust referred to as document 54 on page 52 in the CHI Report. **[Check to make sure we have got copies of all these documents].**

589. Items 9 and 10 are extracts from the British National Formulary, dated September 1998 ie the sections relating to prescribing in terminal care and prescribing in the elderly. **[Check to make sure we have got copies of these documents].**

590. Items 11 and 12 are copies of statements provided by Dr Barton, the first undated the second dated 15 September 2005. **[Check to make sure that we have got copies of this statement].**

591. Items 13 and 14 are previous draft reports prepared by Dr Wilcock in respect of Mrs Spurgin, on 1 November 2005 and 5 January 2006. **[Check that we have copies]**

592. Item 15 is a draft report prepared by a Mr Redfearn dated 22 January 2006. **[Check that we have a copy].**

593. The report contains a summary of conclusions on pages 3 and 4 **[this is a very concise and useful document which could form part of a key bundle for the client/PWJ].**

594. Dr Wilcock is highly critical of Dr Barton, and to a lesser degree Dr Reid. Dr Wilcock considers that both doctors breached their duty of care both failing to adequately assess her condition and by not taking suitable and prompt action when she complained of pain. Instead Drs Barton and Reid exposed Mrs Spurgin to the use of inappropriate doses of Diamorphine and Medazolam which in Dr Wilcock's view "would have contributed more than minimally, negligibly or trivially to her death".

595. Dr Wilcock's chronology starts on page 8 and he refers to various page references **[check to make sure that we have a paginated bundle of medical records and that page references in the report match up with the relevant pages of the reports in our possession].**

596. The chronology indicates that Mrs Spurgin was admitted to hospital after fracturing her hip in an accident. She was admitted initially to the Haslar Hospital and it was repaired surgically on 20 March 1999.

597. After the operation there was a complication in that the thigh became very swollen and painful.

598. She was seen by a Consultant at Halsar, Commander Scott and was referred to Dr Lord for rehabilitation. **[Later in the chronology it states that Mrs Spurgin was admitted to Dryad Ward which is the continuing care ward. Query why she was admitted to this ward when she was initially referred for rehabilitation. I had assumed that Daedulus Ward dealt with rehabilitation pateints].**

599. On page 11 of the report Dr Wilcock refers to Mrs Spurgin being reviewed by Dr Reid on 24 March 1999. He confirmed that he would be happy to admit Mrs Spurgin to Gosport Hospital provided that "orthopaedically all is well".

600. Mrs Spurgin was reviewed again by Commander Scott on 25 March. He noted that there was increased swelling of her leg and that a haematoma had developed and broken down. Nevertheless Commander Scott considered that Mrs Spurgin was fit enough to go to the Gosport Hospital.

601. Page 11 and 12 of the note indicates that whilst she was at the Haslar Hospital Mrs Spurgin received small doses of morphine and paracetamol.

602. Pages 12 - 20 of the report set out the chronology after the patient's transfer to Dryad Ward. She remained there between 26 March and 13 April 1999, the latter being the date of death. The chronology indicates that she was in pain throughout this period. She was prescribed various analgesics, including morphine. She was not prescribed diamorphine until 12 April, the day before she died. The notes indicate that she did receive diamorphine on 12 April.

603. The notes indicate that Dr Barton and Dr Reid were both involved in the management of her care whilst she was on Dryad Ward.

604. Dr Wilcock's opinion of the patient's treatment at the Dryad Ward commences on page 26.

605. He refers to infrequent entries in the medical notes made during her stay which he says makes it difficult to closely follow her progress over the last 18 days of her life.

606. He says that there are three entries in the medical notes prior to confirmation of death taking up a total of 1 page. The expert then goes onto summarise the content of the medical notes without making it clear which entries were made on

which dates. Also it is not clear whether the notes were all prepared by Dr Barton or whether some of them were prepared by Dr Reid. There does not appear to be any distinction between medical notes and prescription charts. More detailed work needs to be done to specify exactly what appeared in the notes, on what date and who prepared the notes. Also, as a general conservation, whilst Dr Wilcock is critical of Dr Reid, it is difficult to identify precisely the basis of the criticism apart from pages 36 and 37 where, Dr Wilcock appears to criticise Dr Reid even though he reduced the dose for diamorphine. Dr Wilcock indicates that the dose was still too high. He considers that the syringe driver should have been discontinued instead of the dose being reduced, and that Mrs Spurgin's condition should have been closely monitored for respiratory depression, pain or agitation.

607. **Dr Wilcock also does not consider Dr Reid's responsibility to supervise Dr Barton but nor does he specifically refer to the dates on which Dr Reid is recorded as having seen the patient.**

608. The main criticism of the expert appears to be the doctors' failure to assess the root cause of the patient's pain, ie, this is not only a failure to assess on her admission, but also a failure to carry out further assessment when after a period of 2 weeks the patient still appears to be in considerable pain. The doctors responded by prescribing analgesic instead of referring the patient to an orthopaedic surgeon for specialist advice and/or dealing with the infection which appears to have been the prime cause of the pain/discomfort, ie different antibiotics should have been tried.

609. A useful summary of the expert's criticisms can be found at page 30 and 31.

609.1 Insufficient assessment and documentation of the patient's pain and treatment.

609.2 Failing to seek an orthopaedic opinion when the pain did not improve with time but instead increasing doses of morphine which is associated with undesirable effects.

609.3 Failure to carry out an assessment when Mrs Spurgin's condition deteriorated - when she became more drowsy and her wound was more painful and inflamed.

609.4 The doses of diamorphine and medazalan were excessive to her needs.

In summary whilst the report contains a lot of useful detail and is reasonably well presented, I think further work needs to be done to give a more detailed analysis of dates, entries in notes and which doctor/doctors were responsible at a particular time.

610. Immediately following Dr Wilcock's report in tab 2 is two reports prepared by Dr Black and a report prepared by Dr Redfearn.

611. Dr Black's first statement is dated 27 June 2005. He is a Consultant Physician. On page 1 he refers to Mrs Spurgin as being a very elderly lady with a number of chronic conditions who had a fall leading to a fracture. He goes onto say that the prognosis after such a fracture is generally poor - up to 25% of patients in this category will die shortly after their fracture from many varied causes and complications. **[Important observation].**

612. On page 1 the expert refers to an "apparent lack of medical assessment and lack of documentation at Gosport".

613. Page 2 refers to a number of areas of poor clinical practice - further reference to a lack of a medical assessment on admission, a lack of documentation, and a failure to address the cause of the patient's pain after her admission. The expert also criticises the use of ormorphine on a regular basis without considering other possible analgesics.

614. On page 2 he also says that "subsequent management" of the patient's care was within current practice with the exception of the starting dose of diamorphine. He describes a dose of 80mg as being at best "poor clinical judgement". However he is unable to satisfy himself beyond reasonable doubt that this high dose of diamorphine hastened death by anything other than a very short period of time (hours). **[The reference to the subsequent management of pain being within current practice needs to be clarified to determine exactly which period the expert is referring to and to establish whether there is a difference of opinion vis a vis Dr Wilcock's report].**

615. Note that the list of documents seen by the expert on page 11 of his report does not include statements prepared by Dr Barton - it is possible that Dr Barton had not provided the statement at the time that the expert prepared his report.

616. Page 12 helpfully includes details of the entries in the medical records with entries for the following dates: 26 March, 7 April and 12 March (this entry must be incorrect. It must refer to 12 April). **[The expert does not say in his report who prepared each of these notes ie, whether they are Dr Barton's notes or a combination of Dr Barton and Dr Reid's notes].**

617. Page 12 also refers to entries in the nursing notes and the admission care plan. **[Presumably the admission care plan is a nursing plan rather than a plan prepared by either Dr Barton or Dr Reid - query whether the nurses would have liaised with either doctor to prepare the plan.]**

618. Page 13 - the first paragraph refers to an X-Ray. **[Even if this isn't mentioned in the notes it suggests that some attempt was made to review the cause of pain].**

619. Page 14 - paragraph 5.17 refers to the prescription of diamorphine at 20-100mgs but also notes that the amount actually administered is 80mgs, later reduced to 40mgs. **[Check to see whether the evidence explains why the initial dose was 80mgs].**

620. Page 14 paragraph 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."

621. Page 14 paragraph 6.3 - expert expresses a view that the prognosis for this 92 year old patient with all her previous problems is that the likelihood of her returning to independent existence at home would be extremely low.

622. Page 15 paragraph 6.5 - expert says that the medical assessment undertaken at Gosport was inadequate. **[Check that this was Barton's work]**. The reason why it was inadequate was that it failed to record the patient's history or whether a general examination had been performed. There is no explanation as to why the patient was in pain, particularly as she did not appear to have been in pain when she left the Haslar Hospital. **[In paragraph 6.4 of the report, the expert notes difficulty in trying to reconcile the fact that at Haslar the patient was prescribed paracetamol, which suggests that the pain was at a very low level, whereas on her admission to Gosport the medical plan was to sort out her analgesia. The nursing notes on her admission on 26 March also refer to her being continually in pain]**.

623. Page 15 paragraph 6.6 refers to the fact that immediately on her admission the patient is started on a regular dosage of strong opioid analgesia. The reason is not documented and represents poor clinical practice.

624. Page 16 paragraph 6.7 - expert says that when the patient was restarted on opioid analgesia on 31 March the pain management was appropriate at that stage. (He doesn't say why. Also it appears that Dr Wilcock does not share this view).

625. Page 16 paragraph 6.9 - the expert's view is that a decision to start using a syringe driver on 12 April was appropriate as "in my view Mrs Spurgin was now dying". He says that the likeliest cause is an unresolved infection in the wound.

626. Page 16 paragraph 6.9 - expert refers to the initial dose of 80mgs of diamorphine and notes that it is not clear whether Dr Barton or the nurse in charge suggested this note.

627. Expert also says that a starting dose of 40mgs would have been appropriate. He expresses a view that 80mgs was excessive even though this was reduced after the intervention of the Consultant, Dr Reid. **[Again this is a different view to that expressed by Dr Wilcock, who believes that even a dose of 40mgs was too high].**

628. Page 17 paragraph 6.12 - expert appears to contradict his opinion in 6.9 when he says that the dose of diamorphine used in the "last hours" was inappropriately high. In 6.12 he goes onto say that he cannot satisfy himself beyond reasonable doubt that this had a definite effect of shortening the patient's life, "in more than a minor fashion of a few hours".

629. Page 18 - the expert summarises his findings - lack of medical assessment alternatively failure to document an assessment. Failure to address the cause of the patient's pain or consider "any other action" from 26 March to 7 April. **[It would be helpful it the expert could have stated what other action might have been considered].** He is critical of the use of oramorphine on a regular basis from admission without considering other possible analgesic regimes.

630. He seems to be saying that from 7 April until her death the management of the patient's pain was acceptable with the exception of the starting dose of diamorphine. He regards a starting dose of 80mgs as "poor clinical judgement" at best. He confirms that he is unable to satisfy himself beyond reasonable doubt that the high dose of morphine hastened death by anything other than a very short period of time (hours).

631. Dr Black's second statement - dated 23 November 2005 is by way of a review to reflect that by that stage he had seen Dr Barton's statement relating to Mrs Spurgin. His statement confirms that there is nothing in Dr Barton's report which causes him to alter the conclusions in his first report. **Note that Dr Black prepared a further report of this patient dated 22 August 2006. A copy can be found at Tab 1 in File 14.**

632. The next document at tab 2 is a copy of a report from Mr Redfearn dated 22 January 2006. She is a Consultant Orthopaedic Surgeon.

633. On page 2 he refers to the possibility of the patient suffering "compartment syndrome" following her operation. He expresses grave concern that no further action can be identified (presumably by the Haslar or Gosport Hospitals) to deal with this potentially serious and reversible diagnosis. In the second paragraph on page 2 he refers to no X-Ray exams being conducted at either hospital. **[However there is some reference in the other expert's report to Dr Reid asking for an X-Ray to be taken. However there are no X-Ray results amongst the medical records and it is not clear whether or not the X-Ray was actually obtained].**

634. Pages 6 and 7 refer to the administration of morphine between 20 and 21 March whilst the patient was at the Haslar Hospital. **[Seems to undermine the observation of Dr Black in his first report - page 15 paragraph 6.4, to the effect that the patient may not have been suffering significant pain prior to her transfer to Gosport - see also page 9 of Mr Redfearn's report**

which records an examination by Dr Reid on 23 March 1999, whilst the patient was still at Haslar. "She is still in a lot of pain which is the main barrier to mobilisation at present - could her analgesia be reviewed?"]

635. Page 10 includes what may be a complete transcript of the medical notes as recorded on 26 March, 7 and 12 April 1999.

636. Pages 10-14 of the report contained detailed notes of entries in the nursing care plans and in prescription charts.

637. The expert considers three possible causes of Mrs Spurgin's pain following her operation which in general terms consist of swelling due to internal bleeding, a failure in the "operation fixation of her fracture" and a possibility of an infection of the wound. The expert says that all three possibilities would cause pain which should have been capable of being treated. The first of these possibilities, if it had occurred, probably would have happened in the immediate post-operative period, ie when the patient was still at the Haslar Hospital.

638. With regard to the possibility of an infection the expert says in the second paragraph on page 18 that "broadly, her treatment seems to have been appropriate" but on page 20 he is critical of a failure of Barton/Reid to consider a possible orthopaedic cause of her symptoms. ie, implant failure or uncontrolled infection. He says that at that point it would have been "prudent" to seek a further orthopaedic opinion.

639. **Reviewing the evidence from the experts as a whole there are a number of grey areas: the patient was in obvious pain following her operation. It appears that Dr Reid sought an X-Ray at one stage although it is not clear whether that was obtained. Therefore there seems that there was some attempt made to try and determine the underlying cause of the pain. She was also treated with antibiotics whilst at Gosport and so obviously the possibility of an infection was also considered. The main criticism therefore appears to be a failure by Barton/Reid to seek specialist assistance to diagnose the reason for the pain and then treat it appropriately. The orthopaedic expert criticises management of the patient's care whilst at the Haslar Hospital.**

640. **There is a consensus amongst the experts that a proper assessment was not conducted and proper reviews were not carried out when over a very lengthy period her pain persisted. Inadequate notes have been made and there is some but varying criticism with regard to the way analgesics were administered. In my view we have sufficient evidence in these reports to refer the matter to a case examiner to deal with Dr Barton's position. The position is more difficult with regards to Dr Reid. His role is criticised by a case examiner may need more specific details**

before making a decision on whether Dr Reid should also be referred to the Fitness to Practice Panel.

641. **NB - None of the experts appear to give many detailed considerations to the certified cause of death - cerebral vasular accident. Check with experts to see whether there is any evidence that this is likely to have been the true cause of death. Is there any requirement by a doctor certifying cause of death to provide reasons in support of their opinion.**

TAB 3

642. This is a transcript of a taped interview with Dr Barton and her solicitor on 15 September 2005. This interview concerns the care and treatment of Mrs Spurgin. During the interview the transcript records that Dr Barton simply read out a pre prepared statement (the statement which appears at tab 4 and which is dated 15 September 2005).

TAB 4

643. This is a copy of Dr Barton's statement concerning Mrs Spurgin.

644. In paragraph 1 she confirms that between 1998 and 2000 she worked as the sole Clinical Assistant at Gosport Hospital.

645. In paragraph 2 she claims, due to the passage of time, that she has no recollection at all of Mrs Spurgin. She also refers to an earlier statement that she gave to the Police on 4 November 2004 which gave information about her practice generally. **[*Check to make sure we have a copy of this statement].**

646. In paragraph 3 she refers to a change in the level of dependency of the patients over a period of time. Initially the dependency was relatively low and that changed and patients became increasingly dependent. She claims that by 1998 many of the patients were "profoundly dependent with minimum Barthel scores and that there was significant bed occupancy". She also claims that demands on both her time and the time of the nursing staff were considerable.

"In effect I was left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting other patients."

647. She claims this was the position both in 1998 but she says later in paragraph 3 of her statement that if anything the position had become even more difficult by 1999 when she was involved in the care of Mrs Spurgin.

648. In paragraph 4 Dr Barton refers to Mrs Spurgin's medical history - in particular her depression and loss of independence (November 1997).

649. In paragraph 6 she refers to a number of falls in 1998.

650. Paragraph 8 refers to the fall in March 1999 when she fractured her right leg.

651. In paragraph 8 she refers to a transfer of the patient to Dryad Ward on 26 March 1999 - "I do not know anything of the circumstances in which she came to be admitted, in the absence of medical records in that regard".

652. Referring to the nursing note accompanying Mrs Spurgin on her transfer, Dr Barton notes that the patient's only medication at the time she was transferred was paracetamol, as required.

653. Paragraph 10 helpfully includes a transcript of a note which Dr Barton wrote in the patient's records on the date of her admission - 26 March 1999.

654. In paragraph 11 she says that on transfer she was concerned to reassess the patient's wound and ensure that she should have adequate analgesia "anticipating" that she would be in pain.

655. Paragraph 12 refers to a nursing entry on 26 March by the patient's named nurse, Lynne Barratt - the nurse noted that Mrs Spurgin was experiencing a lot of pain on movement.

656. Dr Barton confirms that she did a prescription for oramorph initially. She seems to be saying in her statement that she did this on the advice of the nurse who suggested prescribing analgesia and monitoring the effect. **[Dr Barton does not explain why she prescribed oramorph, or the dose that she prescribed].**

657. In paragraph 15 Dr Barton confirms that Mrs Spurgin did in fact receive oramorph on 26 March.

658. In paragraph 16 she says that on the following day, 27 March which was a Saturday, she visited the ward and "would therefore have assessed Mrs Spurgin's condition" although she said that she did not have an opportunity to make an entry in her records. **[It may be difficult to disprove the fact that Dr Barton did not assess the patient on 27 March].** She says she looked at her nursing notes and could see that despite regular doses of oramorph the patient was still in pain. Dr Barton goes on to say:

"I <u>anticipate</u> (emphasis added) that when I assessed her on the morning of 27 I was concerned that the oramorph previously administered had not been adequate in relieving pain, and the drug chart shows that I increased the prescription accordingly." **[Check to see whether the statements taken from the nurses support Dr Barton's version of events - ie that she**

carried out assessments without making notes, presumably due to the pressure of time].

659. Paragraph 17 refers to oramorph being taken by the patient on the following day - 28 March. Dr Barton refers to the nursing records which state that Mrs Spurgin had been vomiting. Dr Barton said that she therefore advised that oramorph should be discontinued. Instead Dr Barton prescribed co-dydramol (presumably a painkiller).

660. In paragraph 18 Dr Barton says that she reviewed the patient again on 29 March. She refers to the nursing records which show that the patient's wounds were redressed and further swabs were taken from the wound site to test for MRSA and other infections. Swabs were subsequently reported as being negative for infection. **[Check with experts - does this effectively discount the possibility that the patient's pain was due to infection?].**

661. Paragraph 20 says that Dr Reid generally carried out a weekly ward round. However there is no entry to confirm this on 29 March (presumably a day that he would have carried out the ward round) and Dr Barton is unable to say whether or not Dr Reid saw a patient during that week.

662. Paragraph 21 refers to the fact that co-dydramol appears to have been adequate in dealing with Mrs Spurgin's pain.

663. Paragraph 21 also refers to the prescription for morphine sulphate to be administered because co-dydramol was not adequate to relieve the pain.

664. In paragraph 21 Dr Barton also says that in addition to morphine sulphate, the patient received a dose of oramorph at 1.15pm. **[Check to see whether the experts commented upon morphine sulphate and oramorph being used at the same time. Also Dr Barton doesn't explain why oramorph was being administered on 31 March, in view of the fact that she says in paragraph 17 of her statement that oramorph had been discontinued on 28 March due to Mrs Spurgin vomiting].**

665. Paragraph 24 refers to the fact that morphine sulphate appears to have been unsuccessful in alleviating the patient's pain. Dr Barton refers to the nursing record which records that the patient was still having pain on 1 April.

666. In paragraph 26 Dr Barton says that she would have reviewed the patient's condition again on 5 April (she doesn't say what form the review would have taken, presumably she cannot specifically recall what happened in any event).

667. Paragraph 27 - Dr Barton says that she saw Mrs Spurgin on 6 April. She said that she would not have had an opportunity to make a specific note in her records. **[She does not explain the reason for this].**

668. She goes onto say that the patient was still experiencing pain which resulted in an increase in the dose of morphine sulphate.

669. In paragraph 28 - Dr Barton refers to the nursing staff noticing that fluid was oozing from the patient's wound. Dr Barton says she believes that she would have been concerned that an infection from the wounds was developing. She says that swabs were taken and staphylococcus infections were reported several days later.

670. Paragraph 29 - Barton says she saw the patient again - the nursing staff had recorded that the fracture site was inflamed. Dr Barton prescribed antibiotics in advance of the results of the swabs, in anticipation that the patient was developing an infection.

671. In paragraph 30 Dr Barton refers to Dr Reid seeing the patient on 7 April during his ward round. Dr Reid noted that the patient was in a lot of pain and very apprehensive. Dr Reid recorded the fact that the dose of morphine sulphate prescribed by Dr Barton had been increased the previous day. In the same paragraph Dr Barton states that Dr Reid asked for an X-Ray to be taken of the hip because it was still quite painful. Dr Barton refers to the fact that there is no X-Ray report available in the medical records and she is therefore unable to say what the X-Ray demonstrated.

672. In paragraph 31 she refers to the nursing records which confirmed that an X-Ray was arranged "for the following day" (8 April?).

673. Paragraph 32 - Dr Barton says that she "anticipates" that she would have seen Mrs Spurgin again on 8 & 9 April - "noted" that her condition remained essentially unchanged. **[Is the use of the word "noted" to be taken literally? ie, do the medical notes show entries for 8 & 9 April by Dr Barton which record the patient's condition as being unchanged?].**

674. Also in paragraph 32 Dr Baron refers to the nursing entry on 9 April which records that the patient was to stay in bed until Dr Reid had seen the X-Ray of her hip. Dr Barton says that this suggests that the X-Ray was in fact undertaken.

675. Paragraph 34 refers to a deterioration in the patient's condition over the weekend of 10 and 11 April. Dr Barton refers to a nursing entry on 11 April which described the patient leaning to the left. Dr Barton takes the reference to the patient leaning to raise the possibility that the patient "might" have suffered a cerebrovascular accident. **[The use of the word "might" does not indicate any degree of certainty. Check with the expert. If a cerebrovascular accident had been suspected, should a note have been made of this in the patient's records? Also, what further investigation or treatment would be required if this had been suspected. Is there anything in the**

notes to suggest that Dr Barton responded with the possibility that the patient had had a stroke?]

676. In paragraph 34 there is further reference to a dose of oramorph being used as a consequence of pain and Dr Barton's original PRM prescription.

677. **[I don't understand why oramorph is still being used when according to the statement it was discontinued because of the vomiting. Also why was it necessary to use oramorph and morphine sulpahte].**

678. In paragraph 36 Dr Barton refers to a further deterioration in the patient's condition on the afternoon on 11 April. There is reference to the patient being "very drowsy and unrousable and refusing food and drink" (could this have been as a consequence of the analgesics?).

679. Paragraph 37 and 38 indicate that Dr Barton next reviewed the patient on the morning of Monday 12 April. She then prescribed diamorphine and medazolam. Dr Barton confirms that she prescribed a dose range of 20-200mgs for diamorphine.

680. In paragraph 39 she confirms that diamorphine was commenced by syringe driver at 9am on 12 April - the first dose of diamorphine being 80mgs. She says

"I anticipate (emphasis added) that the dose of both diamorphine and medazolam would have been discussed with me. I believe that I would have considered 80mgs to be appropriate at that time given the fact that the oramorph was clearly inadequate in alleviating the pain and distress" - she had by this time been receiving 40mgs of morphine sulphate per day and a further 5mgs of oramorph.

"I considered this increase in medication to be reasonable one in view of her condition at the time".

681. In paragraph 40 Dr Barton refers to a further ward round carried out by Dr Reid and Dr Reid's decision to reduce the dose of diamorphine from 80mgs to 40mgs **[According to Dr Barton the patient had been receiving diamorphine since 9am that morning and it was not clear when Dr Reid did his ward round, save for that it was in the afternoon. In any event, the patient would not have received a dose at the level prescribed by Dr Barton for more than a few hours. Check with the experts with regard to timescale - would a few hours of diamorphine at a dose of 80mgs have any significant effect?].**

682. Note that in paragraph 40 the patient's drowsiness on 12 April is attributed by Dr Barton to her infection. **[Check with the experts to see whether Dr Barton had by this stage acted appropriately to deal with the possibility of an**

infection. There is reference earlier in the statement to swabs being taken].

683. Paragraph 42 gives a clearer indication of how long the patient received diamorphine at the 80mgs dose level - the lower dose of 40mgs started at 4.40pm on 12 April - Dr Barton claims that only approximately 25mgs of diamorphine would have been administered in accordance with her initial prescription.

684. In paragraph 43 Dr Barton refers to the nursing staff record which indicate that even with the benefit of 40mgs of Diamorphine it was not possible to relieve the patient's pain and distress entirely. **[Have the experts considered this?]**

685. In the final paragraph of her statement - paragraph 45, Dr Barton claims that all the medication which she prescribed was administered solely with the intention of relieving pain and distress and that at no time was medication provided with the intention of hastening the patient's death.

686. **NB - it is clear from the statement that Dr Barton's recollections are all based on the medical records, such as they are, and the nursing records. She also makes it clear that she doesn't have enough time to make detailed notes in the medical records.**

FILE 13 - VOLUME 2 OF PAPERS RELATING TO MRS SPURGIN

687. It contains copies of various witness statements.

Witness Statement of Carl Jewell

688. The first statement is Carl Jewell. He is Mrs Spurgin's nephew. He visited her on a number of occasions whilst she was in hospital. On early visits he describes her as being visited by friends and speaking quite happily to them - "she seemed fine". She was complaining about not being seen by doctors or physiotherapists.

689. He describes the visit on 12 April 1999 (the day before she died) - "she was unconscious and I was unable to rouse her". He also describes seeing Dr Reid who he says told him that she was on too high a dose of morphine and also told him that the dose would be reduced.

Witness statement of Dr McCormack

690. The next statement is from Dr McCormack. The witness worked in older people's mental health in Fareham between 1997 and 1999. The statement contains details of Mrs Spurgin's state of mind in November 1997 - "depressed and becoming increasingly frail".

Witness statement of Fraser Harban

691. Fraser Harban - Specialist Registrar who worked as a Senior House Officer, Anaesthetics at the Haslar Hospital between August 1998 and August 1999. He has no specific recollection of Mrs Spurgin. His statement refers to an anaesthetic pre-operation assessment carried out on 20 March 1999. His statement refers to the assessment which he did for anaesthesia for Mrs Spurgin before her operation. He describes the fact that she was given fluids because she was dehydrated. Her pain relief was changed before her operation. **[Overall I am not sure there is much in this statement which is of great relevance to the GMC proceedings.]**

Witness statement of Ian Gurne

692. In February 1999 he worked at the Haslar Hospital as a pre-registration House Officer. He does not recall Mrs Spurgin but wrote a number of entries in her medical records whilst she was at the Haslar Hospital.

693. Page 3 of his statement refers to a letter which he sent to Dr Lord concerning the patient and asking for advice regarding the patient's rehabilitation and consideration of a place at Gosport Hospital. **[It is not clear whether Dr Lord in fact had any involvement in the referral. It appears instead that Dr Reid saw the patient before she was transferred to Gosport. Check Reid's interview with the Police to see if the reason for this is apparent].**

694. Note that Mr Gurne's letter to Dr Lord refers to an "unremarkable" post-operation recovery but "difficult" to get the patient mobilised and "rehabilitation may prove somewhat difficult".

Witness statement of Gill Rankin

695. A nurse who worked at the Haslar Hospital between December 1998 and January 2000.

696. Page 2 of her statement includes details of a letter of transfer for the patient which she prepared on 26 March 1999. The letter is addressed to "Dear Sister". The letter refers to the fact that the patient is "now mobile from bed to chair with two nurses and can walk short distances with a zimmer frame". It refers to her only medication being analgesia (paracetamol).

697. **Useful statement giving details of Mrs Spurgin's condition before her transfer. This statement and Mr Gurne's statement could be useful in the proceedings - plus the statement from her nephew.**

Witness statement of Gillian Hamblin

698. **(Some nurses have criticised Nurse Hamblin - see statements in the generic file).**

699. She was a Senior Sister and Clinical Manager in 1999. In page 2 she says that Barton did ward rounds at 7.30am Monday to Friday and would see every patient on the ward. The witness would accompany Dr Barton if she was on duty and if she was not on duty Dr Barton would be accompanied by the Senior Nurse.

700. Page 1 she claims that patients transferred to Gosport normally came from acute wards, ie they were transferred with complicated medical issues as opposed to continuing care wards.

701. Page 3 she confirms that Dryad Ward was a continuing care ward and Daedalus was a rehabilitation/stroke ward.

702. Page 2 says that Barton was responsible as Clinical Assistant for patients on both the wards. **[*This is important as previous indications are that Barton dealt only with Dryad Ward under the supervision of Dr Reid. Need to check to make sure whether the ten category 3 patients are Dryad patients or Daedalus patients].**

703. Page 3 - the witness says that Barton saw every patient on each ward round. Barton read any reports from night staff regarding change in patients' condition and if appropriate she changed medication. Witness says Barton always discussed this with nursing staff. Claims there were occasions when Barton contacted Consultants before varying medication or to discuss other issues. **[Important details to support Dr Barton's working practices].**

704. Page 3 - witness says that Dr Barton returned to the ward almost every day after her ward rounds to address any newly admitted patients or to talk with relatives and receive updates from staff. The witness feels that Barton was very good in this regard. The witness says that Barton was always available on the telephone for advice or to discuss patient issues.

705. Page 4 - third paragraph witness says that wherever she felt that a patient was suffering adverse affects from a drug she would speak to the doctor and in some cases it would result in a dosage being reduced or medication being discontinued.

706. Page 4 4th paragraph - witness says that changes in the type of medication or dose would be written up. In exceptional circumstances a doctor gave authorisation to change medication over the telephone. In these cases the doctor then had 24 hours to write up the prescription and sign it.

707. Page 4 penultimate paragraph - witness says that she was party to discussions between Barton and Consultants during the ward rounds they did together. Witness says ward rounds were always well conducted and she never had any criticism of Barton by her Consultants.

708. Page 4 final paragraph - refers to Mrs Spurgin's medical notes. Witness confirms that she was the Manager in overall charge of the patients. The named nurse was Lynne Barratt and the Consultant was Dr Reid.

709. Page 5 - witness confirms that she was the manager in charge of all aspects of the patient's care with the exception of drug prescription.

710. Page 5 final paragraph - witness confirms that she did not administer drugs to Mrs Spurgin.

711. Page 6 lists Mrs Spurgin's medication with reference to the prescription records. **(There is no reference to oramorph. Query why this has been omitted).**

712. Page 6 refers to the prescription for diamorphine - 80mgs which the witness describes as "slightly increased dose but not dramatic".

713. At the top of page 7 the witness says that drugs prescribed by doctors were not always given by the nursing staff "until the nursing staff thought they required them", ie they were prescribed on a PRN basis - which means whenever necessary.

714. ***This is an important witness and the last point mentioned in her statement needs to be looked at in more detail ie query the practice of giving nurses discretion to administer drugs which have already been prescribed on a PRN basis - in particular does this mean that when a nurse considers it necessary to administer, she does so without any further reference to the doctor, or does she need approval/authorisation from the doctor before doing so.**

715. Nurse Hamblin will also be in a position to give much more detailed information about Dr Barton's general practice with regard to the use of Diamorphine and syringe drivers. In particular whether or not this was a practice which she regularly adopted and if so in what circumstances?

Continuation of GMC/Barton Notes Part 1

DICTATION TAPE 6

Witness Statement of Lynne Barrett

1. Witness was a Staff Nurse at Gosport Hospital. Worked on Dryad Ward in 1999. Gives evidence with regard to the treatment of Mrs. Spurgin.

2. She has knowledge of the analgesic "ladder". Says that syringe drivers are applied when patients are no longer capable of taking their medication orally.

3. Says that in 1999 every patient was automatically tested for MRSA i.e., for screening/prevention of infection.

4. Page 4 refers to Mrs. Spurgin's nursing notes and an entry completed by another nurse - Beverley Turnbull.

5. On the same page the reference refers to Mrs. Spurgin's care plan which includes at item 4 the following:

   "Give prescribed analgesics/night sedation and monitor their effectiveness".

6. The nurse refers to Mrs. Spurgin's notes which record that she was having trouble sleeping.

7. On page 5 referring to an entry on 26 March 1999 the records include the following entry:-

   "Enid is experiencing a lot of pain in movement. Desired outcome - to eliminate pain if possible and keep Enid comfortable, which should facilitate easier movement and mobilisation.

   Nursing action - Given prescribed analgesia and monitor effect. Position comfortably. Seek advice from Physiotherapist regarding moving and mobilisation."

8. Page 5 of the statement includes further references to the nursing notes including references to the patient still being in pain and pain relief being reviewed.

9. The entries include a record made by the witness in the notes on 31 March. This indicates that Oramorph was given for pain "with not too much affect".

10. Page 6 refers to further records which note the patient was still suffering from pain.

11. On page 8 there is reference to antibiotics being given to deal with the infected hip wound.

12. Page 8 also refers to an entry on 12 April when the patient was seen by Reid. The dose of Diamorphine was reduced to 40mgs. The entry goes onto state that:

    "If pain reoccurs the dose can gradually be increased as and when necessary".

13. Page 8 refers to the reduction of dose from 80mgs to 40mgs and the original "drug parameters" set by Dr. Barton i.e., 20- 200mgs.

14. On pages 9 and 10 there is reference to the patient being given a starting dose of Diamorphine of 60mgs. On page 10, the witness says that when a range of doses was given by the doctor, the nursing staff would always start on the lowest dose unless otherwise told by the doctor.

15. On page 10, she indicates that the starting dose in this case was 60mgs. There is no reference to the dose going up to 80mgs, which is somewhat confusing. Elsewhere it is suggested that the dose was 80mgs until it was halved by Dr. Reid.

16. Page 10 - the witness also says that she has no idea why Dr. Barton started the dose at 60mgs. **[*This indicates that Dr. Barton was responsible for determining the dose even when she had prescribed a range of doses. It appears that the nurses did not have discretion to determine that a dose or increase in dose within the range specified.]**

17. ***Cross check the experts' reports to make sure that they have considered this witness' statement, and specifically whether the experts have given due consideration to the fact that although Dr Barton's practice was to prescribe a wide range of dose, she appears to have been consulted by nursing staff and given instructions to prescribe a specific dose within the range. Also we need to check with this witness and the other nurses to seek clarification that this is how things worked, i.e., that the nurses themselves never determined a dose or varied a dose without consulting a doctor. This is an important point because if it is the case that Dr. Barton has effectively been consulted with regard to initial dose and any variation in dose, the fact that a broad range of doses may have been written into the records at the outset, would have no practical significance. It does however beg the question why writing in a broad range of dosage was necessary in the first place.**

<u>**Witness statement of Freda Shaw**</u>

18. Witness is a nurse who is one of the nurses who looked after Mrs. Spurgin, and made a number of entries in Mrs. Spurgin's nursing notes.

19. On page 4 the witness says that when Barton did the ward round she only examined patients where there had been a significant or relevant change in the patient's condition.

20. Page 5 - witness confirms that she administered 80mgs of Diamorphine at 9am on 12 April. She also refers to Dr Barton's prescription for Diamorphine within the range of 20-200mgs.

21. On page 5 the witness cannot remember whether Dr. Barton calculated the dose or whether the witness together with Nurse Hamblin made a dose calculation based on the dose of morphine tablets that the patient had been given on the preceding day. The witness notes that the record state that the patient was seen by Dr. Barton 12 April.

22. On page 6, the witness says that at 9am on 12 April she administered 60mgs of Diamorphine. **[This is inconsistent with the statement made by the witness on the previous page, where she says she administered 80mgs at 9am on 12 April. Also, confusingly, page 6 refers to a further entry in the patient's notes which record a dose of 20mgs being administered at 9am on 12 April.]**

23. ***The witness statement is confusing with regard to some very important factual matters, ie, the exact dose of Diamorphine which was administered on 12 April at 9am - was it 20mgs, 60mgs or 80mgs? Also, have the experts noted the inconsistency in the evidence? We will need to check the notes themselves to see if they correspond with the details in the witness statements.**

24. ***We also need to check with the witness to determine if possible whether Dr. Barton specified the initial dose or whether, as appears to be the case, the nurses themselves made a calculation to determine the initial dose with reference to the dosages of Morphine sulphate given to the patient previously, i.e., whether the nurses were converting with the intention of giving a dose of Diamorphine equivalent to the dose of morphine sulphate. (KEY WITNESS FOR THIS PATIENT).**

<u>Witness statement of Susan Melderson</u>

25. In 1998 the witness was a nurse working on Daedalus Ward, but on occasions did night duty cover on Dryad Ward.

26. Page 3 - the witness was involved in the nursing care of Mrs. Spurgin and wrote a number of entries in Mrs. Spurgin's care plan. Her entry on 10 April 1999

includes a note to record "pain on movement" and the administration of Oramorph.

Witness statement of Lorraine Walker

27. Worked as a Sister at Gosport Hospital between 1982 and 2001.

28. Page 3 refers to concerns expressed by staff in 1991 about the levels of Diamorphine being prescribed. Witness says that this was resolved internally.

29. Page 4 - nurse confirms that she recorded Mrs. Spurgin's death on 13 April 1999. Mrs. Spurgin died at 1.15 in the morning and the witness confirms that a doctor would not generally be called out during the night to confirm death. The doctor would be called first thing in the morning by the day staff.

Witness statement of Marie Collins

30. Started working as a Nurse on Dryad Ward in November 1997. Worked there until July 2003.

31. Page 2 - Nurse worked mainly on night shifts.

32. On page 3 she says that there were no ward rounds during the night. Says that on occasion she worked days and confirms that a nurse would accompany Dr. Barton during her ward rounds.

33. Page 4 - the nurse details her involvement in the care and treatment of Mrs. Spurgin; specifically the witness made notes on 11 and 12 April. The entry on 12 April includes a reference to "very shallow" breathing and the patient being in discomfort.

34. Page 5 refers to notes made by the witness on other days - 30 March, 31 March, 1 April and 6 April.

35. Page 6 - witness refers to her note on 13 April recording a dose of 40mgs of Diamorphine being administered. **[The witness doesn't include any details in her statement regarding Dr. Barton's prescription practice. Query whether this witness would be able to shed any light on this. It is possible that she may be able to do so, even though she worked on night duty. She would presumably be able to say whether, when a range of doses was given by Dr. Barton, Dr. Barton's authorisation was required before determining the initial dose and/or varying a dose.]**

Witness statement of Irene Dorrington

36. Witness was a Staff Nurse at Gosport. On pages 2 and 3 of her statement she refers to notes which she made in Mrs. Spurgin's records. **(The witness does**

not give any details concerning Dr. Barton's prescribing practice and does not therefore shed any light on the practice of prescribing ranges of doses. The witness presumably would be in a position to provide evidence in connection with this.)

37. Page 3 - the witness expresses her concerns in 1991 about the use of syringe drivers and Diamorphine. **[Check to see whether this statement appears in the generic file. The generic file includes a number of statements taken from witnesses dealing with their concerns in 1991].**

38. Witness says that all patients under Dr. Barton's care were prescribed syringe drivers.

"She set the parameters for the amount of drugs and it was at the trained nursing staff's discretion as to when increases were given, depending on the patient's increased level of pain".

[We need to take statement from other nurses to see whether they confirm that this was the case].

39. On page 3 the witness also expresses concern that patients were going straight onto strong drugs without weaker analgesics being tried.

40. Page 3 - witness refers to concerns expressed by the nurses - Nurse Giffin and Nurse Tubbritt.

41. Pages 3 and 4 - the witness goes on to describe events in 1991 when staff raised concerns about this practice and the fact that she felt she was being labelled a trouble maker.

42. Page 5 and sequence, the witness refers to notes which she made with regard to Mrs. Spurgin which includes references to Oramorph being administered **(witness does not say in the statement whether she was concerned with the prescriptions for Mrs. Spurgin. Neither does she expressly refer to a range of dosages being specified by Dr. Barton for this patient, or whether to her knowledge, she or other nurses determined the dose to administer within the prescribed range.**

KEY WITNESS

<u>Witness statement of Anita Tubbritt</u>

43. Witness was a Senior Staff Nurse at Gosport. In 1998 until 1999 she worked on Dryad Ward, reporting to Gill Hamblin.

44. Page 3 in sequence, the witness gives evidence of her involvement in the care of Mrs. Spurgin, including references to the administration of Oramorph.

45. Pages 3/4 - the nurse refers to a note made when the patient was admitted to the fact that she had complained of a lot of pain.

46. On page 4 witness claims that in view of this and the fact that Dr. Barton had written up the prescription, it was appropriate for the patient to receive Oramorph in the circumstances. **[The witness does not deal with Dr. Barton's practice of prescribing a range of doses. Neither does she deal with any concerns she may have had about Dr. Barton, especially in 1991. Check the generic files to see whether this witness has made any further statements].**

Witness statement of Dawn Lloyd

47. The witness worked as a Staff Nurse on Dryad Ward between 1996 and 1999. She was in charge of the ward in the absence of "a senior member of staff". Her line manager was Gill Hamblin.

48. Pages 3 and 4 of her statement deal with the witness' involvement in the care of Mrs. Spurgin. She administered various doses of Oramorph.

49. On page 4 she says that she administered drugs which were prescribed and written up by Dr. Barton, and she says she only administered drugs with Dr. Barton's authority. **[The detail in the statement is vague and needs to be clarified. The witness makes no comment on Dr. Barton's practice of prescribing within a range of dosages and whether nurses had any discretion to determine a dose within that range].**

Witness statement of Shirley Dunleavy

50. Witness was a Senior Physiotherapist at Gosport. Defines her responsibility as to rehabilitate patients.

51. Page 2 refers to her involvement in the care of Mrs. Spurgin. She saw her on 1 April and made a note that she was to remain in bed during the day over the Easter holiday. She was to walk with a frame once or twice a day.

52. On page 3 witness says the note made on 1 April suggests the witness was in pain because the witness asked the patient to stay in bed rather than sit in a chair. The use of her frame suggested that the patient had difficulty in walking without pain. **[The witness does not say whether she can recall Mrs. Spurgin and there is nothing in the statement which deals with Mrs. Spurgin's prospects for recovery/rehabilitation on the date that she was seen, i.e., 1 April 1999.**

FILE 14

53. This file contains further evidence relating to Mrs. Spurgin's case.

TAB 1

54. This is a further report from Dr. Black, i.e., report dated 22 August 2006. His two earlier reports dated 27 June 2005 and 23 November 2005 are in file 12, tab 2. **[Note that immediately before a copy of Dr. Black's August 2006 report is a note from the Police with a list of additional evidence on the file. It refers to <u>two</u> further statements from Dr Black. There is only 1 report at tab 1. We need to check with the Police to see if there is a further report.**

55. On page 1 of the report Dr. Black refers to his instructions "examine and comment on medical notes obtained from the Police from the Haslar Hospital". Dr. Black is then asked to say whether these records affect advice given by him in earlier reports concerning Mrs. Spurgin.

56. Page 2 paragraph 3.4 refers to a note made at the Haslar Hospital by Dr. Reid. Dr. Reid's note states that Mrs. Spurgin's hip was still very painful after her surgery.

57. Page 2 paragraph 4.2 - Dr. Black refers to a significant bleed following the operation which caused swelling and "continual pain". This caused a haematoma and that would have caused "considerable pain" when the patient was transferred to the Gosport Hospital.

58. Page 3 - Dr. Black refers to a lack of evidence that the cause of pain was not thoroughly investigated when the patient was at Gosport. He notes that Dr. Reid had asked for an orthopaedic "clearance" before transfer, but Dr. Black notes that there is no evidence in the records to show that the orthopaedic team at the Haslar Hospital carried out any further investigations or gave any further thought to the cause of pain or the future management of the pain.

59. In paragraph 4.3, Dr. Black therefore changes the opinion expressed at paragraph 6.4 in his earlier report. He says it is clear that the patient had "under treated pain" whilst she was at Haslar. He goes on to say

"It was reasonable for the doctors treating her at Gosport (Barton and Reid) to make an assumption that this was a resolving problem and nothing more needed to be done or investigations undertaken".

"However, a medical assessment undertaken was still inadequate and there was no explanation in the notes to say it was noted that she had been in pain for several days and this should be treated symptomatically".

60. **This change of view lets Dr. Barton (an possibly Dr. Reid) off the hook slightly, although there is still criticism with regard to an inadequate assessment.**

61. In paragraph 4.5 he says that the lack of a medical assessment or the apparent failure to address the cause of Mrs. Spurgin's pain were "unlikely to have made any significant difference to her subsequent death". **(This is a slightly unusual choice of words and leads to some ambiguity. I think what the doctor is trying to say is that these were not contributory factors in Mrs. Spurgin's death but this needs to be checked.)**

62. In paragraph 4.5. Mr. Black also refers to the Death Certificate and the certified cause of death - "cerebrovascular accident". Dr. Black says he can find no evidence to support this diagnosis for cause of death. **(This is an important point. Can he go any further and say that this was not the cause of death and that the cause of death has been misrepresented?)**

63. His overall view is restated on page 4. He considers that there are a number of areas of poor clinical practice. Specifically he refers to a lack of medical assessment, or documentation of that assessment on admission to Gosport. Also the use of Oramorphine on a regular basis from the date of admission without considering other possible analgesic regimes. Also the recording of cerebrovascular accident as the cause of death with no evidence, or history, or any examination to support this conclusion. **[He does not mention the prescribing of Diamorphine - check his previous report to see if he covers this].**

64. **AT SOME STAGE, WE NEED TO CROSS CHECK ALL THE EVIDENCE IN EACH OF THE CASES AND MAKE A NOTE OF ALL THE WITNESSES PARTICULARLY, NURSES, INVOLVED IN EACH CASE. IT IS POSSIBLE THAT INDIVIDUAL NURSES HAVE MADE MORE THAN ONE STATEMENT IN THE POLICE INVESTIGATION. WE WILL ALSO NEED TO BRING TOGETHER ALL THE REPORTS PREPARED BY THE EXPERTS.**

Tab 2

<u>Witness Statement of David Sinclair</u>

65. The Witness was Mrs. Spurgin's GP.

66. On page 2, he refers to her as a "spritely, active and independent woman who was in good general health - a person we did not see often".

67. On page 3, he says he last saw her on 4 January 1999 **[i.e., about 4 months before she died, for some itching veins in her legs and heartburn/indigestion.]**

68. On page 3, the GP confirms that he did not see the patient while she was in hospital before she died.

<u>Witness statement of Malcolm Scott</u>

69. He is a Consultant Orthopaedic Surgeon.

70. The Witness describes the treatment which Mrs. Spurgin received at the Haslar Hospital after her fall in March 1999.

71. Page ______________ refers to the letter sent to the witness by Dr. Reid following Dr. Reid's examination of the patient on 24 March 1999. Dr. Reid's letter refers to the patient's hip being "very painful". Dr. Reid goes on to say that he would like to be "reassured that all is well from an orthopaedic point of view", i.e., before the patient is transferred to Gosport.

72. Pages 8 and 9 - the Witness refers to Mrs. Spurgin's discharge from the Haslar Hospital - "She can manage independently". "Her only medication is Analgesia (Paracetamol)".

73. Page 10 - He refers to a sizeable swelling after surgery. She received Morphine and Paracetamol with infrequent doses of Paracetamol - the Witness assumes that she would have been asked several times a day if she required pain relief. **[The inference is that she was not in a great deal of pain.]**

74. Page 10 - The Witness confirms that when considering her Analgesia, his team would have sought to establish the cause of pain. He refers to x-rays taken before and after the operation although the x-rays themselves are not available.

75. He refers to another x-ray dated 23 March 1999 which indicates that the x-ray was checked and it did not reveal anything untowards. He therefore assumes that the pain was caused by swelling.

76. Page 10 (at the foot of the page), the Witness refers to an assessment by Dr. Reid following the patient's recovery from surgery, when she was deemed fit to be transferred to Gosport Hospital on 26 March. **[Cross check the police interview of Dr. Reid to make sure this is dealt with.]**

Witness statement of Jeanette Florio

77. Witness worked as a Nurse at Gosport between 1996 and 2004. Between December 1998 and April 2004, she worked on Dryad Ward on day shifts.

78. On page 3 and sequence, she refers to notes she made relating to the care of Mrs. Spurgin.

79. Page 3 - Witness refers to an entry in the notes made by her on 26 March 1999 - "Enid is experiencing a lot of pain on movement". The desired outcome is noted to be "to eliminate pain if possible and keep Enid comfortable".

80. Page 4 refers to the patient receiving regular Oramorph "but still in pain". **[HAVE THE EXPERTS CONSIDERED THE FACT THAT THE PATIENT WAS STILL IN PAIN HAVING RECEIVED ORAMORPH? EVEN IF DR. BARTON COULD BE CRITICISED FOR STARTING THE PATIENT ON ORAMORPH, DOES THE FACT THAT THE PATIENT WAS STILL SUFFERING PAIN HAVING RECEIVED ORAMORPH JUSTIFY STARTING THE PATIENT ON DIAMORPHINE?]**

81. Page 6 and sequence deals with notes made by the Witness relating to Mrs. Spurgin.

82. On page 7, the first paragraph, the Witness says that the patient was in a lot of pain and that the decision to employ a syringe driver was taken to keep her comfortable.

83. Page 9 - the Witness expresses the view that Dr. Barton acted in accordance with the protocol and the Analgesic Ladder.

Witness Shirley Hallmann

84. The Witness worked as a Nurse on Dryad Ward from January 19989 to 2000. Deputised for Nurse Hamblin when the latter was not on duty. Refers to there being tension between herself and Nurse Hamblin. **[This Witness gave a further statement which can be found in File 2.]**

85. On page 2, the Witness says she was concerned at the premature use of syringe driver. Expressed her concerns to Nurse Hamblin and, on one occasion, to Dr. Barton. **[Witness gives details of conversation with Barton.]**

86. Page 5 - the Witness gives details of her involvement in the care of Mrs. Spurgin. In particular, the Witness confirms that she made a note on 12 April for the patient to be seen by Dr. Barton who had authorised the commencement of a syringe driver.

87. Pages 5 and 6 refers to the starting dose of Diamorphine. The Witness refers to page 131 of the note **[CROSS CHECK THE REFERENCE]** where a record is made of 80mgs of Diamorphine at 8:00a.m. The Witness also refers to there being a notation of "dose discarded". **[NO EXPLANATION IS GIVEN IN CONNECTION WITH THIS IN THIS STATEMENT.]**

88. On page 6, first paragraph, the Witness says that Dr. Barton "could (emphasis added) have authorised the starting dose which could (emphasis added) be used in a range 20 to 200mgs".

89. In the second paragraph on page 6, the Witness goes on to say that she cannot recall whether the dose was calculated by herself and Nurse Shaw or by Dr. Barton. She goes on to say that any calculation would have been based on the

amount of Morphine that the patient had been given in the preceding day. **[FURTHER EVIDENCE IS REQUIRED TO CLARIFY THE POSITION. IT IS NOT CLEAR WHETHER THE NURSES HAVE BEEN GIVEN DISCRETION TO DETERMINE DOSAGE OR WHETHER THEY REQUIRE INSTRUCTIONS ON DOSAGE FROM DR. BARTON. REFERENCE TO CALCULATIONS BASED ON THE AMOUNT OF MORPHINE GIVEN TO THE PATIENT IN THE PRECEDING DAYS DOES NOT FULLY EXPLAIN THE POSITION. HOW IS THE CALCULATION MADE AND, IN THIS PARTICULAR CASE, WHAT WOULD HAVE BEEN THE APPROPRIATE CALCULATION/CONVERSION?]**

90. At page 7, the penultimate paragraph, Witness says that she saw Nurse Shaw give the patient 60mgs of Diamorphine on 12 April **[AGAIN, WE NEED TO CLARIFY THIS BECAUSE THERE IS REFERENCE, IN OTHER STATEMENTS, TO A DOSE OF 80MGS - SEE PARAGRAPH 39 OF DR. BARTON'S STATEMENT. THIS IS AN IMPORTANT POINT BECAUSE AT LEAST ONE OF THE EXPERTS CRITICISES THE INITIAL DOSE OF DIAMORPHINE. I THINK ON THIS BASIS THAT THE INITIAL DOSE WAS 80mgs NOT 60mgs.]**

<u>**Witness statement Shirley Hallmann**</u>

91. **Note that another statement for this Witness is in the generic file - File 2 - see my notes at paragraphs 82-97.**

92. The statement in File 14 deals with the witnesses involvement in the care of Mrs. Spurgin.

93. Pages 1 and 2 refer to the administration of Diamorphine on 14 April at 9:00a.m. **[THIS APPEARS TO CLEAR UP THE EARLIER CONFUSION ABOUT THE DOSAGE ADMINISTERED AT THIS TIME. THE WITNESS REFERS TO THE PATIENT RECEIVING 60mgs FOLLOWED BY A SECOND DOSE OF 20mgs AT 9:00A.M., I.E. A TOTAL OF 80mgs.]**

94. In the last paragraph on page 2, the Witness again says that she cannot recall whether the dose rate was worked out by herself and Nurse Shaw or whether this was done by Dr. Barton. She says the calculation would have been based on the previous dose of Morphine. She then explains that the calculation is done by taking the daily dose of Morphine and dividing it by three to give the correct dose of Diamorphine.

95. Page 3, second paragraph - the Witness then says that she did not do the conversion herself because she notes that 80mgs is four times too much.

"I would not have worked it out to be so high a dose." She then goes on to say:

Shrift

"I always argued with Dr. Barton over things like this, but I was always given short ____________(shrift?) by her. I was basically ignored by her."

[THE EVIDENCE AS TO HOW A DOSE OF 80mgs WAS DETERMINED IS NOT CLEAR. THIS WITNESS, NURSE HALLMANN, REFERS TO THE POSSIBILITY OF A CALCULATION BEING MADE REFERENCE TO PREVIOUS DOSES OF MORPHINE, ALTHOUGH SHE SEEKS TO DISTANCE HERSELF FROM MAKING THE CALCULATION BECAUSE SHE CAN SEE THAT 80mgs, BASED ON THE PREVIOUS DOSAGE OF MORPHINE, IS FAR TOO HIGH. DR. BARTON, IN PARAGRAPH 39 OF HER STATEMENT, CLEARLY USING HER WORDS VERY CAREFULLY, STATES THAT SHE "ANTICIPATED" THAT THE DOSE OF DIAMORPHINE HAD BEEN DISCUSSED WITH HER. HOWEVER, THE FACT REMAINS THAT A DOSE OF 80mgs WAS, IN FACT, ADMINISTERED. DR. BARTON THINKS IT IS JUSTIFIED, BUT THE EXPERTS DISAGREE.]

Witness statement of Lynne Barrett

96. This is a supplemental statement for this Witness which seeks to clarify that Mrs. Spurgin was given a dose of 80mgs of Diamorphine on 12 April and the dose was halved on Dr. Reid's instructions at 16:40 on the same day.

Witness statement of Kathryn Henning

97. The Witness was as Student Nurse working on Dryad Ward in 1999.

98. Page 2 confirms that she made a note relating to Mrs. Spurgin on 6 April. The note simply confirms that the Nurse removed a dressing and found that the wound/infection was healing.

99. ***General observation on evidence obtained by the police from nursing staff - the evidence ~~help would~~ appears to helpfully cover all the entries in the relevant nursing records and prescription charts. However, the police have not probed in any detail to try and establish to what extent if any the staff were given a discretion to determine dosages or varied dosages within the range of dose authorised by Dr. Barton. We need to create a list of all witnesses involved in this case and any other cases and hopefully a large number of nurses' evidence will be relevant to most of the other cases. We can then identify the total number of nursing witnesses we need to interview to prepare the case.**

Tab 9

100. This is a transcript of an interview with Dr Reid which specifically deals with the case of Mrs. Spurgin. **Note that the interview took place in July 2006.** Dr. Black confirms in his August 2006 report that he has read and considered the transcript of Dr. Reid's interview.

101. Dr. Wilcock's three reports in respect of Mrs. Spurgin were all prepared before July 2006. It would therefore appear that he has not considered Dr. Reid's evidence and reviewed whether the evidence affects any of the advice given by him previously.

102. **Note also that File 7 contains transcripts of Dr. Reid's interviews with the police on 4 July 2006, i.e., when he was questioned generally about his work at the Gosport Hospital. Therefore, the police therefore structured their interviews with him in July 2006 to deal firstly with his general involvement in the Hospital, and following on from that, they interviewed him with regard to the case of Mrs. Spurgin. We need to check whether he was interviewed separately in respect of any other individual cases.**

103. Page 5 - Reid says that he does not remember Mrs. Spurgin. On the following page, he says what he says is based on the records that have been provided to him.

104. Page 6 re-confirms that he saw Mrs. Spurgin whilst she was at the Haslar Hospital and that he wrote a letter to the consultant there agreeing to take over her care, but expressing some concern about the pain she was having in her hip. He had asked the Consultant to check that all was well with her hip before she was transferred. Reid does not know whether the check was carried out, but notes that Mrs. Spurgin was transferred to Gosport.

105. Page 7- Reid says that she was transferred on 26 March and that he saw her on 7 April and 12 April, before she died on 13 April **(no reference to Reid seeing Mrs. Spurgin at Haslar after her operation on 23 March as mentioned in the final paragraph of Dr. Scott's statement in File 14 Tab 3).**

106. Page 7/8 - he refers to his first examination of Mrs. Spurgin after her transfer - says she was in a lot of pain. He appears to have increased her dose of Morphine tablets to 20mgs twice daily. He also refers to a request for an x-ray of her hip as movement in the hip was noted to be quite painful.

107. On page 8, he also refers to his examination on 12 April when he reduced the dose of Diamorphine to 40mgs. At the same time, he authorised an increase in dose up to 60mgs if necessary. His notes at the time also state that when he did this he was able to move the patient's hip without pain, but the patient was not "rousable".

108. His view on 12 April was that the patient had been over sedated, hence his decision to reduce the dose.

109. On page 10, Reid refers to notes prepared by Dr. Barton when the patient was admitted on 26 March.

110. Page 14 - Reid is asked whether Barton carried out a suitable assessment of Mrs. Spurgin's care on her admission. Reid says that although it is a brief assessment "all the salient features" are covered. Reid commented at the reference in Barton's assessment to "sorting out an analgesia" implies that the patient was in pain when she was transferred.

111. Page 18 - Reid says that he has never had anything other than positive feedback about Barton's role and the support she offered to the nurses. **KEY POINT.**

112. Pages 19/20 - it is pointed out to Reid that there is a gap of about a week from the first note that Barton did for this patient and the next note. Reid says that he would not expect the patient to be seen every day. Rather he would expect Barton to go to the Ward every day and ask the nursing staff if there were any problems and for them to direct Barton to any patient they were particularly concerned about.

113. Page 23 - Reid says he would not expect Barton to write up notes routinely. However, he would expect significant changes in the patient's condition to be recorded.

114. Page 24 - He is asked "Who is responsible for prescribing drugs?" He responds that initially responsibility rests with the prescriber, but he accepts that he carries ultimate responsibility. (**KEY POINT**)

115. Page 26 - Reid confirms that patients requiring continuous care (i.e. Dryad patients) are people who are "very dependent, usually on nursing care".

116. Page 26/27 - Question with regard to the possibility of rehabilitating Mrs. Spurgin at the age of 92 following a hip operation. Barton explains that whilst the possibility of rehabilitation would have been considered, the chances of rehabilitating this client were "remote" **[Would the experts agree with this assessment, bearing in mind the patient's recent history before she fractured her hip?]**

117. Page 28 - Reid accepts that this patient was admitted "to attempt (emphasis added) rehabilitation" **[is there any evidence of an attempt at rehabilitation being made in this case?]**.

118. Page 33 - Reid is asked why this patient went to Dryad Ward rather than Daedalus given that the former was a rehabilitation ward and the later was for continuing care. Reid explained that at the time there was some empty beds on Dryad Ward which they were having difficulty in filling. Therefore, if they didn't have continuing care patients, they would take the "next most suitable patient". In other words, he is saying that Dryad Ward was used as a sort of back-up to Daedalus because there was a waiting list for rehabilitation on Daedalus ward whereas there were empty beds on Dryad Ward.

119. Page 36 - When challenged again about the adequacy of Barton's initial assessment, Reid points out that her assessment included a brief resume of the history, that she addressed functional status of the patient, but what she has not referred to is having undertaken any examination - heart, pulse, blood pressure etc., to make sure that the patient was stable when she was transferred. To that extent, Reid acknowledges that the assessment was lacking.

120. Page 38 - Reid says that he would expect a patient coming into hospital to have a basic examination, but is unable to say whether or not Dr. Barton carried out such an examination in this case. He acknowledges that he is unable to confirm the position because there is no record in the notes of an examination having taken place. **(*This is an important point because elsewhere it is clear that as Dr. Reid and Dr. Lord, the other Consultant, carried out their ward rounds at the same time each week, Dr. Barton was only able to accompany one or other of them. In other words, on occasions Dr. Barton would not have accompanied Dr. Reid and presumably Dr. Reid would have had to rely on Dr. Barton's notes in such circumstances**).

121. Page 39 - Reid cannot recall whether Dr. Barton was with him when he saw Mrs. Spurgin on 7 April. He came to the conclusion that if she had not been there he would have asked the nursing staff about the patient, because the nurses make observations when the patients are admitted. They record pulse and blood pressure, etc., and would know if any of these indicators had been awry.

weight

122. Page 40/41 - it is put to Reid that immediately prior to her transfer, Mrs. Spurgin was recorded as being mobile from bed to chair with two nurses and that whilst she is continent during the day, she is sometimes incontinent at night. In contrast, when Barton assesses her, she notes that the patient is not continent and not ___________ **[word cut off]** transferring. In response on page 41, Reid makes the point that Barton's assessment would be based on what she found at the time of the transfer.

X

123. Page 41/42 - Reid makes the point that the ambulance ride to transfer the patient may not have been comfortable and it is entirely possible that the patient could have been weight bearing when she was in Haslar and no longer weight bearing on arrival at Dryad because of the ambulance journey. On page 42, Reid also points out that in his own notes of his examination of the patient at Haslar, he recorded that the lady was in a lot of pain. He also makes the point that there was a tendency to "over egg the pudding" in terms of what people's capabilities were in an effort to get the patient accepted in a different ward.

by the transferring hospital

124. On page 43, he continues this theme and explains that often he was told, for example, that patients were independent but when they were transferred the reality was completely different.

Continuation of GMC/Barton Notes Part 1

DICTATION TAPE 6

Witness Statement of Lynne Barrett

1. Witness was a Staff Nurse at Gosport Hospital. Worked on Dryad Ward in 1999. Gives evidence with regard to the treatment of Mrs. Spurgin.

2. She has knowledge of the analgesic "ladder". Says that syringe drivers are applied when patients are no longer capable of taking their medication orally.

3. Says that in 1999 every patient was automatically tested for MRSA i.e., for screening/prevention of infection.

4. Page 4 refers to Mrs. Spurgin's nursing notes and an entry completed by another nurse - Beverley Turnbull.

5. On the same page the reference refers to Mrs. Spurgin's care plan which includes at item 4 the following:

   "Give prescribed analgesics/night sedation and monitor their effectiveness".

6. The nurse refers to Mrs. Spurgin's notes which record that she was having trouble sleeping.

7. On page 5 referring to an entry on 26 March 1999 the records include the following entry:-

   "Enid is experiencing a lot of pain in movement. Desired outcome - to eliminate pain if possible and keep Enid comfortable, which should facilitate easier movement and mobilisation.

   Nursing action - Given prescribed analgesia and monitor effect. Position comfortably. Seek advice from Physiotherapist regarding moving and mobilisation."

8. Page 5 of the statement includes further references to the nursing notes including references to the patient still being in pain and pain relief being reviewed.

9. The entries include a record made by the witness in the notes on 31 March. This indicates that Oramorph was given for pain "with not too much affect".

10. Page 6 refers to further records which note the patient was still suffering from pain.

11. On page 8 there is reference to antibiotics being given to deal with the infected hip wound.

12. Page 8 also refers to an entry on 12 April when the patient was seen by Reid. The dose of Diamorphine was reduced to 40mgs. The entry goes onto state that:

    "If pain reoccurs the dose can gradually be increased as and when necessary".

13. Page 8 refers to the reduction of dose from 80mgs to 40mgs and the original "drug parameters" set by Dr. Barton i.e., 20- 200mgs.

14. On pages 9 and 10 there is reference to the patient being given a starting dose of Diamorphine of 60mgs. On page 10, the witness says that when a range of doses was given by the doctor, the nursing staff would always start on the lowest dose unless otherwise told by the doctor.

15. On page 10, she indicates that the starting dose in this case was 60mgs. There is no reference to the dose going up to 80mgs, which is somewhat confusing. Elsewhere it is suggested that the dose was 80mgs until it was halved by Dr. Reid.

16. Page 10 - the witness also says that she has no idea why Dr. Barton started the dose at 60mgs. **[*This indicates that Dr. Barton was responsible for determining the dose even when she had prescribed a range of doses. It appears that the nurses did not have discretion to determine that a dose or increase in dose within the range specified.]**

17. ***Cross check the experts' reports to make sure that they have considered this witness' statement, and specifically whether the experts have given due consideration to the fact that although Dr Barton's practice was to prescribe a wide range of dose, she appears to have been consulted by nursing staff and given instructions to prescribe a specific dose within the range. Also we need to check with this witness and the other nurses to seek clarification that this is how things worked, i.e., that the nurses themselves never determined a dose or varied a dose without consulting a doctor. This is an important point because if it is the case that Dr. Barton has effectively been consulted with regard to initial dose and any variation in dose, the fact that a broad range of doses may have been written into the records at the outset, would have no practical significance. It does however beg the question why writing in a broad range of dosage was necessary in the first place.**

<u>**Witness statement of Freda Shaw**</u>

18. Witness is a nurse who is one of the nurses who looked after Mrs. Spurgin, and made a number of entries in Mrs. Spurgin's nursing notes.

19. On page 4 the witness says that when Barton did the ward round she only examined patients where there had been a significant or relevant change in the patient's condition.

20. Page 5 - witness confirms that she administered 80mgs of Diamorphine at 9am on 12 April. She also refers to Dr Barton's prescription for Diamorphine within the range of 20-200mgs.

21. On page 5 the witness cannot remember whether Dr. Barton calculated the dose or whether the witness together with Nurse Hamblin made a dose calculation based on the dose of morphine tablets that the patient had been given on the preceding day. The witness notes that the record state that the patient was seen by Dr. Barton 12 April.

22. On page 6, the witness says that at 9am on 12 April she administered 60mgs of Diamorphine. **[This is inconsistent with the statement made by the witness on the previous page, where she says she administered 80mgs at 9am on 12 April. Also, confusingly, page 6 refers to a further entry in the patient's notes which record a dose of 20mgs being administered at 9am on 12 April.]**

23. ***The witness statement is confusing with regard to some very important factual matters, ie, the exact dose of Diamorphine which was administered on 12 April at 9am - was it 20mgs, 60mgs or 80mgs? Also, have the experts noted the inconsistency in the evidence? We will need to check the notes themselves to see if they correspond with the details in the witness statements.**

24. ***We also need to check with the witness to determine if possible whether Dr. Barton specified the initial dose or whether, as appears to be the case, the nurses themselves made a calculation to determine the initial dose with reference to the dosages of Morphine sulphate given to the patient previously, i.e., whether the nurses were converting with the intention of giving a dose of Diamorphine equivalent to the dose of morphine sulphate. (KEY WITNESS FOR THIS PATIENT).**

<u>Witness statement of Susan Melderson</u>

25. In 1998 the witness was a nurse working on Daedalus Ward, but on occasions did night duty cover on Dryad Ward.

26. Page 3 - the witness was involved in the nursing care of Mrs. Spurgin and wrote a number of entries in Mrs. Spurgin's care plan. Her entry on 10 April 1999

includes a note to record "pain on movement" and the administration of Oramorph.

Witness statement of Lorraine Walker

27. Worked as a Sister at Gosport Hospital between 1982 and 2001.

28. Page 3 refers to concerns expressed by staff in 1991 about the levels of Diamorphine being prescribed. Witness says that this was resolved internally.

29. Page 4 - nurse confirms that she recorded Mrs. Spurgin's death on 13 April 1999. Mrs. Spurgin died at 1.15 in the morning and the witness confirms that a doctor would not generally be called out during the night to confirm death. The doctor would be called first thing in the morning by the day staff.

Witness statement of Marie Collins

30. Started working as a Nurse on Dryad Ward in November 1997. Worked there until July 2003.

31. Page 2 - Nurse worked mainly on night shifts.

32. On page 3 she says that there were no ward rounds during the night. Says that on occasion she worked days and confirms that a nurse would accompany Dr. Barton during her ward rounds.

33. Page 4 - the nurse details her involvement in the care and treatment of Mrs. Spurgin; specifically the witness made notes on 11 and 12 April. The entry on 12 April includes a reference to "very shallow" breathing and the patient being in discomfort.

34. Page 5 refers to notes made by the witness on other days - 30 March, 31 March, 1 April and 6 April.

35. Page 6 - witness refers to her note on 13 April recording a dose of 40mgs of Diamorphine being administered. **[The witness doesn't include any details in her statement regarding Dr. Barton's prescription practice. Query whether this witness would be able to shed any light on this. It is possible that she may be able to do so, even though she worked on night duty. She would presumably be able to say whether, when a range of doses was given by Dr. Barton, Dr. Barton's authorisation was required before determining the initial dose and/or varying a dose.]**

Witness statement of Irene Dorrington

36. Witness was a Staff Nurse at Gosport. On pages 2 and 3 of her statement she refers to notes which she made in Mrs. Spurgin's records. **(The witness does**

not give any details concerning Dr. Barton's prescribing practice and does not therefore shed any light on the practice of prescribing ranges of doses. The witness presumably would be in a position to provide evidence in connection with this.)

37. Page 3 - the witness expresses her concerns in 1991 about the use of syringe drivers and Diamorphine. **[Check to see whether this statement appears in the generic file. The generic file includes a number of statements taken from witnesses dealing with their concerns in 1991].**

38. Witness says that all patients under Dr. Barton's care were prescribed syringe drivers.

    "She set the parameters for the amount of drugs and it was at the trained nursing staff's discretion as to when increases were given, depending on the patient's increased level of pain".

    [We need to take statement from other nurses to see whether they confirm that this was the case].

39. On page 3 the witness also expresses concern that patients were going straight onto strong drugs without weaker analgesics being tried.

40. Page 3 - witness refers to concerns expressed by the nurses - Nurse Giffin and Nurse Tubbritt.

41. Pages 3 and 4 - the witness goes on to describe events in 1991 when staff raised concerns about this practice and the fact that she felt she was being labelled a trouble maker.

42. Page 5 and sequence, the witness refers to notes which she made with regard to Mrs. Spurgin which includes references to Oramorph being administered **(witness does not say in the statement whether she was concerned with the prescriptions for Mrs. Spurgin. Neither does she expressly refer to a range of dosages being specified by Dr. Barton for this patient, or whether to her knowledge, she or other nurses determined the dose to administer within the prescribed range.**

KEY WITNESS

Witness statement of Anita Tubbritt

43. Witness was a Senior Staff Nurse at Gosport. In 1998 until 1999 she worked on Dryad Ward, reporting to Gill Hamblin.

44. Page 3 in sequence, the witness gives evidence of her involvement in the care of Mrs. Spurgin, including references to the administration of Oramorph.

45. Pages 3/4 - the nurse refers to a note made when the patient was admitted to the fact that she had complained of a lot of pain.

46. On page 4 witness claims that in view of this and the fact that Dr. Barton had written up the prescription, it was appropriate for the patient to receive Oramorph in the circumstances. **[The witness does not deal with Dr. Barton's practice of prescribing a range of doses. Neither does she deal with any concerns she may have had about Dr. Barton, especially in 1991. Check the generic files to see whether this witness has made any further statements].**

Witness statement of Dawn Lloyd

47. The witness worked as a Staff Nurse on Dryad Ward between 1996 and 1999. She was in charge of the ward in the absence of "a senior member of staff". Her line manager was Gill Hamblin.

48. Pages 3 and 4 of her statement deal with the witness' involvement in the care of Mrs. Spurgin. She administered various doses of Oramorph.

49. On page 4 she says that she administered drugs which were prescribed and written up by Dr. Barton, and she says she only administered drugs with Dr. Barton's authority. **[The detail in the statement is vague and needs to be clarified. The witness makes no comment on Dr. Barton's practice of prescribing within a range of dosages and whether nurses had any discretion to determine a dose within that range].**

Witness statement of Shirley Dunleavy

50. Witness was a Senior Physiotherapist at Gosport. Defines her responsibility as to rehabilitate patients.

51. Page 2 refers to her involvement in the care of Mrs. Spurgin. She saw her on 1 April and made a note that she was to remain in bed during the day over the Easter holiday. She was to walk with a frame once or twice a day.

52. On page 3 witness says the note made on 1 April suggests the witness was in pain because the witness asked the patient to stay in bed rather than sit in a chair. The use of her frame suggested that the patient had difficulty in walking without pain. **[The witness does not say whether she can recall Mrs. Spurgin and there is nothing in the statement which deals with Mrs. Spurgin's prospects for recovery/rehabilitation on the date that she was seen, i.e., 1 April 1999.**

FILE 14

53. This file contains further evidence relating to Mrs. Spurgin's case.

TAB 1

54. This is a further report from Dr. Black, i.e., report dated 22 August 2006. His two earlier reports dated 27 June 2005 and 23 November 2005 are in file 12, tab 2. **[Note that immediately before a copy of Dr. Black's August 2006 report is a note from the Police with a list of additional evidence on the file. It refers to <u>two</u> further statements from Dr Black. There is only 1 report at tab 1. We need to check with the Police to see if there is a further report.**

55. On page 1 of the report Dr. Black refers to his instructions "examine and comment on medical notes obtained from the Police from the Haslar Hospital". Dr. Black is then asked to say whether these records affect advice given by him in earlier reports concerning Mrs. Spurgin.

56. Page 2 paragraph 3.4 refers to a note made at the Haslar Hospital by Dr. Reid. Dr. Reid's note states that Mrs. Spurgin's hip was still very painful after her surgery.

57. Page 2 paragraph 4.2 - Dr. Black refers to a significant bleed following the operation which caused swelling and "continual pain". This caused a haematoma and that would have caused "considerable pain" when the patient was transferred to the Gosport Hospital.

58. Page 3 - Dr. Black refers to a lack of evidence that the cause of pain was not thoroughly investigated when the patient was at Gosport. He notes that Dr. Reid had asked for an orthopaedic "clearance" before transfer, but Dr. Black notes that there is no evidence in the records to show that the orthopaedic team at the Haslar Hospital carried out any further investigations or gave any further thought to the cause of pain or the future management of the pain.

59. In paragraph 4.3, Dr. Black therefore changes the opinion expressed at paragraph 6.4 in his earlier report. He says it is clear that the patient had "under treated pain" whilst she was at Haslar. He goes on to say

    "It was reasonable for the doctors treating her at Gosport (Barton and Reid) to make an assumption that this was a resolving problem and nothing more needed to be done or investigations undertaken".

    "However, a medical assessment undertaken was still inadequate and there was no explanation in the notes to say it was noted that she had been in pain for several days and this should be treated symptomatically".

60. **This change of view lets Dr. Barton (an possibly Dr. Reid) off the hook slightly, although there is still criticism with regard to an inadequate assessment.**

61. In paragraph 4.5 he says that the lack of a medical assessment or the apparent failure to address the cause of Mrs. Spurgin's pain were "unlikely to have made any significant difference to her subsequent death". **(This is a slightly unusual choice of words and leads to some ambiguity. I think what the doctor is trying to say is that these were not contributory factors in Mrs. Spurgin's death but this needs to be checked.)**

62. In paragraph 4.5. Mr. Black also refers to the Death Certificate and the certified cause of death - "cerebrovascular accident". Dr. Black says he can find no evidence to support this diagnosis for cause of death. **(This is an important point. Can he go any further and say that this was not the cause of death and that the cause of death has been misrepresented?)**

63. His overall view is restated on page 4. He considers that there are a number of areas of poor clinical practice. Specifically he refers to a lack of medical assessment, or documentation of that assessment on admission to Gosport. Also the use of Oramorphine on a regular basis from the date of admission without considering other possible analgesic regimes. Also the recording of cerebrovascular accident as the cause of death with no evidence, or history, or any examination to support this conclusion. **[He does not mention the prescribing of Diamorphine - check his previous report to see if he covers this].**

64. **AT SOME STAGE, WE NEED TO CROSS CHECK ALL THE EVIDENCE IN EACH OF THE CASES AND MAKE A NOTE OF ALL THE WITNESSES PARTICULARLY, NURSES, INVOLVED IN EACH CASE. IT IS POSSIBLE THAT INDIVIDUAL NURSES HAVE MADE MORE THAN ONE STATEMENT IN THE POLICE INVESTIGATION. WE WILL ALSO NEED TO BRING TOGETHER ALL THE REPORTS PREPARED BY THE EXPERTS.**

Tab 2

<u>Witness Statement of David Sinclair</u>

65. The Witness was Mrs. Spurgin's GP.

66. On page 2, he refers to her as a "spritely, active and independent woman who was in good general health - a person we did not see often".

67. On page 3, he says he last saw her on 4 January 1999 **[i.e., about 4 months before she died, for some itching veins in her legs and heartburn/indigestion.]**

68. On page 3, the GP confirms that he did not see the patient while she was in hospital before she died.

<u>Witness statement of Malcolm Scott</u>

69. He is a Consultant Orthopaedic Surgeon.

70. The Witness describes the treatment which Mrs. Spurgin received at the Haslar Hospital after her fall in March 1999.

71. Page ______________ refers to the letter sent to the witness by Dr. Reid following Dr. Reid's examination of the patient on 24 March 1999. Dr. Reid's letter refers to the patient's hip being "very painful". Dr. Reid goes on to say that he would like to be "reassured that all is well from an orthopaedic point of view", i.e., before the patient is transferred to Gosport.

72. Pages 8 and 9 - the Witness refers to Mrs. Spurgin's discharge from the Haslar Hospital - "She can manage independently". "Her only medication is Analgesia (Paracetamol)".

73. Page 10 - He refers to a sizeable swelling after surgery. She received Morphine and Paracetamol with infrequent doses of Paracetamol - the Witness assumes that she would have been asked several times a day if she required pain relief. **[The inference is that she was not in a great deal of pain.]**

74. Page 10 - The Witness confirms that when considering her Analgesia, his team would have sought to establish the cause of pain. He refers to x-rays taken before and after the operation although the x-rays themselves are not available.

75. He refers to another x-ray dated 23 March 1999 which indicates that the x-ray was checked and it did not reveal anything untowards. He therefore assumes that the pain was caused by swelling.

76. Page 10 (at the foot of the page), the Witness refers to an assessment by Dr. Reid following the patient's recovery from surgery, when she was deemed fit to be transferred to Gosport Hospital on 26 March. **[Cross check the police interview of Dr. Reid to make sure this is dealt with.]**

<u>Witness statement of Jeanette Florio</u>

77. Witness worked as a Nurse at Gosport between 1996 and 2004. Between December 1998 and April 2004, she worked on Dryad Ward on day shifts.

78. On page 3 and sequence, she refers to notes she made relating to the care of Mrs. Spurgin.

79. Page 3 - Witness refers to an entry in the notes made by her on 26 March 1999 - "Enid is experiencing a lot of pain on movement". The desired outcome is noted to be "to eliminate pain if possible and keep Enid comfortable".

80. Page 4 refers to the patient receiving regular Oramorph "but still in pain". **[HAVE THE EXPERTS CONSIDERED THE FACT THAT THE PATIENT WAS STILL IN PAIN HAVING RECEIVED ORAMORPH? EVEN IF DR. BARTON COULD BE CRITICISED FOR STARTING THE PATIENT ON ORAMORPH, DOES THE FACT THAT THE PATIENT WAS STILL SUFFERING PAIN HAVING RECEIVED ORAMORPH JUSTIFY STARTING THE PATIENT ON DIAMORPHINE?]**

81. Page 6 and sequence deals with notes made by the Witness relating to Mrs. Spurgin.

82. On page 7, the first paragraph, the Witness says that the patient was in a lot of pain and that the decision to employ a syringe driver was taken to keep her comfortable.

83. Page 9 - the Witness expresses the view that Dr. Barton acted in accordance with the protocol and the Analgesic Ladder.

Witness Shirley Hallmann

84. The Witness worked as a Nurse on Dryad Ward from January 19989 to 2000. Deputised for Nurse Hamblin when the latter was not on duty. Refers to there being tension between herself and Nurse Hamblin. **[This Witness gave a further statement which can be found in File 2.]**

85. On page 2, the Witness says she was concerned at the premature use of syringe driver. Expressed her concerns to Nurse Hamblin and, on one occasion, to Dr. Barton. **[Witness gives details of conversation with Barton.]**

86. Page 5 - the Witness gives details of her involvement in the care of Mrs. Spurgin. In particular, the Witness confirms that she made a note on 12 April for the patient to be seen by Dr. Barton who had authorised the commencement of a syringe driver.

87. Pages 5 and 6 refers to the starting dose of Diamorphine. The Witness refers to page 131 of the note **[CROSS CHECK THE REFERENCE]** where a record is made of 80mgs of Diamorphine at 8:00a.m. The Witness also refers to there being a notation of "dose discarded". **[NO EXPLANATION IS GIVEN IN CONNECTION WITH THIS IN THIS STATEMENT.]**

88. On page 6, first paragraph, the Witness says that Dr. Barton "could (emphasis added) have authorised the starting dose which could (emphasis added) be used in a range 20 to 200mgs".

89. In the second paragraph on page 6, the Witness goes on to say that she cannot recall whether the dose was calculated by herself and Nurse Shaw or by Dr. Barton. She goes on to say that any calculation would have been based on the

amount of Morphine that the patient had been given in the preceding day. **[FURTHER EVIDENCE IS REQUIRED TO CLARIFY THE POSITION. IT IS NOT CLEAR WHETHER THE NURSES HAVE BEEN GIVEN DISCRETION TO DETERMINE DOSAGE OR WHETHER THEY REQUIRE INSTRUCTIONS ON DOSAGE FROM DR. BARTON. REFERENCE TO CALCULATIONS BASED ON THE AMOUNT OF MORPHINE GIVEN TO THE PATIENT IN THE PRECEDING DAYS DOES NOT FULLY EXPLAIN THE POSITION. HOW IS THE CALCULATION MADE AND, IN THIS PARTICULAR CASE, WHAT WOULD HAVE BEEN THE APPROPRIATE CALCULATION/CONVERSION?]**

90. At page 7, the penultimate paragraph, Witness says that she saw Nurse Shaw give the patient 60mgs of Diamorphine on 12 April **[AGAIN, WE NEED TO CLARIFY THIS BECAUSE THERE IS REFERENCE, IN OTHER STATEMENTS, TO A DOSE OF 80MGS - SEE PARAGRAPH 39 OF DR. BARTON'S STATEMENT. THIS IS AN IMPORTANT POINT BECAUSE AT LEAST ONE OF THE EXPERTS CRITICISES THE INITIAL DOSE OF DIAMORPHINE. I THINK ON THIS BASIS THAT THE INITIAL DOSE WAS 80mgs NOT 60mgs.]**

<u>Witness statement Shirley Hallmann</u>

91. **Note that another statement for this Witness is in the generic file - File 2 - see my notes at paragraphs 82-97.**

92. The statement in File 14 deals with the witnesses involvement in the care of Mrs. Spurgin.

93. Pages 1 and 2 refer to the administration of Diamorphine on 14 April at 9:00a.m. **[THIS APPEARS TO CLEAR UP THE EARLIER CONFUSION ABOUT THE DOSAGE ADMINISTERED AT THIS TIME. THE WITNESS REFERS TO THE PATIENT RECEIVING 60mgs FOLLOWED BY A SECOND DOSE OF 20mgs AT 9:00A.M., I.E. A TOTAL OF 80mgs.]**

94. In the last paragraph on page 2, the Witness again says that she cannot recall whether the dose rate was worked out by herself and Nurse Shaw or whether this was done by Dr. Barton. She says the calculation would have been based on the previous dose of Morphine. She then explains that the calculation is done by taking the daily dose of Morphine and dividing it by three to give the correct dose of Diamorphine.

95. Page 3, second paragraph - the Witness then says that she did not do the conversion herself because she notes that 80mgs is four times too much.

"I would not have worked it out to be so high a dose." She then goes on to say:

"I always argued with Dr. Barton over things like this, but I was always given short ____________(shrift ?) by her. I was basically ignored by her."

[THE EVIDENCE AS TO HOW A DOSE OF 80mgs WAS DETERMINED IS NOT CLEAR. THIS WITNESS, NURSE HALLMANN, REFERS TO THE POSSIBILITY OF A CALCULATION BEING MADE REFERENCE TO PREVIOUS DOSES OF MORPHINE, ALTHOUGH SHE SEEKS TO DISTANCE HERSELF FROM MAKING THE CALCULATION BECAUSE SHE CAN SEE THAT 80mgs, BASED ON THE PREVIOUS DOSAGE OF MORPHINE, IS FAR TOO HIGH. DR. BARTON, IN PARAGRAPH 39 OF HER STATEMENT, CLEARLY USING HER WORDS VERY CAREFULLY, STATES THAT SHE "ANTICIPATED" THAT THE DOSE OF DIAMORPHINE HAD BEEN DISCUSSED WITH HER. HOWEVER, THE FACT REMAINS THAT A DOSE OF 80mgs WAS, IN FACT, ADMINISTERED. DR. BARTON THINKS IT IS JUSTIFIED, BUT THE EXPERTS DISAGREE.]

<u>Witness statement of Lynne Barrett</u>

96. This is a supplemental statement for this Witness which seeks to clarify that Mrs. Spurgin was given a dose of 80mgs of Diamorphine on 12 April and the dose was halved on Dr. Reid's instructions at 16:40 on the same day.

<u>Witness statement of Kathryn Henning</u>

97. The Witness was as Student Nurse working on Dryad Ward in 1999.

98. Page 2 confirms that she made a note relating to Mrs. Spurgin on 6 April. The note simply confirms that the Nurse removed a dressing and found that the wound/infection was healing.

99. ***General observation on evidence obtained by the police from nursing staff - the evidence help would appear to helpfully cover all the entries in the relevant nursing records and prescription charts. However, the police have not probed in any detail to try and establish to what extent if any the staff were given a discretion to determine dosages or varied dosages within the range of dose authorised by Dr. Barton. We need to create a list of all witnesses involved in this case and any other cases and hopefully a large number of nurses' evidence will be relevant to most of the other cases. We can then identify the total number of nursing witnesses we need to interview to prepare the case.**

<u>Tab 9</u>

100. This is a transcript of an interview with Dr Reid which specifically deals with the case of Mrs. Spurgin. **Note that the interview took place in July 2006.** Dr. Black confirms in his August 2006 report that he has read and considered the transcript of Dr. Reid's interview.

101. Dr. Wilcock's three reports in respect of Mrs. Spurgin were all prepared before July 2006. It would therefore appear that he has not considered Dr. Reid's evidence and reviewed whether the evidence affects any of the advice given by him previously.

102. **Note also that File 7 contains transcripts of Dr. Reid's interviews with the police on 4 July 2006, i.e., when he was questioned generally about his work at the Gosport Hospital. Therefore, the police therefore structured their interviews with him in July 2006 to deal firstly with his general involvement in the Hospital, and following on from that, they interviewed him with regard to the case of Mrs. Spurgin. We need to check whether he was interviewed separately in respect of any other individual cases.**

103. Page 5 - Reid says that he does not remember Mrs. Spurgin. On the following page, he says what he says is based on the records that have been provided to him.

104. Page 6 re-confirms that he saw Mrs. Spurgin whilst she was at the Haslar Hospital and that he wrote a letter to the consultant there agreeing to take over her care, but expressing some concern about the pain she was having in her hip. He had asked the Consultant to check that all was well with her hip before she was transferred. Reid does not know whether the check was carried out, but notes that Mrs. Spurgin was transferred to Gosport.

105. Page 7- Reid says that she was transferred on 26 March and that he saw her on 7 April and 12 April, before she died on 13 April **(no reference to Reid seeing Mrs. Spurgin at Haslar after her operation on 23 March as mentioned in the final paragraph of Dr. Scott's statement in File 14 Tab 3).**

106. Page 7/8 - he refers to his first examination of Mrs. Spurgin after her transfer - says she was in a lot of pain. He appears to have increased her dose of Morphine tablets to 20mgs twice daily. He also refers to a request for an x-ray of her hip as movement in the hip was noted to be quite painful.

107. On page 8, he also refers to his examination on 12 April when he reduced the dose of Diamorphine to 40mgs. At the same time, he authorised an increase in dose up to 60mgs if necessary. His notes at the time also state that when he did this he was able to move the patient's hip without pain, but the patient was not "rousable".

108. His view on 12 April was that the patient had been over sedated, hence his decision to reduce the dose.

109. On page 10, Reid refers to notes prepared by Dr. Barton when the patient was admitted on 26 March.

110. Page 14 - Reid is asked whether Barton carried out a suitable assessment of Mrs. Spurgin's care on her admission. Reid says that although it is a brief assessment "all the salient features" are covered. Reid commented at the reference in Barton's assessment to "sorting out an analgesia" implies that the patient was in pain when she was transferred.

111. Page 18 - Reid says that he has never had anything other than positive feedback about Barton's role and the support she offered to the nurses. **KEY POINT.**

112. Pages 19/20 - it is pointed out to Reid that there is a gap of about a week from the first note that Barton did for this patient and the next note. Reid says that he would not expect the patient to be seen every day. Rather he would expect Barton to go to the Ward every day and ask the nursing staff if there were any problems and for them to direct Barton to any patient they were particularly concerned about.

113. Page 23 - Reid says he would not expect Barton to write up notes routinely. However, he would expect significant changes in the patient's condition to be recorded.

114. Page 24 - He is asked "Who is responsible for prescribing drugs?" He responds that initially responsibility rests with the prescriber, but he accepts that he carries ultimate responsibility. (**KEY POINT**)

115. Page 26 - Reid confirms that patients requiring continuous care (i.e. Dryad patients) are people who are "very dependent, usually on nursing care".

116. Page 26/27 - Question with regard to the possibility of rehabilitating Mrs. Spurgin at the age of 92 following a hip operation. Barton explains that whilst the possibility of rehabilitation would have been considered, the chances of rehabilitating this client were "remote" **[Would the experts agree with this assessment, bearing in mind the patient's recent history before she fractured her hip?]**

117. Page 28 - Reid accepts that this patient was admitted "to attempt (emphasis added) rehabilitation" **[is there any evidence of an attempt at rehabilitation being made in this case?]**.

118. Page 33 - Reid is asked why this patient went to Dryad Ward rather than Daedalus given that the former was a rehabilitation ward and the later was for continuing care. Reid explained that at the time there was some empty beds on Dryad Ward which they were having difficulty in filling. Therefore, if they didn't have continuing care patients, they would take the "next most suitable patient". In other words, he is saying that Dryad Ward was used as a sort of back-up to Daedalus because there was a waiting list for rehabilitation on Daedalus ward whereas there were empty beds on Dryad Ward.

119. Page 36 - When challenged again about the adequacy of Barton's initial assessment, Reid points out that her assessment included a brief resume of the history, that she addressed functional status of the patient, but what she has not referred to is having undertaken any examination - heart, pulse, blood pressure etc., to make sure that the patient was stable when she was transferred. To that extent, Reid acknowledges that the assessment was lacking.

120. Page 38 - Reid says that he would expect a patient coming into hospital to have a basic examination, but is unable to say whether or not Dr. Barton carried out such an examination in this case. He acknowledges that he is unable to confirm the position because there is no record in the notes of an examination having taken place. (***This is an important point because elsewhere it is clear that as Dr. Reid and Dr. Lord, the other Consultant, carried out their ward rounds at the same time each week, Dr. Barton was only able to accompany one or other of them. In other words, on occasions Dr. Barton would not have accompanied Dr. Reid and presumably Dr. Reid would have had to rely on Dr. Barton's notes in such circumstances**).

121. Page 39 - Reid cannot recall whether Dr. Barton was with him when he saw Mrs. Spurgin on 7 April. He came to the conclusion that if she had not been there he would have asked the nursing staff about the patient, because the nurses make observations when the patients are admitted. They record pulse and blood pressure, etc., and would know if any of these indicators had been awry.

122. Page 40/41 - it is put to Reid that immediately prior to her transfer, Mrs. Spurgin was recorded as being mobile from bed to chair with two nurses and that whilst she is continent during the day, she is sometimes incontinent at night. In contrast, when Barton assesses her, she notes that the patient is not continent and not ___________**[word cut off]** transferring. In response on page 41, Reid makes the point that Barton's assessment would be based on what she found at the time of the transfer.

123. Page 41/42 - Reid makes the point that the ambulance ride to transfer the patient may not have been comfortable and it is entirely possible that the patient could have been weight bearing when she was in Haslar and no longer weight bearing on arrival at Dryad because of the ambulance journey. On page 42, Reid also points out that in his own notes of his examination of the patient at Haslar, he recorded that the lady was in a lot of pain. He also makes the point that there was a tendency to "over egg the pudding" in terms of what people's capabilities were in an effort to get the patient accepted in a different ward.

124. On page 43, he continues this theme and explains that often he was told, for example, that patients were independent but when they were transferred the reality was completely different.

TAB 10

125. Page 2 - Reid is questioned further with regard to Barton's initial assessment of the patient and the adequacy of the examination which took place. It is put to him that Dr Barton should have recorded the patient's pulse. Dr Reid's response is not clear. He seems to be saying that in some cases nursing staff would take the patient's pulse, blood pressure, temperature etc. In circumstances where an examination was carried out by him, he may do a shorthand note if there was not enough time to do a full note. For example, he may write "CDS" (Cardio Vascular System) and then put a tick next to it to show that he had listened to the patient's heart. **It is not entirely clear what Reid is saying here.** He appears to be saying he would undertake some form of check to verify details obtained by the nursing staff and then record that he had done so, but he wouldn't necessarily carry out all the tests - pulse, blood pressure and temperature himself.

126. Page 4 - Reid refers to the letter which he sent to Commander Scott just before the patient was transferred, to emphasis that he (Reid) had considerable doubt as to whether the patient would "get back on her feet".

127. Page 5 - Reid claims that Dr Barton was probably more experienced than him in dealing with palliative care issues and patients who were dying. **REVEALING POINT OR IS IT AN ATTEMPT BY REID TO TRY AND DEFLECT CRITICISM OF HIS ROLE AS SUPERVISING CONSULTANT?**

128. Page 6 - Reid refers again to the fact that in making an assessment of the patient on admission, Dr Barton may have relied upon information obtained from the nurses - the nurses may have told her that the patient had been admitted on a stretcher and was therefore not weight bearing.

129. Page 7 - Reid is asked about his other duties - he confirmed that he was responsible for a ward at the Queen Alexandra Hospital. He also confirms that he supervised a Senior Registrar and a House Officer.

130. Page 10 - Reid is questioned further about the adequacy of Dr Barton's assessment of the patient on the date of transfer. He says he would not expect the same standard of clerking for someone who had been transferred from another hospital as opposed to someone who had been admitted "from the community". However, he concedes that in her notes Dr Barton should have recorded something - either that an examination had been conducted or that the patient was medically stable. (with regard to the latter, he means noting an assessment made with reference to details of pulse, blood pressure, etc provided by the nursing staff).

131. Page 11 - Reid is asked whether there should have been a plan to establish the cause of the patient's pain. In response, he says that it is not uncommon for a patient to have a lot of pain following hip surgery.

132. On Page 12 he says that the pain appeared to be coming from the hip, hence the importance of obtaining an X-ray - either to see whether the hip had become dislocated or to see whether there was an infection.

133. Page 13 - he is asked why Dr Barton didn't obtain an X-ray straight away. Reid says that when Dr Barton saw the patient she may not have been in as much pain and he says that it is possible that the pain got worse in the 12 days following her admission. He concedes that if there had been increasing pain in this period, an entry to record this should have been made in the note.

134. Page 14 - Reid confirms that the clerking and note taking in this case was not adequate.

135. Page 16 - Reid is asked again about the Doctor's responsibility to record temperature, blood pressure and pulse in the notes as part of the initial assessment. He confirms that he would expect these tests to be carried out but he would not necessarily expect the Doctor to do the test - "there is little point in repeating it if it has been done by the nursing staff".

136. Pages 16 and 17 - It is put to Dr Reid that in the period 26 March to 7 April there is no record in the patient's notes of her temperature, blood pressure and pulse, i.e. no reference in the medical or nursing notes. On page 17, Reid acknowledges that "that is unacceptable". **(The police make no mention in their questions of there being any pain assessment in the same period. We need to check the records).**

137. Page 18 - Reid confirms that he first saw this patient on 7 April (approximately 12 days after the patient's admission).

138. Page 19 - Reid confirms that when he saw the patient on 7 April she was clearly in pain and he was concerned to establish the cause.

139. Page 21 - Reid is asked whether Barton ever explained to him why she was prescribing regular morphine for this patient from the date of her admission. Reid cannot recollect whether he discussed the matter with Dr Barton. He does not recall whether Dr Barton was present when he did his ward round on 7 April.

140. Page 22 - It is put to Reid that the patient was prescribed only paracetamol whilst at the Haslar Hospital. It is also put to Reid that Barton started prescribing morphine on the day of the transfer. Reid confirms that he would expect to see a note to justify this in the patient's records.

141. Page 23 - Reid concedes that prescribing Morphine, where previously a patient had been prescribed paracetamol, is "quite a jump on the analgesic ladder".

142. Page 24 - Reid acknowledges that he would have expected the patient's notes to include some history relating to her pain, the current analgesia being prescribed and the patient's response to the analgesia.

143. Pages 25-27 - Reid confirms that from the note it can be established that Barton's care plan for the patient was concerned principally with pain relief. Reid has asked questions with regard to the possible causes of the pain. He says that the pain could be from the hip itself, as a result of the surgery. For example, she may have been suffering "referred" pain from her back or pain from an infection in the wound. He believes that the most likely cause, given that the patient had just undertaken a hip operation, is that the pain was from the hip.

144. Page 28 - It is put to Reid that if pain had resulted from an infected wound, then antibiotics would have been more appropriate. Reid says that he may well have prescribed both antibiotics and morphine.

145. Pages 28/29 - Reid says that there are two types of infection which result from a hip operation - one is fairly obvious and evidence of the infection appears on the surface of the skin. The other is deep in the hip joint itself which is very difficult to diagnose. Even with the benefit of an X-Ray it may not be possible to detect an infection of the joint in its early stages.

146. Page 32 - Reid acknowledges that an increase in pain following a hip operation clearly shows that something is wrong.

147. Pages 32/33 - Reid is asked what sort of experience Barton would have had of patients who had just undergone surgery for a fractured femur. Reid is not sure but he thinks Barton would have had some experience.

148. Page 33 - Reid is asked what sort of care plan he would have expected to have been in place for this patient. Reid says that any abnormal features on medical examination should have been noted, together with a plan to address these. He said that the care plan would include the history, details of an examination, the medical management plan and the longer term plan, i.e. rehabilitation or continuing care.

149. Page 34 - Reid says that when he saw the patient at Haslar, he was not optimistic about her chances of getting back on her feet.

150. Pages 34/35 - Reid says it is unlikely that he would have discussed the patient with Dr Barton before she was admitted.

151. Page 35 - He is asked what notes would have been made available on the date of the patient's admission. Reid said he couldn't say whether a full set of Haslar notes would have accompanied the patient or whether there would just have been a transfer letter. He says that getting notes and records for patients who had been transferred was a major problem. Reid is not able to say whether in this particular case Dr Barton would have received a full set of notes or whether no notes were sent across. **Presumably if no notes had been sent there would have been a greater need for a more detailed examination and for this examination to be written up.**

152. Page 37 - Reid is asked why Dr Barton did not continue to prescribe Paracetamol when the patient was admitted and says "when someone is pain you have to make a judgment about what is the appropriate level of analgesia to administer".

153. Pages 37/38 - Reference is made to a nursing note on 26 March which records the patient "experiencing a lot of pain on movement". Attention is drawn to a record on the same date showing that oramorph is prescribed on an "as required basis". Reid is referred to four further (separate) prescriptions for oramorph. It is put to Reid that there are no entries in the note to explain why oramorph was being prescribed. Reid confirmed that this was not acceptable and that reasons for starting oramorph should have been stated in the records.

154. Page 41 - Reid is asked if he picked this up at the time but he has no recollection of it or of taking the matter up with Dr Barton.

155. Page 42 - Reid confirms that if the patient was admitted without any notes from Haslar, a thorough investigation should have been carried out. A record of the examination should also have been made.

156. Page 43 - Reid says that there were occasions when Dr Barton made a record that no notes had come across with the patient. As such a record has not been made in this particular case, Reid assumes that the notes were sent with the patient. Reid acknowledges that Dr Barton does not appear to have done anything to investigate the cause of the patient's pain from the date of the patient's admission on 26 March until the date that Dr Reid examined the patient on 7 April. Reid makes the point that it is not unreasonable to wait for a period to assess the effects of the analgesia, where a patient is suffering pain after a hip operation. At some point, if the pain persists, further investigation is required - but, for example, it would not have been reasonable to expect Dr Barton to order an X-Ray on the date of admission.

TAB 11

157. Page 2 - Reid tables a list of his responsibilities as Medical Director of the Portsmouth PCT in 1999 - referred to as Exhibit GJQ/HF40.

158. Page 3 - With reference to questions asked previously about the level of support that Dr Barton received, Reid says that he had been reminded that the Consultancy Department ran a training programme for clinical assistants and that Dr Barton was a regular attendee.

159. Page 4 - The Police make reference to a GMC Booklet "withholding and withdrawing life prolonging treatments - Exhibit JTQ/HF15 **KEY DOCUMENT (Make sure that this particular exhibit was in print in 1999)**.

160. Pages 7/8 - Reid confirmed that Dr Barton's notes were inadequate and on page 8 Reid also says that he would have expected any change in the patient's condition to have been recorded in their notes and this was not done.

161. Page 10 - Reid says that as stated previously, whilst Barton didn't write a note every time she saw a patient, any important decision was recorded. However, Reid acknowledges that important decisions were not recorded in this particular case.

162. Pages 10/11 - Reid is referred to Exhibit CSY/HF6 (**Check in the exhibit bundle**), which appears to be a copy of some guidance relating to the analgesic ladder. Reid appears to be saying that he personally developed this guidance in response to the complaint made in 1999 on behalf of Gladys Richards.

163. Page 13 - Reid does not recollect hearing the phrase "analgesic ladder" until he developed the guidance on pain management in 2000/2001. However, he acknowledges that the analgesic ladder guidelines reflected good practice before the guidance was introduced.

164. Page 17 - Referring to the patient's notes from Haslar, it is put to Dr Reid that whilst the patient did receive a number of doses of morphine they then went on to Paracetamol. The morphine was prescribed in relation to the pain following the operation.

165. Page 18 - Reid says that it is possible, if a patient is in a lot of pain, to jump to the top of the analgesic ladder (a possibility that a patient's transfer to Dryad had been a painful experience is noted by the interviewing officer).

166. Page 19 - Reid acknowledges that the difficulty in assessing whether morphine was prescribed in this particular case contains a lack of documented evidence. Reid refers to the reference in the nursing notes which state that the patient was in considerable pain when she was admitted.

167. Page 20 - Reid partially accepts that when he first saw the patient on 12 April he should have queried the prescription of oramorph, although he seems to indicate that there was probably no alternative.

168. Page 22 - The interviewing officer makes reference to Dr Barton's claims that she visited the ward three times a day. The office calculates that in Mrs Spurgeon's case that relates to 54 possible occasions when Dr Barton visited the ward from the date the patient was admitted to the date that she died. Taking into account weekends, and the possibility of other doctors covering for Dr Barton in this period, the Officers still calculate that there would have been about 30 occasions when she would have been able to review the patient.

169. Page 23 - The interviewing officer puts it to Reid that in Mrs Spurgeon's case, Dr Barton made only one note in the patient's records. The officer notes a number of changes in prescribing were made in this period, but no explanation is recorded in the patient's medical notes. Dr Reid acknowledges this and confirms that he did not speak to Dr Barton about it.

170. Page 25 - Reid confirms that he first saw the patient 12 days after her admission and made a note in the patient's records. He has no recollection of "alarm bells ringing" that there were not more entries in the patient's records.

171. Page 26 - It is put to Reid that it is part of his duty to review a patient's medical notes and that he had overall responsibility for the patient.

172. Page 27 - It is put to Reid that given the lack of details in Barton's notes for the patient, he had no way of knowing what had happened to the patient in the period before he saw her.

173. Page 28 - Reid says that he would have been aware from the notes that Dr Barton had been concerned about the patient's pain but he says he could also have looked at the drug chart and discussed the patient with the nursing staff.

174. Page 33 - Reference is made to Dr Reid's request for an X-Ray when he saw the patient.

175. Page 34 - Reid says that he cannot say from the notes whether an investigation into the cause of the pain should have been initiated before he saw the patient (on 7 April).

176. Page 37 - Reid says it may have been appropriate to have more closely investigated the cause of the pain before he saw the patient on 7 April but he cannot state this with any certainty.

177. Page 38 - Reid cannot recollect whether he was consulted regarding the patient's care and treatment.

178. Pages 38/39 - Reid is asked what he feels about the level of care and treatment received by this patient. He says it is difficult to tell from the note, however, he says he is appalled by the absence of any record regarding pulse, temperature,

blood pressure and no explanation concerning the commencement of diamorphine or increasing the does of diamorphine.

179. Page 39 - Reid refers to his entry in the patient's notes on 12 April - where he reduced the dosage of diamorphine to 40mg and authorised an increase of 60mgs if the pain reoccurred. (Dr Barton had prescribed a diamorphine infusion through a syringe driver earlier the same day.

180. Page 40 - Refers to Dr Barton's initial does of 60mgs and Dr Reid's decision to reduce the dose to 40mgs.

181. Page 40 - Reid says that if Dr Barton had been around when he reduced the dosage, he would have spoken to her about it because the dose which she prescribed was "far too much".

182. Page 41 - The line of questioning then reverts to the request made by Dr Reid for an X-Ray. He is not able to say what happened with regard to the X-Ray.

183. Page 42 - He says he would have expected the patient to have been X-Rayed the same day, not the following day.

184. Page 43 - Reid is referred to an entry in the nursing notes which indicates that the patient was due to have the X-Ray on the day following his ward round (ward round 7 April, X-Ray 8 April ?).

185. Page 44 - It is pointed out to Reid that his entry for the ward round on 12 April makes no reference to the X-Ray.

186. Page 45 - He says he may not have thought about the X-Ray on 12 April because by then the patient was "probably pretty close to death".

TAB 12

187. Page 2 - The interviewing officer confirms that it has not been possible to establish whether the patient was in fact X-Rayed, even though Dr Reid asked for her to be X-Rayed on 7 April and an appointment was made for the X-Ray the following day. There is no record in the patient's notes to explain why an X-Ray may not have been taken.

188. Page 4 - Dr Reid confirms that if an X-Ray had been taken on 8 April as expected, Dr Barton should have reviewed the result of the X-Ray.

189. Pages 7/8 - Reid cannot say whether the patient was X-Rayed at the Haslar Hospital following her operation, although he thinks that would have been the usual procedure following an operation to make sure everything was OK.

190. Page 8 - The interviewing officer refers to an X-Ray taken at the Haslar Hospital on 21 March. Reid says that if had known that the patient was X-Rayed on that day he probably would still have asked for a further X-Ray on 7 April. **(Query why Dr Barton/Reid did not make enquiries at the time to see whether an X-Ray had been taken after the operation - check with experts as to whether such an enquiry should have been made).**

191. Page 16 - Reid explains the difference between morphine and MST. MST is also a form of morphine but it lasts for up to 12 hours, whereas oramorph is only effective for 3-4 hours.

192. Page 17 - Reid is asked again about the practice of "pro-active prescribing". Reid says this is prescribing a drug which is not required at the time.

193. Pages 18/19 - Reid is asked again about the protocol which he prepared (in response to the Gladys Richard complaint?) and he confirms on page 19 that the protocol was issued at the end of 1999. He refers to an accompanying letter which was sent out by him with the protocol, which presumably helps to identify the date that it was implemented. (**KEY DOCUMENT**).

194. Pages 20/23 - Deal with the section in Dr Reid's protocol dealing with prescribing diamorphine in variable dosages. On page 23 Reid says that he had a conversation with Dr Barton to query why she was prescribing a high range of variable dosages. He said that she told him she wasn't always immediately available and sometimes her partners were difficult about attending the patients in a timely way. This was her way of ensuring the patients got adequate analgesia when they required it and did not have to wait several hours for her to attend.

195. Page 24 - Reid is asked who made the decision on the actual dose and where within the range of dosages the starting dose would be determined. Reid says this was down to the nursing staff. The officer queries whether there is anything to stop the nursing staff from starting at the top end of the range. Reid says that you have to trust the nursing staff and with controlled drugs, two nurses have to agree on the dose as an extra safeguard. **KEY POINT**

196. Page 29 - Reid goes on to say that he would expect a nurse to start with the smallest doses in the range.

197. Page 30 - The investigating officer asks a valid question - "why doesn't the prescribing doctor simply prescribe the smallest dose on an as required basis?" (rather than specifying a range). A transcript of the interview regards Dr Reid as being silent when asked the question.

198. Pages 33/35 - It is pointed out to Dr Reid that Dr Barton prescribed a range of 20-200mgs and that the first that was administered was 80mgs. In response

Reid says "I cannot imagine why that was done". ****Cross refer to Dr Barton's statement - file 12 Tab 4 - in paragraph 39 Dr Barton indicates that she was consulted about the starting dose of 80mgs on the basis that the doses of oramorph given to the patient previously had not been sufficient to alleviate the patient's pain and distress.**

199. Pages 35/36 - Reid confirms that he reduced the dose of diamorphine because the dose prescribed by Dr Barton was "too much".

200. Pages 36/37 - Reid confirms that he reduced the dose because the patient was drowsy and unrousable.

201. Page 37 - Reid regards the decision to start the patient at 80mgs, having prescribed a range of 20-200mgs, as completely inexplicable.

202. Page 38 - Reid is asked about the practice of prescribing by telephone. He says that a doctor may give verbal instructions to a nurse and at the first opportunity the doctor will write up the dose when they come onto the ward. (**It is difficult to understand why proactive prescribing was necessary if doctors were able to prescribe over the telephone. It is possible that there may be circumstances where a doctor cannot be contacted and to that extent one could understand why proactive prescribing may be appropriate. However, the point made by the investigating officer seems valid - if a doctor is going to prescribe proactively, why not prescribe a specific dose at the lower end of the range, giving a nurse the opportunity to refer to the doctor in due course to seek authorisation to increase the dose.**

203. Page 41 - Reid is asked whether, with regard to Mrs Spurgeon, it was likely that she was going to require a dose as high as 200mgs as a result of a deterioration overnight? It is put to Dr Reid whether the prescription could have been written within a lower range. Reid acknowledges that this could have been done.

204. Page 49 - Dr Reid acknowledges that the patient's blood pressure may influence the dose of morphine - one might be more cautious about the dose if the patient's blood pressure was low. (**Have the experts looked at this aspect. Do the observation charts completed by nurses record the blood pressure for this patient? Is there any suggestion that the dosages were too high when compared with records in the observation charts?**).

TAB 13

205. Page 8 - With reference to the proactive within a large range of dosages, the interviewing officer makes the point that Dr Barton's job description required her to provide 24 hour medical cover. He therefore makes the point that the

explanation given by Dr Barton to Dr Reid for the large dosage range - so that patients did not suffer if she was not immediately available - lacks credibility.

206. Pages 11/12 - Reid explains the PRN system, i.e. where medication is administered as required. This is in circumstances when the patient's regular medication does not seem to be relieving the symptom - when the pain is "breaking through" and a top-up/faster relief from pain is required. **This is important because I hadn't appreciated that the medication is being prescribed to be used in addition to, rather than in place of, other pain relief. It follows that it may not be necessary to continue using the stronger analgesic if pain relief is achieved. It assumes that the patient is monitored and only receives "top up" medication as and when is necessary. This applies to the oral medication, not to syringe drivers. Syringe drivers ensure continuous supply of medication over a 24 hour period.**

207. Page 14 - Reid believes that in Mrs Spurgeon's case it was appropriate to use a syringe driver - he refers to the nursing records which indicate that she was becoming increasingly distressed and uncomfortable and in Dr Reid's view this would justify the use of a syringe driver.

208. Page 15 - Dr Reid does not know whether Dr Barton or one of the nursing staff informed the patient's family (sought consent?) before the syringe driver was used. There is no reference to consent in the nursing records. Reid acknowledges that a note should have been made in the records. **I don't think Barton's witness statement deals with the issue of consent. This needs to be checked.**

209. Pages 16/17 - refer to the patient taking oral medication up to 11 April. There is a note in her records for 11 April which indicates she was drowsy and irritable on that day. Reid says that if the drowsiness and irritability continue on 12 April, the use of a syringe driver from that date was appropriate.

210. Page 19 - The interviewing officer notes that the nursing records show that the patient had been taking oral medication up until 11.00pm on 11 April. Reid confirms that it would have been good practice to record in the note the reason why the patient was no longer able to take oral medication (if that was the case).

211. Page 21 - The interviewing officer also refers to indications in the nursing notes that the patient was eating up until 10 April.

212. Page 22 - Reid notes that the nursing notes for this patient are also poor.

213. Pages 23/24 - Reid acknowledges that there is no record to show why oramorph specifically was prescribed (instead of a weaker analgesic).

214. Pages 24/25 - deal with the first prescription for oramorph on 26 March (the date of admission?). It appears that there were two prescriptions recorded - the first is for 5mgs four times a time (20mgs) and the second prescription which is on an as required or PRN basis is for 10mgs four times a day (40mgs). This gives a total of 60mgs for the 24 hour period.

215. On page 26 there is reference to an increase in dosage on the following day, 27 March. The daily does increased to 10mgs four times a day and the PRN dose remained the same.

216. Pages 26/27 show that oramorph was stopped on 28 March because it was causing the patient to vomit.

217. Page 27 - the prescription records show that having withdrawn oramorph, codydromol was prescribed, i.e. a less strong and analgesic.

218. Pages 27/32 - The interviewing officer queries why Dr Barton decided to use a weaker analgesic when the patient had a reaction to the oramorph and started vomiting. The investigating officer asks whether oramorph could have been continued in conjunction with other medication to prevent the vomiting, i.e. by using metaclopromide. The notes indicate that this drug was introduced after oramorph had been withdrawn.

219. Page 32 - Reid says that the decision to stop oramorph altogether would depend on the amount of sickness. If the patient was vomiting a lot, Reid would have stopped oramorph. If, on the other hand the patient was just feeling a bit sick, then he might have continued oramorph in conjunction with metaclopromide. **(Check to see whether the experts have actually looked at the prescribing history in the same sort of detail and commented on variations in the prescription regime)**

TAB 14

220. Pages 5/8 - the questions relate to clarification of the medication administered to the patient on 11 April **(Interview notes in Tab 13 - the questions related to medication prescribed on 26 and 27 March. Query why interviewing officers did not cover period from 27 March to 11 April**).

221. Pages 6/7 - Reid confirms that with reference to the notes, that on 11 April the patient was taking MST tablets - this is another type of morphine, not oramorph. It seems that the dose was 20mgs twice a day - a total of 40mgs. (**Apart from seeking clarification on dosage, Reid is not asked any further questions in connection with the usage of MST. Therefore there seems to be a gap in the questioning as to the prescription regime and the appropriateness of drugs prescribed / administered from 27 March to 11 April. Check**

with the police to make sure they were not missing a section of the transcript).

222. Pages 8/9 - The questioning turns to the use of Midazolam. On page 9, Reid confirms that this is frequently used in connection with terminally ill patients who are very distressed. It is not intended to relieve physical symptoms of pain as it is a sedative. Reid refers to the medical notes which indicate that the patient was agitated. Reid regards this as an indication that the use of Midazolam was appropriate.

223. Page 10 - Reid points out that when he saw the patient on 11 April he prescribed a tranquilizer, indicating that the patient was anxious and distressed. The tranquilizer in question is Flupenthixol. Reid confirms that there is no entry in the prescription chart in relation to this. Reid cannot explain why the prescription has not been written up.

224. Page 12 - Reid explains that Midazolam and Flupenthixol are both types of sedatives used to treat the same symptoms but Midazolam is used in terminal care whilst Flupenthixol is used in every day practice, i.e. if the patient is not terminally ill you would prescribe Flupenthixol before you would prescribe Midazolam.

225. Page 14 - Reid acknowledges that there is nothing in the medical records to support the use of Midazolam, save to the extent that the nursing record describes her being irritable at times.

226. Page 14 - Reid says that if a nursing record is correct, when it refers to the patient being drowsy, a syringe driver may have been appropriate. On the next page and subsequent pages, he confirms that Flupenthixol is not capable of being used in a syringe (which will presumably justify the use of Midazolam in the syringe driver), assuming that it was necessary to sedate the patient.

227. Pages 17/18 - Reid is asked about the patient's condition on 7 April. He would not describe her as being terminally ill at that stage, but he did have reservations about whether she would ever get out of hospital.

228. Page 18 - He says that he would have formed the view that she was terminally ill when he saw her on 12 April.

229. Page 21 - Reid is asked why he considered the patient to be terminally ill when he examined her on 12 April. He says that when someone is alternately drowsy and irritable, as described in the nursing notes, it is often a sign that their death is very close.

230. Page 23 - Reid acknowledges that Dr Barton did not record in the notes the reason for administering Midazolam.

231. Page 25 - Refers to ENF guidance on dosages for Midazolam used as a subcutaneous infusion. The range stated is 20-100mgs in 24 hours. The prescription in this case was 20-80mgs.

232. Page 26 - Reid is asked how the nurses would know where to start within that range. He said that he would always expect nurses to start at the lowest dose.

233. Page 27 - Dealing with the practice of prescribing within a range of dosages, it is pointed out to Reid that when he reduced the dose of diamorphine on 12 April he also authorised increasing the dose. However, in contrast to Dr Barton's practice of prescribing a range of doses, Dr Reid authorised an increase in dose up to 60mgs. In doing so, he also made a record of it in the notes.

234. Page 35 - Reid indicated he had reservations about Dr Barton's practice of prescribing variable doses. He discussed his concerns with Dr Barton. He cannot recall whether the discussion took place when this patient was being treated or whether it was before this patient was treated. He recalls a discussion concerning a variable dose of something like 20-80mgs and not 20-200mgs. He describes the latter as being "way beyond anything I had ever seen before". Although he cannot recall the exact date of the conversation he believes it took place sometime between the Spring of 1999 and the Spring of 2000.

235. Page 37 - Reid acknowledges that in giving instructions to the nursing staff to reduce the dose, he should also have crossed out Barton's prescription of 20-200mgs and re-written it.

Dictation - Continues at Tab 16 - have printed from there

- Reid says that he should have crossed out the prescription because it large - "it allowed too much discretion to the nursing staff".

- Reid says that if a patient was in a lot of pain and a nurse felt that a nt increase was required, he would expect the nurse to contact a doctor authorisation.

TAB 16

238. Page 3 - Reid agrees that decisions by nurses to increase doses as required, is based on their experience. He was also asked how he would expect a nurse to increase dosages within the range 20-200mgs of diamorphine in a 24 hour period. Reid says that if the pain was under control he would not expect there to be any increase in dose. If the patient was still in pain he would expect an incremental increase in dose equal to 50% of the previous day's dose. For example, a dose of 20mgs a day could be increased to 30mgs per day.

239. On page 5 Reid confirms that there is no guidance or instructions to the nurses, given in the patient's notes, with regard to the appropriate dose.

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239. On page 5 Reid confirms that there is no guidance or instructions to the nurses, given in the patient's notes, with regard to the appropriate dose.

240. Pages 6/7 - The line of questioning is not clear but it seems that it is being put to Reid that when he altered the dose to 40mgs, giving the nurses discretion to go to 60mgs, he did not also countermand Barton's prescription, giving the nurses a discretion to increase the dose by as much as 200mgs. On page 7, Reid seems to acknowledge that there was nothing to prevent the nurses from increasing the dose to 20mgs.

241. Page 11 - Reid acknowledges that he should have crossed out Barton's authorisation to increase the dose up to 200mgs. He says he may not have thought to do this because he felt that the patient was going to die within the next 24 hours and therefore it was unlikely that the patient would need a dose in excess of 60mgs.

242. Page 12 - Reid acknowledges that there is no indication in the medical records as to why the patient was started on diamorphine or the reason for switching from MST to diamorphine.

243. Pages 13/14 - The questions relate to the appropriate conversion dosages when substituting MST (oral morphine) with diamorphine. It appears that the patient had been taking 45mgs of MST. Reid says that if this was not controlling her pain, the starting dose of 25mgs of diamorphine would have been appropriate (Barton prescribed 80mgs and Reid reduced that to 40mgs).

244. Page 15 - It is put to Reid that even 40mgs is on the high side. Reid disagrees. He refers to the indications in the nursing records that if the patient was still distressed, as she claims, that a starting dose of between 25mgs and 45mgs would be appropriate.

245. Page 19 - Reid explains that in prescribing 40mgs, he wanted to make sure that the patient was not over-sedated but at the same time he was trying to ensure that she did not suffer. He claims that she had been suffering pain for three weeks and that the pain had not been successfully controlled in that period.

246. Pages 20/21 - Reid is asked about the apparent increase in dose of Midazalam. Reid confirms that he did not instruct an increase in dose. He agrees that a dose of 20mgs of Midazalam for a 92 year old patient is likely to have a high sedative effect. On page 21 he says he cannot recall whether he reviewed the dose for Midazalam or not.

247. Page 21 - It becomes clear that the dose of Midazalam was increased from 20mgs to 40mgs. Reid says there is nothing in the record to explain the reason for this. He can only assume that the patient was very distressed, although there is nothing to indicate that this was the case.

248. Page 22 - It is not clear whether the increase in dose of Midazalam was the result of a decision by Dr Barton or one of the nurses.

249. Page 23 - Reid is asked about the indicators for increasing Midazalam. He says that it would have been a non-verbal assessment at this stage, e.g. if the patient was irritable and thrashing around. He agrees that no such indications were given in the notes.

250. Reid does not recollect Dr Barton ever contacting him for advice on prescribing.

251. Page 24 - He is asked whether he is confident that Dr Barton's prescribing did not lead to a worsening of the patient's condition. He is not confident that that was the case and refers to his concern that a dose of 80mgs may have caused over-sedation.

252. Page 25 - Reid acknowledges that there was no recording of an ongoing assessment of the patient's response to the pain killers which were administered.

253. Pages 31/33 deals with discussion as to the type of patient being referred to the Dryad Ward - the fact that Dryad Ward was intended to take patients requiring continuing care but that in practice, due to pressure to move people to the ward, patients were taken with acute problems. Reid acknowledges that patients in this category required palliative care. He also acknowledges that this requires specialist knowledge/training. He said that he had never had any training in palliative care. He is not sure whether Dr Barton had any such training apart, possibly, from the odd training day. Reid says there is no formal qualification in palliative care.

254. Page 33 - Reid confirms that he does not consider himself to be an expert in palliative care. On page 33 he specifically asked whether that fact would have had any impact on the treatment of this particular patient.

255. Page 34 - Reid acknowledges that his lack of specialist knowledge could have had an impact.

256. Pages 34/35 - Reid is asked about the cause of death in this case. He says it is very difficult to say in the case of a very elderly and fragile patient who did not successfully recover from her operation, and where there are no other clear cut causes which are diagnosable, i.e. heart attack or chest infection.

TAB 16 (Continued)

NB. In Tab 16 there are 2 sets of transcripts - the first runs to 39 pages, the second transcript starts at Page 1 and ends at page 40. The note below refers to the pagination in the second transcript.

257. Pages 3/4 - Reid reiterates that the starting dose of 80mgs was "completely inexplicable". Reid cannot recall whether he spoke to Dr Barton about this or

even whether she was there at the time that he did his ward round and reduced the dose.

258. Page 4 - The line of questioning turns to the issue of a death certificate. On page 5 Reid says that he very seldom got involved in the issue of death certificates. This is because he did weekly ward rounds and he only therefore had infrequent contact with the patients.

259. Page 8 - Reid confirms that in the case of this patient, Dr Barton recorded the cause of death as being a cerebral vascular accident, i.e. a stroke.

260. Page 9 - Reid refers to an entry on the nursing care plan for 10 April which records the patient as appearing to be "leaning to the left".

261. Page 11 - Other references to the nursing record the patient as having a very poor night on 10/11 April or the night of 9/10 April.

262. Page 12 - Reid says that reference to the patient leaning to the left and having difficulty in swallowing could indicate that she had suffered a stroke.

263. Page 13 - Reid refers to other indications of a stroke having taken place, e.g. weakness in an arm or leg or speech problems. He acknowledges that there is no mention in the notes of these types of symptoms.

264. Page 14 - Reid says that if the patient had suffered a large stroke, sufficient to result in her death, that would have been evident.

265. Page 15 - Reid says that a stroke requires a clinical diagnosis (physical examination). He acknowledges that there is no reference in the medical note of such an examination/assessment having taken place.

266. Pages 16/17 - The question raised the possibility that the patient may have been leaning to the left because of the fact that her right hip was painful as a result of her operation.

267. Page 18 - Reid is asked whether there was any evidence of the patient having suffered a stroke when he last examined her. He says there is no written evidence to suggest that she had suffered a stroke.

268. Page 19 - Reid seems surprised when it is pointed out to him that the rules require a consultant or senior clinician to complete the cause of death details. He would regard Dr Barton as being a senior clinician for the purposes of the requirements.

269. Pages 21/22 - Reid acknowledges that where a patient dies within one year of having an operation, the death should be referred to the coroner. The coroner may then ask for a post-mortem. It is not clear from the line of questioning

whether or not Dr Barton actually referred this patient's death to the coroner. The line of questioning indicates that there was no reference to the coroner.

270. Page 26 - Reid claims that he would not have expected to supervise the death certification process.

271. Pages 26/27 - Reid is asked about his supervisory role and whether he felt that a weekly ward round was sufficient in terms of supervision. He said that he always felt he could do with some more time.

272. On Page 28 he says that he had concerns about his personal workload in the Spring of 1999 because he was working very long hours.

273. Page 29 - He is asked whether he had any concerns about Dr Barton's workload. He said that he realised that she was very busy but only in retrospect had he realised that she was probably under much more pressure than she realised at the time.

274. Pages 29/30 - He expresses a view that due to the high turnover of patients, and the type of patient that was being admitted to the ward, they needed a doctor working at the hospital from 9-5. He says he came to realise this before the end of the first year that he worked there (1999?)

275. Pages 34/35 - There was suggestions by the Interviewing Officer that Dr Barton was not able to discharge all her responsibilities as a clinical assistant, given her responsibilities as a GP. The Interviewing Officer is aware of other GP's taking on clinical assistant roles but adjusting their GP commitments accordingly. The suggestion is that Dr Barton did not do this. She took on more than she could handle. Although not stated, there is a possible inference that there was a financial motivation for this.

276. Page 37 - Reid refers to a conversation with Barton "at the end of that year" (1999?). At the time of the conversation, Reid had come to the conclusion that there was too much work for a GP to cover and he felt that that was a situation which was likely to continue. He asked her to reflect on her position and shortly after that she tendered her resignation.

277. Page 38 - Reid cannot recall whether the circumstances giving rise to the conversation referred to above, were evident at the time that Mrs Spurgin was a patient. He cannot be sure whether he was aware of the same pressures and issues at the time that she was a patient.

278. Page 39 - Reid is asked again about the apparent lack of the observations about patients in the patient's records. Reid refers to the case of Mr Packman (in respect of whom he may also have been questioned) and Reid had noted in Mr Packman's notes that observations were not recorded. He therefore reminded

himself that in 1999 Dryad was a continuing care ward. He refers to a possibility that nursing staff did not undertake routine observations because it was a continuing care ward and patients were expected to be there for the rest of their lives. There may have been a culture of not doing observations because of the nature of care required to the patient, i.e. that observations were not conducted on a routine basis.

TAB 17

279. Pages 3/4 - Reid acknowledges that the patient's symptoms were in keeping with Septicaemia and Toxaemia - potentially reversible conditions.

280. Page 4/5 - Reid confirms that the patient was prescribed antibiotics on only one occasion - 7 April.

281. Page 6 - Reid says that it would not have been appropriate to reduce the dose of analgesics where the patient's pain was increasing throughout the duration of her stay. He accepts, however, that it would be appropriate to investigate whether other factors were present, for example, an infection.

282. Page 6 - He is asked why no referrals were made or advice sought from the Orthopaedic Team (the fact that Dr Reid requested an X-Ray on 7 April is noted). Reid refers also to the fact that before the patient was admitted to Dryad Ward he sought reassurance from the Orthopaedic Team concerning the patient's hip and pain she was having.

283. Page 7 - Reid presumes that the Orthopaedic Team checked things out (**there is no indication that this was done and no indication that Dr Barton or Dr Reid chased the Orthopaedic Team for a response)**. It is inferred from Dr Reid's reply that he may have assumed that the hip operation had not been successful and that she was unlikely to recover.

284. Page 8 - Reid asks himself the question why the patient was experiencing so much pain and why nothing more was done (to investigate the pain) in the 12 day period following her admission. He concedes in retrospect that it is possible that more could have been done but claims it is difficult to be specific in the absence of any detailed medical records.

285. Page 8 - The Interviewing Officer refers to the morbidity rate in elderly patients following the surgery which was carried out on this patient. He refers to a morbidity rate of 75%, although it is not absolutely clear from the way the question is framed as to whether this is the actual morbidity rate. In any event, Reid concedes that even if there is a high morbidity rate those responsible for the patient's care have a duty to look after the patient properly.

286. Page 10 - Reid clarifies the position with regard to his request for an X-Ray. The purpose of this was to see if there was any evidence of infection which was causing the pain, alternatively whether the screw which had been implanted had gone through the head of the femur into the pelvis. Reid says he would have referred the patient to the Orthopaedic Team after the X-Ray results had been obtained if it indicated that there was a problem for the Orthopaedic Surgeon to address.

287. Pages 10/11 - With reference to a prescription chart, Reid notes that Dr Barton started the patient on antibiotics on the morning of 7 April. Dr Reid visited the patient during the afternoon on the same day.

288. Page 11 - Reid is asked whether applying the principles of the analgesic ladder it would follow that a patient receiving Paracetamol would stop taking that, in the event that a stronger analgesic was required. Dr Reid says this depends upon the circumstances - depending on the amount of pain (i.e. he seems to be saying that in certain circumstances it would be appropriate for the patient to take Paracetamol and a stronger analgesic at the same time). On page 11 Reid is asked why Dr Barton prescribed morphine on a regular basis after the patient's admission instead of prescribing Paracetamol.

289. Page 12 - Reid assumes that morphine was used and then increased in bode due to the severity of the pain and the fact that the original dose of morphine was not controlling the pain.

290. Page 13 - In response to questions about sickness being caused by morphine, Reid says that the larger the initial dose, the more likely it is that patients will suffer side affects.

291. Page 14 - Reid is questioned in connection with Barton's decision to withdraw morphine due to vomiting and then replace with Codydramol and then after that she put the patient back onto MST.

292. On Page 14 Reid explains that if Codydramol was not controlling the pain it would be reasonable to go back to morphine. He says that Codydramol is an opiate like substance. Therefore, if the patient had taken this for 2-3 days she might have been able to tolerate morphine.

293. Page 15 - There is reference to the patient's initial prescription of morphine. MST 10mgs twice a day from 31 March. Reid refers to this as being a "tiny" dose of MST - a starting dose.

294. Pages 15/16 - Reid explains that MST is absorbed more slowly into the system and is less likely to cause vomiting. Oramorph on the other hand is quickly absorbed and is more likely to cause vomiting.

295. Page 18 - The Interviewing Officer again makes the point that stronger doses of analgesic are prescribed in the period following the operation - presumably in response to increased pain he makes the point that one would normally expect the pain to decrease following a successful operation. He puts it to Dr Reid that if pain was increasing one would expect there to be a review of the patient's condition to establish the cause of the pain.

296. Page 19 - Reid is asked why Barton prescribed antibiotics. Reid presumes that this was to deal with the wound infection, although he notes that there are no entries in the records to indicate this was the case. (Reid, on pages 18/19, refers to the possibility of a superficial wound infection which is obvious on a visual examination, and the alternative possibility of a deep infection. Such an infection may sometimes be detected on an X-Ray but not in all cases).

297. Page 19 - Reid appears to be having some difficulty in recalling why he asked for an X-Ray. He is not able to say categorically whether he did this because he suspected a wound infection.

298. Pages 19/20 - The Interviewing Officer queries why Dr Barton would have prescribed analgesics in stronger doses if she felt that the wound was infected, i.e. he is asking why it was necessary to use analgesic when antibiotics would have cleared up the infection and therefore the pain. Reid says that it would have taken several days to clear up the infection.

299. Page 20 - Reid is asked about his entry in the notes on 7 April which records a shortening of the patient's right leg by two inches. Reid says this could be an indication of the screw which has been inserted, pushing into the head of the femur which can be very soft. Alternatively, it could indicate dislocation of the hip. In the case of the latter, there is usually a sudden and obvious change when the dislocation takes place. In the case of Mrs Spurgin, Reid thinks that the most likely reason for the shortening of the right leg was due to the femur collapsing, following the operation i.e. the first of the two scenarios referred to. He also believes that was the reason why he asked for an X-Ray.

300. Page 21 - He is asked whether he considered the possibility that the pain was being caused by a large haematoma. Reid cannot recall there being a haematoma and notes that he made no records of a haematoma. He acknowledges that haematomas around wounds are likely to get infected.

301. Page 21 - Reference is made to a micro-biological report of 9 April which evidences some infection. (**However, confusingly, the swab which resulted in the microbiological report seems to have been taken from the patient's calf not her hip. Therefore Dr Barton does not appear to have investigated the possibility of an infection to the wound resulting from the surgery. We need input from the experts in connection with this**).

302. Pages 23/24 refers to references in the notes to the fact that the patient was not drinking and that her urine was very concentrated. Reid says this could be due to a sign of dehydration, infection or the fact that the patient simply had concentrated looking urine. However, he acknowledges that there is nothing in the notes to indicate that any investigation was carried out to investigate this, e.g. nothing to indicate whether a sample of urine was sent to the laboratory.

303. Page 24 - Reference is made to the enhanced effect of a dose of morphine in a patient who is dehydrated. On page 25 it is put to Reid that due to dehydration the patient was effectively being overdosed with morphine. Reid says that as the records indicate that the patient was still in pain, and was still lucid, she had not received an overdose.

304. Pages 25/26 - It is put to Reid that the patient was on antibiotics for five days and there is no note in the records to indicate the affect, if any, of the antibiotics. Reid says that he would have expected a note to record the affect of the antibiotics unless it was considered that she was so ill that she was entering a palliative or terminal phase, in which case the wound infection would have been a secondary consideration.

305. Page 27 - Reid is asked about the decision to discontinue antibiotics on 12 April. He believes the fact that by then the patient was in a terminal phase of her illness as being the reason.

306. Page 30 - It is put to Reid that the patient's nephew spoke to him on 12 April and that Reid told him that there was nothing wrong with his aunt and that she was on too high a dose of diamorphine. Reid has no recollection of this. He has also no recollection of saying to the nephew that his aunt would be "alright". Further, he cannot imagine ever having said that in view of what is recorded in the notes.

307. Pages 31/32 - Reid is referred to witness statements given to the police on a previous occasion, i.e. statements given to Eric Greenall and Chris Lee (**DO WE HAVE COPIES OF THESE STATEMENTS?**).

308. Page 32 - Reference is made to Reid being distressed during his previous interviews with the police, when discussing the prescribing of diamorphine.

309. Page 32 - Reid is reminded of a comment made to Officer Greenall when he described Dr Barton and Sister Hamblin as a "formidable pair". Reid recalls making the comment. He is asked to explain what he meant by it. He says that when he spoke to Dr Barton about prescribing a wide dosage range, Sister Hamblin was present. The impression he got, speaking to them both, was that he was the "new kid on the block" but he was on their "patch" and he should not interfere.

310. On page 32/33 he refers to more complaints being made by relatives of patients by the end of the first year that he worked there. He said that one of the complaints was made by the family of Mrs Devine (he does not mention any other names). In one case, Reid recalls a patient being admitted to Dryad from a care home. Prior to the admission, the patient had been receiving large doses of MST. Dr Barton and Nurse Hamblin had decided to prescribe Fentinyl instead. The patient complained of being in a lot of distress and her son was upset by the condition. Reid had to go and speak to the patient's son. **(This particular example is interesting because it appears to relate to a decision by Dr Barton to reduce a morphine dose).**

311. Page 33 - Reid goes on to say that he felt that if the relatives had been handled in a different way there would not have been any complaints. He says his issue with Dr Barton was not about prescribing as such but the attitudes which Dr Barton and Sister Hamblin presented to some relatives. He felt that once they had made a decision relating to a patient, they were not prepared to take a different course of action. There was no room for negotiation and in Dr Reid's view, that upset a lot of relatives. He stresses that Dr Barton and Nurse Hamblin were very caring in their own ways, although he says that Dr Barton had a very "brusque manner".

312. Page 34 - Reid elaborates by saying that he felt that Dr Barton and Nurse Hamblin were doing their best to look after patients in difficult circumstances but their attitudes were "a bit old fashioned".

313. Page 34 - The Interviewing Officer refers Reid to an incident described by a nurse where the nurse claims she saw Dr Barton prescribe 60mgs of diamorphine as an initial dose but that Dr Reid saw the patient and stopped the diamorphine. Reid has no recollection of this.

314. Page 35 - Reid is reminded of another incident referred to by Officer Grennall at an earlier police interview, concerning a patient who had received diamorphine for heart failure. However, Reid confirms that he has no recollection of this.

SUMMARY

According to Dr Barton, this patient suffered increasing pain following her hip operation. The extent to which enquiries were made to try and determine the cause of pain is unclear. Dr Reid asked for some X-Rays. It is not clear whether X-Rays were actually carried out. Dr Barton prescribed antibiotics with reference to an infection but it is not clear what type of infection was being treated. Neither Dr Barton nor Dr Reid seem to have a specific recollection of this particular patient. They are relying on medical and nursing records. They both acknowledge that the records are deficient. Dr Barton will say that her analgesic regime for this patient was appropriate but the experts will have to

look very closely at what was prescribed in the period after admission and whether on each occasion the prescriptions were appropriate. Dr Reid confirms the prescription of 80mgs of diamorphine and there will almost certainly be a strong case against Dr Barton that this particular dose was excessive to the patient's needs. The other issue highlighted in this particular case is the practice adopted by Dr Barton of "proactive prescribing", i.e. prescribing a wide range of doses. This seems very unsatisfactory and the explanation given by Dr Barton is unconvincing.

NOTES RELATING TO GLADYS RICHARDS

Statement of Mrs Lack

1. Mrs Lack is Mrs Richards' daughter. The Daughter was a Registered General Nurse for over 40 years and retired in 1996. For 25 years prior to her retirement she was involved in the care of elderly patients.

2. She gave her first statement to the Police on 31 January 2000, approximately 17 months after her mother's death.

3. Page 1 describes her mother's health at the start of 1998 as being generally well physically, but suffering from dementia. However, she was able to stand, walk and go to the toilet. Mrs Lack used to take her mother out for trips in the car.

4. Her mother was admitted to the Haslar Hospital on 29 July 1998, having suffered a fall on the same day. She was diagnosed as having broken the neck of her femur.

5. On page 2, her daughter criticises the level of care which her mother received whilst she was at the nursing home at which she suffered the fall.

6. On page 4 the witness confirms that on admission to the Haslar Hospital an X-Ray confirmed that Mrs Richards had broken her femur. Her injury was also consistent with her mother having been walked after the fall, i.e. the inference being that the fact that she had broken her femur had not been picked up until some time after the fall.

7. Pages 4/5 confirms that her mother underwent a hip replacement at the Haslar Hospital on 29 July. She remained at the Haslar Hospital for 11 days until 11 August. She says that her mother appeared to make a good recovery in this period. [**Check to see whether any statements have been taken from medical staff at Haslar as to Mrs Richards' condition at this time**].

8. Page 5 - Witness says prior to her mother's discharge and transfer to the Gosport Hospital she was responding to physiotherapy. She could walk a short distance with the aid of a zimmer frame. She recognised family members and was able to talk sensibly to relatives. She was also eating and drinking naturally. Significantly, she was no longer in need of pain relief and witness says that she was "pain free".

9. Mrs Richards was admitted to Gosport Hospital on 11 August 1999. Whilst she was at Gosport the witness made detailed notes which are exhibited to her witness statement. [**Key document - obtain copy of the notes and any other exhibits referred to**].

10. Page 6 - The witness visited her mother on the day after her admission to Gosport, i.e. on 12 August. She was surprised to discover that she could not rouse her mother. Witness was told by staff that mother had been given Oramorph "for pain". Witness was surprised by this because when her mother had been discharged from the Haslar Hospital she had not required pain relief for several days. [**We need to check whether there is any evidence of problems during the transfer to Gosport and whether any nursing staff have provided statements to say that the patient was in pain on her arrival at Gosport**].

11. Page 6 - Witness says that on 12 August the staff told her that her mother had been calling out and had been showing signs of anxiety. On page 7 witness says that she believes that the staff had misconstrued her mother's behaviour - due to her dementia. She was prone to becoming very anxious, particularly when she wanted to use the toilet. Therefore witness believes that her mother's reported behaviour could have been wrongly attributed to the presence of pain as opposed to anxiety. [**Witness does not say whether she queried the position with Dr Barton - further evidence required?**].

12. Page 7 - Witness refers to a further visit to her mother on 13 August. Witness noted her mother to be uncomfortable and in pain. She was "weeping" and "calling out". Her mother was sitting in a chair [**not clear whether mother was receiving Oramorph at this stage, it seems unusual that the previous day mother had been unrouseable but on 13 August she was sitting in a chair**].

13. Witness says that she expressed her concern to staff. Witness was told that there was nothing wrong with her mother and that her behaviour was the result of her dementia. Witness says that she was not satisfied with the explanation and was convinced that her mother was in pain. [**There is an apparent contradiction in the witnesses' evidence - she says that when her mother was admitted the staff may have misinterpreted the mother's calling out as a result of being in pain when in fact she was anxious. She now seems to be saying that the reverse was the case, i.e. that her mother was in fact in pain**].

14. Page 8 - a possible explanation for the contradiction is the fact that the witness was then told by a member of staff that her mother had fallen from her chair - the pain that she was suffering therefore appears to be related to the fall.

15. Page 9 - on 14 August, Mrs Richards was taken for an X-Ray. The X-Ray caused her mother a great deal of pain. The X-Ray revealed that her mother's right hip had been dislocated.

16. On 14 August Mrs Richard was sent back to the Haslar Hospital. She underwent a further operation to put the hip back into its socket.

17. On page 10 the witness says that following the operation no analgesic was required. Her mother began to eat and drink and she became more easily manageable. She appeared to be recovering well.

18. On 17 August it was recommended that she be sent back to the Gosport Hospital [**check to see whether statements have been taken from medical staff at Haslar Hospital for details of the position at this stage**]

19. On 17 August, Mrs Richards was taken back to Gosport Hospital. Witness visited her at 12.15pm. On page 11 she says that at the time of the visit staff were having problems feeding her mother and she was "screaming all the time".

20. On page 11 the witness says that her mother stopped screaming when she was repositioned - she had been lying awkwardly and her hips were uneven. Witness was so appalled about her treatment that she decided to go back to the Haslar Hospital to find out what condition her mother had been in when she had been discharged earlier that morning. Witness indicates that there had been no problems prior to her discharge. She says that she spoke to a consultant at Haslar who was happy to take her mother back (**further evidence required to identify the consultant to whom witness spoke**].

21. Page 12 - witness then went back to Gosport where she noted that her mother was still in pain. [**There is an inference that the level of pain was not solely related to the patient's awkward position. There is a further inference that there was obviously some underlying cause which was not immediately apparent**]. Witness asked for her mother to be re-X-rayed, it being acknowledged that something must have happened to her between the discharge from Haslar and the arrival at Gosport. [**Check whether the police obtained statements on the second transfer to see whether there were any problems during the transfer/or signs of pain during the transfer**].

22. Page 12 - Witness refers to a conversation with Dr Barton. Dr Barton did not think there was any further dislocation but authorised a further X-Ray. Witness says that she could hear her mother "wailing" when the X-Ray was taken.

23. Page 13 - The results of the X-Ray showed no dislocation but witness was told that something had happened. [**Witness does not say who told her this. Check whether X-Rays are available and whether they have been seen by the experts**].

24. Page 13 - Witness says that she told Dr Barton that the Haslar Hospital would accept her mother back but Dr Barton felt that this was inappropriate as the mother would not survive further surgery. [**Check expert evidence to see**

whether experts consider that Barton should have sought Specialist Advice or advice from the Consultant at this stage].

25. Page 13 - Witness refers to a conversation with the Ward Manager, Mr Beed, on 18 August. Beed told the witness that her mother had developed a "massive haematoma" in the vicinity of the operation site which was causing her severe pain. The Manager therefore suggested the use of a syringe driver to ensure that Mrs Richard was kept pain free at all times.

26. Pages 13/14 - Given the witnesses experience as a nurse, she knew that this effectively meant that no further steps would be taken to facilitate her recovery and this would result in her mother's death. Witness said she was very upset and said she just wanted her mother to be pain free.

27. Page 14 - In retrospect witness believes that she knew that her mother was not terminally ill and that she should have challenged Dr Beed on the decision to use the syringe driver. She regrets not having insisted that her mother be referred back to the Haslar Hospital where witness believes her mother would have a further chance of recovery.

28. Page 14 - Witness confirms that her mother died on 21 August.

29. The remaining pages of the witnesses statement refer to various documents [**we need to request copies of all the exhibits from the police to make sense of the witnesses' comments. Note, however, on page 15 to a report prepared by the Consulant Dr Lord, witness claims that Dr Lord had no involvement with Mrs Richards.**

30. On page 18 witness strongly disputes Dr Barton's contention that Mrs Richards had a rattly chest or any other symptoms of broncho-pneumonia.

31. On page 19 witness refers to some notes which indicate that the way that her mother was transferred on 17 August may not have been appropriate.

Second statement of Mrs Lack [Note that the statement is made in her maiden name, Richards]

Date of statement - 11 August 2004 [Not clear why this statement was taken so late in the police investigation].

32. Witness disputes that there was any evidence of her mother having suffered a haematoma. Witness and her daughter (also a nurse) laid out Mrs Richards when she died. As they changed her they had a clear view of her body. There was no sign of any haematoma or any pressure sores.

33. Referring to the cause of death as recorded in the death certificate - broncho pneumonia, witness says that her mother showed no symptoms of suffering from

broncho-pneumonia in the final days of her life. "My mother's breathing was soft and gentle and quiet throughout the last days of her life". [**Check to see whether experts have considered this evidence in reaching their conclusions**].

34. The following key points arise from this evidence :

- the witness is highly critical of the general standard of care which her mother received at the Gosport, including the standard of nursing care.
- the evidence raises questions as to why Mrs Richards received Oramorph on the first transfer to Gosport as she had not received any analgesics in the days before her transfer.
- should Dr Barton have sought specialist advice or discussed the patient with a consultant following the second X-ray and should Dr Barton have sent the patient back to the Haslar Hospital on the second occasion to investigate the cause of the pain when the X-ray showed that there had been no further dislocation?

Statement of Gillian MacKenzie

35. The witness is also a daughter of Mrs Richards. Her first statement is dated 6 March 2000.

36. Page 1 - fourth paragraph says that her sister was not concerned in any way with the management of the nursing home [**contrary to what Mrs Lack says in her statement. Not particularly relevant to the case against Dr Barton but the difference between their statements sees odd**].

37. Witness was with Mrs Richards whilst she was at the Haslar Hospital. She praises the standard of care which her mother received at that hospital and understood that there was a possibility that she may not have survived the hip replacement operation but was delighted with the progress which she showed in her recovery after the operation.

38. Page 3 records that following her mother's operation her mother looked far better than she had done for several months. She was eating well.

39. Pages 34 - witness refers to her mother's transfer to Gosport and the fact that she was told that her mother had suffered a fall whilst she was there. Refers to her mother's transfer back to Haslar for treatment and her subsequent move back to Gosport.

40. Page 4 - witness attended at Gosport Hospital on the day that her mother returned there [**this would have been on 17 August. This witness does not therefore appear to be in a position to give any direct evidence of**

the mother's condition from the date of her first admission to Gosport up until 17 August on the date of her second admission].

41. Page 4 - witness refers to her mother being in pain [**on 17 August**] but the care assistant attributed this to her mother's dementia.

42. Page 5 - witness refers to her mother lying in a very awkward position and witness expresses a view that she had been placed awkwardly on her transfer to the hospital. Witness says it was obvious to her and her sister that her mother was still in great pain. They suspected that something had happened, presumably during the transfer to cause this. They made enquiries but no explanation was forthcoming.

43. Page 5 - The Ward Manager Mr Beed, acknowledged that Mrs Richards was in pain and that something should be done. He helped to arrange for an X-Ray. The witness refers to an examination of her mother by Dr Barton [**presumably on 17 August? Check the medical notes**]. Witness says that Dr Barton agreed that her mother should be X-Rayed.

44. Page 6 - Witness says that following the X-Ray Mr Beed reassured her that her mother had not dislocated her hip again but that she "may have suffered some bruising". The witness says that Mr Beed then suggested that Mrs Richards should receive an injection of Diamorphine. A few moments later, the witness and her sister had a discussion with Dr Barton. The witness says that her sister told Dr Barton that the Haslar staff were happy to take Mrs Richards back. The witness says that Barton felt that Mrs Richards had experienced enough trauma for one day but she agreed to review the position the following day.

45. Page 6 - The witness says the following morning they met with Mr Beed who told them that nothing could be done for Mrs Richards. He told them that she had developed a haematoma on the site of her hip operation and the only possible means of treating her was to put her on a syringe driver with Diamorphine so that she would have a pain free death. The witness says that Beed gave her the impression that her mother's death was imminent. [**Later the witness criticises Beed for this because her mother survived for another five days without any food. Witness says that because of this her mother must have been relatively strong and in retrospect she should have gone back to the Haslar Hospital for treatment**].

46. Page 7 - Witness acknowledges that she was aware of the implications of her mother being put on a syringe driver. She also says that they both agreed to this. Dr Barton made a brief appearance to check that the use of the syringe driver had been explained to them. Mrs McKenzie and her sister acknowledged that this had been done [**By Mr Beed, not by Dr Barton herself**]. It appears that some of the notes indicate that Dr Barton explained the implications herself,

giving rise to a suspicion on the part of the witness that Dr Barton has not been entirely honest in dealing with this aspect of her mother's case.

47. Page 7 - Witness indicates that Dr Barton did not see her mother in the two or three days prior to her mother's death. [**This is important because if true it is not clear how Dr Barton could have certified the cause of death**].

48. Page 8 - The witness makes two points which we need to check that the experts have considered : First, the point referred to earlier in these notes - observation that her mother must have had considerable reserves of strength to survive 5 days without any food or water. The second point confirms the existence or otherwise of the haematoma. Both Mrs McKenzie and her sister are clear in their evidence that there were no signs of a haematoma when they laid out Mrs Richards after she had died. Mrs McKenzie thinks that the haematoma, if it existed, would have shown up on the X-Ray that was taken before her mother's death. [**Check whether the police have the X-Ray records**].

49. Page 13 - The witness refers to conversations with two health care support workers. Witness thinks their names were Jean and Linda. She says that Linda told her that when her mother was transferred from the Haslar to the Gosport Hospital on 17 August she seemed to be in pain. [**Check to see whether the police took statements from them**].

50. Page 14 - Witness says that Linda also mentioned that her mother had been transferred on a trolley instead of a stretcher.

51. Page 14 - Witness refers to a letter [**copy required**] in response to her complaint. The letter includes a reference from the Ambulance Crew who apparently commented that Mrs Richards showed signs of being in pain when she was put into the ambulance. [**Check whether there are statements from the ambulance men**].

52. Page 14 - In the same letter there are references to assertions made by Dr Barton with which the witness disputes, i.e. witness denies that she was told that the surgeon intervention necessary to deal with the haematoma would have required a general anaesthetic. [**We need to check the letter very carefully to see whether or not the witness has simply misconstrued what has been said on behalf of Dr Barton. Alternatively, does the letter contain evidence which points towards dishonesty on Dr Barton's part?**].

53. Page 16 - Witness refers to an entry in the notes made by Dr Barton who is happy for the nursing staff to confirm death. This note was made on the patient's admission. The witness asks why Dr Barton had assumed that Mrs Richards was going to die. [**Check to see whether the experts have commented on this**].

54. Page 20 - The witness says that there was no indication that her mother had a chest infection up until the time of her death. The witness also refers to a conversation with Dr Barton on 18 August - several days before Mrs Richards dies - when Dr Barton said "the next thing will be a chest infection". The witness makes the point that Dr Barton did not therefore consider that Mrs Richards had a chest infection on that particular day. [**Elsewhere the witness says that Dr Barton did not see her mother two or three days prior to her death. Check the medical notes/nursing notes to see whether there was any indication of a chest infection in the period leading up to her death.**]

Further Witness Statement of Mrs McKenzie

55. Mrs McKenzie also made a statement to the police on 27 April 1999. This statement makes a number of complaints about the police's investigation of her mother's death. On pages 4/5 it appears that Mrs McKenzie also reported to the police a separate matter - she alleged that her sister Mrs Lack had destroyed part of her mother's will. [**This needs to be clarified. Is it the case that Mrs McKenzie and Mrs Lack fell out over their mother's will?**].

Transcript of Mrs McKenzie's interview with the Police

56. Mrs McKenzie was interviewed by the Police on 17 November 1999 with a view to obtaining information for a witness statement. [**Reading through the transcript it is clear that Mrs McKenzie's witness statement of 6 March 2000 was prepared with reference to a police interview**].

Transcript of Police Interviews with Dr Barton (File 56) - Tab 1

57. Dr Barton was interviewed by the Police in the presence of her solicitor, Mr Barker of Hempsons, on 25 July 2000, i.e. before the Police had obtained any expert evidence. The interview was in connection with the Police's investigation into the complaint made by Mrs Richards' daughters Mrs McKenzie and Mrs Lack.

58. On page 2 of the transcript, there is reference to Dr Barton having prepared a statement and the transcript records that she read out the statement during the interview. [**One assumes this is the statement which appears at Tab 2 in File 56. Therefore Dr Barton's statement has been prepared approximately two years after Mrs Richards' death**].

59. The transcript records that on the advice of a solicitor Dr Barton elected to make no comment in connection with any questions asked by the Police in connection with their investigation. The reason stated by the solicitor is that Dr Barton felt very upset by the allegations and would not be able to do herself justice by making any other comments. Dr Barton is then asked a number of questions and in accordance with the advice of her solicitor decides not to make any comments.

60. Tab 2 is a copy of Dr Barton's statement which runs to approximately ten and a half pages.

61. Paragraph 2 - Dr Barton says that she qualified as a doctor in 1972. She confirms that she is a partner in private practice. She says that in 1998 she took up the post of clinical assistant in elderly medicine on a part time sessional basis. She says that she retired from the position "this year" i.e. sometime in 2000.

62. Paragraph 3 - Dr Barton says she is responsible for 1500 patients. As a GP she conducts half of the on-call responsibilities in the practice - on-call one night each fortnight and one weekend every quarter. She conducts morning surgeries every day and evening surgeries on a "pro-rata" basis.

63. Paragraph 4 gives details of her work at GWMH. Each week she carried out five sessions, attended the hospital every weekday morning at an early hour to review patients and conducted two formal ward rounds each week with the consultant geriatrician. She says that in 1998 there was only one supervising consultant - Dr Lord who covered both wards, i.e. Daedalus and Dryad.

64. Paragraph 5 - The consultant did two ward rounds each week - one for patients seeking continuing care and the other in respect of patients who had suffered a stroke.

65. Paragraph 6 - She says that the work involved seeing a large number of elderly patients approaching the end of their lives and requiring continuing care.

66. Paragraph 6 - She claims that one of the strengths of her unit was that patients could be offered "freedom" from pain discomfort and says that a complicating factor for the patients concerned transfer from one unit to another - this caused a marked deterioration in their condition which was frequently irreversible.

67. In Paragraph 9 Dr Barton refers to assessments and consultations carried out by Dr Reid and Dr Bank.

68. Paragraph 10 refers to Dr Reid's view that the patient, despite her dementia, should be transferred to GWMH (to try to remobilise).

69. Paragraph 11 - She says that the patient's admission to GWMH was a "holding manoeuvre" to see whether the patient would recover and mobilise after surgery. In the case of recovery she could be transferred to a nursing home. **"If, as was more likely, she should deteriorate due to her age, her dementia, her frail condition and the shock of the fall, followed by the major surgery, then she was to be nursed in a calm environment away from the stresses of an acute ward".** This gives an insight into Barton's view

of the patient, in particular her opinion that it was more likely that she would not go back to a nursing home.

70. Paragraph 12 - Barton refers to the notes that she made on the patient's admission on 11 August. These include reference to the patient being "not obviously in pain" and "I am happy for nursing staff to confirm death".

71. Paragraph 13 - Barton expresses a view that the patient was "probably near to death in terms of weeks and months from her dementia before the hip fracture supervened". [**The experts have not specifically commented on this, as it seeks to explain the reference in the patient's notes to confirmation of death by nursing staff**].

72. Paragraph 15 - Barton confirmed that as recorded in her notes, the patient did not appear to be in pain when she was assessed on arrival. Barton says that pain relief and sedation then became a problem. She refers to the patient screaming, acknowledges that this can be a symptom of dementia but expresses the view that in fact it was caused by pain because the screaming was not controlled by Haloperidol alone. She claims that dementia is frequently controlled by this sedative. [****Comment required from experts]**.

73. Paragraph 15 refers to the prescription written up on 11 August, including Oramorph and Diamorphine. She claims this was done "given my assessment that she was in pain". [**There is a lack of consistency in what she says here because the prescription was written up on the date of the patient's admission and in paragraph 12 Barton confirms that on the date of admission the patient was not obviously in pain.**]

74. Paragraph 15 - she says it was not necessary to give Diamorphine in the first few days following admission. She says that a number of small doses of Oramorph were given which in Dr Barton's view amounted to an appropriate level of pain relief, following the patient's operation.

75. Paragraph 16 refers to the discovery by nursing staff that the patient had slipped out of her chair on 13 August and injured herself. Barton was not on duty. The duty Doctor, Doctor Brigg advised analgesia through the night and an X-Ray the following morning. Barton reviewed the patient the following morning. The plan was that if the X-Ray confirmed that the patient had dislocated her hip, she was to be returned to the Haslar Hospital. The X-Ray did confirm this and Mrs Richards was sent back to Haslar.

76. Paragraph 17 - Barton refers to the notes which she made when she reviewed the patient on 14 August, before making a decision to send her back to the Haslar Hospital. The entries which she made in the patient's medical notes refer to the patient's screaming not being controlled by Haloperidol.

77. Paragraph 19 - Barton refers to the procedure carried out at Haslar Hospital to deal with the dislocated hip. Barton points out that the patient remained unconscious and unresponsive for 24 hours after the procedure. She said that normally a healthy patient would wake up within minutes at the end of an intravenous anaesthetic. Barton refers to this as a "worrying response to the anaesthetic". [**Experts to comment upon**].

78. Paragraphs 21 and 22 - Barton deals with the patient's re-admission to GWMH on 17 August. She says that patient "appeared peaceful and not in severe pain". Notwithstanding this, Barton decided to issue instructions to give the patient Oramorph but only if in severe pain. Barton says that at the time she made up the prescription she was unaware that the patient had received morphine at the Haslar Hospital shortly before the transfer.

79. Paragraph 22 - She says that in her experience the transfer of an elderly frail patient in these circumstances frequently causes a set back in their condition with a marked deterioration. "It can be something from which the patient does not recover".

80. Paragraph 23 - Barton expresses belief that the patient later experienced further pain. In support of this she refers to the fact that nursing staff were required to give Oramorph on four occasions during 17 and 18 August. During that period Barton says that she was contacted by the nursing staff who feared that the patient may have suffered a further dislocation. She says that she asked for another X-Ray to be arranged. The X-Ray did not show any dislocation.

81. Paragraph 24 refers to her entries in the patient's medical notes on 18 August which refer to a reference to the patient "still in great pain".

82. Paragraph 25 - Barton claims that by this stage there had been a marked deterioration. She says the patient was barely responsive and in a lot of pain. Also that she was not eating or drinking. She examined the patient and noted a lot of swelling and tenderness around the area of the hip replacement. No evidence of infection. She says her assessment was that the patient had developed a haematoma or bruising around the dislocation. She says that this complication would not have been amenable to any surgical intervention and says that a further transfer of the patient was not in her best interest and was not appropriate. She said that at this stage her belief was that the patient was dying. [**The experts are all critical of Barton's failure to consult with a colleague to seek specialist advice at this stage**].

83. Paragraph 26 refers to a discussion with the patient's daughter on 18 August in the presence of Mr Beed, the ward manager. She says that she explained to the daughters her concern that appropriate and effective pain relief should be administered and without this the patient was a "significant problem". She says

that her daughters did not like the idea that Diamorphine was to be given. She explained that this was the most appropriate drug. She says that both Doctors reluctantly agreed to the use of the syringe driver. [**Dr Barton's account of her conversations with the patient's daughters is different to the daughters' recollections in their witness statements. The daughters both indicated that explanations relating to the use of the syringe driver were given by Mr Beed. Mrs McKenzie says that Dr Barton then made a brief appearance simply to check that the use of the syringe driver had been explained to them - check to see what Beed says in his evidence.**]

84. Paragraph 28 - Barton believes that she also explained to the daughters that Subcutaneous fluids were not appropriate. [**Check with the daughters**]. Barton then goes on to justify the decision not to give the patients fluids. [* **Professor Livesley refers to the decision not to use fluids but does not deal with Dr Barton's explanation. Further expert evidence required**].

85. Paragraphs 29 and 30 - Barton gives some more details of her conversations with the daughters. She claims that she told them that it was likely that the patient would develop a chest infection and that she also told the daughters that her mother's prognosis was very poor and that she was not well enough for a further transfer to an acute unit. "I was concerned in all the circumstances to provide an honest view". [**Check whether Mrs Lack and Mrs McKenzie have been asked to comment on whether this is an accurate account of the matters discussed**]

86. Paragraph 31 - Barton believes that the daughters reported that their mother might be sensitive to morphine when Mrs Richards was first admitted to GWMH. [**We need to check this with the daughters**].

87. Paragraph 31 - Barton claims that in the first 18 hours following the transfer back from the Haslar Hospital - on 18/19 August? she had received 45 mgs of morphine in less than 24 hours. She claims that this was insufficient to manage the pain and hence the decision to start the patient on 40mgs of Diamorphine. She claims that the patient would have developed a tolerance to opiates through the pre-administrations of Oramorph. [**Dr Black in his report considers that the decision to administer these drugs was appropriate, although he says the dose of Diamorphine was inappropriately high. Professor Livesley and Professor Ford hint that the decision was inappropriate. Professor Livesley concludes that the continuous administration of these drugs shortened the life of the patient but neither expert specifically states that the decision to administer the drugs was inappropriate. If, as Dr Barton seeks to claim, Oramorph had not been sufficient to deal with the patient's pain, do the experts not consider that there is at least an argument that the administration of Diamorphine was justified?**].

88. Paragraph 32 - Barton seeks to justify the decision to use Midazolam and Haloperidol, apparently at the same time. [**Check to see whether the experts have considered whether this was appropriate**].

89. Paragraph 33 - Barton claims that she reviewed the patient's condition with "senior trained staff" on the morning of 19 August. [**She does not identify the staff she spoke to - check other witness statements**].

90. Paragraph 33 - She says that from her assessment on 19 August it was apparent that the patient had developed bronco-pneumonia. Barton refers to a "rattly" chest. Barton refers to this to justify the prescribing of Hyoscine [**check with daughters to see whether they recall the rattly chest**].

91. Paragraph 33 - Barton says she is clear that there was no apparent depression of the patient's respiration. She claims that if this had occurred, she would have reviewed the drug regime. [**Need to check this with the daughters**].

92. Paragraphs 33 and 34 - Barton says that she saw the patient again on the morning of the 20 and 21 August. [**Check daughters' evidence - at least one daughter claims that Dr Barton did not see her mother in the last three days of the patient's life**]

93. Paragraph 34 refers to Dr Barton's note dated 21 August. [**If the note has been dated accurately it suggests that the daughters' recollection is incorrect**.]

94. Paragraph 35 - In Barton's opinion by 19 August the patient had developed bronchopneumonia.

95. Paragraph 38 - Barton claims that her primary and only purpose in administering Diamorphine was to relieve pain and suffering. She also claims that at no time was the treatment aimed at hastening the patient's demise.

Transcript of Police Interviews with Mr Beed. Tab 3 File 56

96. This is a transcript of a police interview with Mr Beed, just short of two years after Mrs Richards' death. The transcript appears to be split up into a number of sections. Each section is paginated, although the pagination starts again at number 1 at the beginning of each section.

Section 1

97. Page 2 - Mr Beed confirms that he is a clinical manager and nurse in charge of Daedalus Ward. He has 24 hour accountability for nursing care and the management of the nursing team delivering the care. He manages a team of nurses and support workers and has 20 years experience in nursing. No specific

training in the care of the elderly, but has broad based experience of caring for the elderly.

98. Pages 4/5 - The ward that he is on deals specifically with continuing care and "slow stream/stroke rehabilitation". He refers to a consultant who has overall responsibility for the patients and a clinical assistant who provides day to day medical cover. He confirms that Dr Lord was the consultant in charge in 1998. Dr Lord attends the ward twice a week to do a ward round - Monday and Thursday. There is telephone contact with her at other times, if required. Communication is not usually a problem.

99. Page 5 says that Dr Lord would be contacted if there was a particular problem that the nursing staff could not sort out with the clinical assistant or if the clinical assistant was not available.

100. Page 6 says that Dr Barton worked at the Hospital on a daily basis between Monday and Friday to carry out patient reviews. Barton also clerked newly admitted patients. Barton could be contacted on Monday to Friday during "office hours" if she was not at the hospital. On evenings and weekends Dr Barton's partners were on call.

101. Page 7 - Prior to admission of new patients, the admission has to be approved by a consultant - either Dr Lord or one of her colleagues. [**Barton does not therefore appear to have a say in which patients were admitted**].

102. Page 7 - Most patients are transferred from other hospitals, usually for assessment or rehabilitation. She says that sometimes patients were not well enough to be rehabilitated.

103. Page 8 - Refers to 30 staff in total - 5 nurses (either registered general nurses or enrolled nurses), the remainder being healthcare support workers and nursing auxiliaries.

104. Page 8 - Says there are 20 beds on the ward but the ward has only been full on three or four occasions in the period that he has worked at GWMH. Usually there are approximately 17/18 patients.

105. Page 9 - He says that with 18 patients the ward gets very busy and if patient numbers go above 18 they needed to bring in extra (bank) staff.

106. Pages 9-10 indicates that whilst on occasions patient demands mean that staff are "very very pushed" his responsibility is to make sure the ward is properly staffed and to get extra staff if necessary.

107. Page 11 says that Dr Barton's practice, or a doctor in her practice or Dr Lord are responsible for prescribing drugs.

108. Page 13 - Witness confirms that generally speaking patients admitted to GWMH are stable and are able to be nursed.

109. Page 14 - Says that the pharmacist with responsibility for the ward is Jean Dalton [**the police do not appear to have taken a statement from her**].

110. Page 14 - Witness says that if the file noted any contradiction in the patient's medication, or if doses were below those normally expected, she would contact Dr Lord.

111. Page 15 - Witness acknowledges that due to his experience he would normally be able to identify when a drug regime was not "proper".

112. Pages 15/16 - Accepts that the nurses had the responsibility to know that a patient was being given the correct medication, i.e. the purpose of the medication and whether the dose is the normal dose. With regard to "normal dose" he makes the point that a range of doses can be given and (by inference) the nurses need to know what the appropriate dose within the range should be.

113. Page 16 - The interviewing officer does not ask the witness whether nurses have a discretion to prescribe within a dose range set by a doctor. Instead, the witness confirmed that the nurses' responsibility is to check dosages and if there is any reason to believe that the dose is not correct, they should consult the doctor.

114. Page 17 - Witness refers to cases where doctors can legitimately prescribe outside the normal dose range, e.g. patients with mental health problems frequently receive higher doses as part of their effective treatments.

115. Pages 17/18 - Witness confirms that the guidelines are guidelines and not hard and fast rules.

116. Page 19 - Witness describes the role of the named nurse, i.e. a nurse who is responsible for a specific patient. Each nurse has 3 or 4 patients in this category. [**We need to establish the named nurse in each case under review**].

117. Note that page 20 is missing.

118. Page 21 - Witness says that on admission/transfer to GWMH the patient's medical and nursing notes should accompany them, together with drug record and a transfer letter. [*** Check in the cases under review the extent to which Dr Barton followed an existing drug regime / imposed her own drug regime - is there a pattern?**].

119. Page 22 - Witness indicates that existing care plans would be reviewed by nursing staff following a patient's transfer to GWMH. A care plan is divided into

specific areas dealing with nutrition, prevention of care, continence/hygiene and ADL (activities of daily living).

120. Page 23 - Review of nursing plan is usually the responsibility of the named nurse.

121. Page 24 - A care plan is usually completed within 48 hours of admission - a little time is needed after admission to make the necessary assessments.

122. Pages 26/27 - Witness described how a syringe driver is used. This is usually used when delivering palliative care, when a patient is dying.

123. Page 29 - Witness says that usually in cases of palliative care there is a recognition that a patient is dying. The patient is being kept comfortable for purposes to seek to achieve a high level of pain control. Patients are usually fairly heavily sedated as well.

124. Page 31 - Witness says that the nursing staff are best placed to assess the full picture relating to the patient and would therefore be involved in discussions with medical staff in making decisions about patient care.

125. Page 31 - Witness says that nurses are empowered to initiate a syringe driver where there has been a prior review with a doctor and it has been noted that the patient's condition may deteriorate - "if the patient's condition worsened you could utilise a syringe driver and keep that patient pain free". [***Interviewing Officer does not ask the witness how a nurse determines the dose when a range of doses is prescribed on an as required basis.**].

126. Witness confirms that any significant event relating to the patient should be recorded in the care plan. Witness refers to an investigation following receipt of the initial complaint (by Mrs Richards' daughters?). Witness says that on investigation it was found that the nursing records were not "terribly good".

Section 2

127. Page 1 - Witness is asked what happens if Dr Lord, the consultant, was not available to deal with queries. Witness says that firstly, one could ask the clinical assistant if the advice of a consultant was needed. A nurse or clinical assistant could call a consultant at the Queen Alexandra Hospital and obtain advice over the telephone.

128. Page 1 - Witness is asked whether Dr Barton ever assumed a "higher role". Witness says this didn't happen. He says the advice of a consultant was not needed very often. On occasions he obtained advice from a consultant, where necessary.

129. Page 1 - The witness is referred to Dr Lord's report about Mrs Richards - Dr Lord said in her report that she has no knowledge of Mrs Richards because at the relevant time Dr Lord was on a course.

130. Page 2 - Witness says that Dr Lord was actually on the ward on the day that Mrs Richards was admitted, which is the day that the witness says Mrs Richards fell from her chair. However, witness says that Dr Lord was conducting a ward round, looking at the stroke patients, and therefore wasn't planning or required to see Mrs Richards on the day. Witness says in retrospect that it would have been helpful if the nurse who was looking after Mrs Richards, had actually asked Dr Lord to look at Mrs Richards.

131. Page 6 - Witness is asked about Dr Barton's daily routine. Witness says that each day she spent 20-30 minutes on a ward. There would be discussion with the nurses to deal with such things as changes in care and medication and any particular aspects of a patient's care. Also to identify if any particular patients needed to be seen by the doctor. If so, the nurse in charge would accompany Dr Barton to see the patient.

132. Page 7 - Witness confirms that Dr Barton did not see every patient every day - he only saw those patients which the nurses had identified as having a need to be seen. Witness acknowledges that Dr Barton relied upon the nurses to identify which patient needed to be seen. However, witness makes the point that most of the patients were fairly stable and their condition did not change much on a day to day basis.

133. Page 8 - Witness is asked how a doctor would know if a patient was improving or deteriorating. Witness explains as the nursing staff were working very closely with the patient, they are in a position to get a very good picture of how the patient is doing so a doctor is actually getting a better picture by talking to a nurse who has observed the patient over the last 24 hours and the doctor is likely to see for his or her self at any one point in time. [**An interesting question is whether or not Dr Barton relied purely on nurses' observations before commencing a patient on Diamorphine or authorising an increase in dose**].

134. Page 9 - Witness confirms that there is a great deal of trust between himself and Dr Barton. They worked together for three years. He confirms that on occasions they disagreed but indicates that there was nothing untoward in this. On occasions witness also disagreed with Dr Lord. Sometimes decisions were not absolutely clear cut so there was room for discussion.

135. Page 10 - Witness gives an example of occasions where there had been disagreement - whether or not a particular patient should be discharged to return home, there would be a discussion and a decision based on the

discussion. Usually agreement was reached on the basis of what the patient wanted to do.

136. Page 15 - The interviewing officer commences to ask the witness about the specific case of Mrs Richards.

137. Page 16 - The witness says that on the day that Mrs Richards was admitted she was "in my judgment in considerable pain" and that the witness and another nurse, Monica Crawford, gave her a small dose of Oramorph to make her comfortable. [**There is no reference in the expert's report to a note having been made in the nursing records to say that the patient was in considerable pain at this stage. On the contrary Dr Barton in her own notes states on the date of admission that the patient was "not obviously in pain". The witness does not explain why the patient was commenced on Oramorph and why an alternative form of analgesic relief was not considered as a first option. It is possible that by this stage Dr Barton had already prescribed Oramorph in anticipation that the patient may require pain relief. This highlights one of the difficulties in this case. The experts, particularly Professor Livesley, prepared their reports on the basis of the available documentation/records. Earlier in his police interview Mr Beed has acknowledged that the nursing records were not as good as may have been expected. The experts need to review their reports with reference to the evidence of witnesses such as Mr Beed. We need to check whether Monica Crawford confirms Mr Beed's evidence. We need to take account of the possibility that the nurses in this case are likely to be defensive in their interviews with the Police in view of their role in the management of the patient's care**].

138. Page 17 - Witness refers to the patient receiving a further dose of Oramorph at a quarter to midnight by Staff Nurse Marjoram [**check her evidence regarding the level of pain at that time. Also check to see what steps Nurse Marjarom, and for that matter Mr Beed, took to establish that the screaming was actually attributable to pain and not anxiety/dementia as suggested by the patient's daughter. Mr Beed in his interview does not say how he came to the conclusion that the patient was in pain. He acknowledges on page 17 that the patient was not able to communicate very effectively. This opens up another potential difficulty in the case; if the nursing staff believed, albeit incorrectly, that the patient was in pain and reported this to Dr Barton, was it reasonable for Dr Barton to assume that any report she received from the nurses was accurate?**]

139. Page 17 - Witness refers to the discovery of the patient's dislocated hip and the patient's transfer to the Haslar Hospital to have the dislocation reduced under sedation.

140. Page 19 - Witness refers to the patients' daughters as being quite upset. Witness says that potentially he could see that they could be quite angry and difficult to deal with. He claims that he told them they had the option of looking for alternative arrangements if they did not want their mother to return to GWMH after her dislocation had been dealt with.

141. Page 20 - Witness refers to Mrs Richards' return to GWMH on 17 August. Witness says that when Mrs Richards arrived she was uncomfortable and in pain from the time she arrived. He recalls the daughters making an issue of the fact that their mother was in pain and he determined that he would need to be closely involved with Mrs Richards' care from then on. He could see that there were potential difficulties as to both the patient's care and the family.

142. Page 21 - Witness believes that the patient actually settled down after a while. He recalls Dr Barton seeing her at this stage, however, when Dr Barton left the ward witness says that the patient began screaming again and was in "obvious pain and distress". Witness says that the patient was given a further dose of Oramorph to try to make her comfortable.

143. Pages 21/22 - Witness says that a further X-Ray was carried out. It was reviewed by Dr Peters, one of Dr Barton's partners, and Dr Peters confirmed that there was no further dislocation. Witness says that a decision was made to make sure that the patient was reviewed by Dr Barton the next morning. Witness claims that at this point, the patient was in a lot of pain, a lot of distress and looking generally unwell. She was also refusing to eat or drink anything other than a very small amount.

144. Page 22 - Witness says that the patient was given a further dose of Oramorph at 1.00 in the morning and a further dose was given at 3:15am, administered by the witness himself. He says that this was not effective so that he had to give her a supplementary dose at 4.45am. [**These details seem to have been recorded in the prescription chart - see paragraph 5.1.1.6 in Professor Livesley's report. Note however, that not all these details are included in the report of Professor Ford; in section 2.11 of his report. We need to query whether he has properly recorded/transposed all the details from the relevant medical records. Both experts need to review the nursing staff's decision to give the patient several doses of Oramorph within a relatively short period of time. Have the experts given sufficient consideration to the fact that by this stage Oramorph in the doses administered did not seem to be adequately relieving the pain. The experts also need to consider the fact that four doses of Oramorph were administered on the previous day - 17 August.**]

145. Pages 22/23 - Witness says that there was obviously something going on between Mrs Lack and Mrs McKenzie - different daughters were saying different

things at different times and there was an obvious dispute and disagreement going on between them.

146. Page 23 - Witness makes a slightly ambiguous statement. When referring to the morning of 18 August - "there was really no improvement overnight and the pain control was obviously keeping her comfortable".

147. Page 23 - Witness says Dr Barton reviewed the patient on the following morning e.g. Tuesday 18 August. A decision was made that a transfer to Haslar was not appropriate and the likely cause of the pain is stated to be a haematoma and that the pain control wasn't effective. The patient's overall condition was very poor and likely to deteriorate further. The appropriate course of action was to use a syringe driver to give continuous analgesia. This would enable the patient to be kept comfortable, as opposed to giving individual doses of medication every four hours and a "top up if they weren't quite right". [**Query whether the experts have considered this evidence and/or given sufficient weight to the evidence. Professor Ford's report confirms that he has seen a transcript of the police interview with Mr Beed. Professor Livesley's report does not specifically refer to the transcript, although there is reference to him having seen a five page statement prepared by Mr Beed. It is not clear whether Dr Black considered Mr Beed's evidence in reaching his conclusion.**]

148. Page 24 - Witness says that he wanted to discuss the use of a syringe driver with the family before starting with it. He said he presented the overall picture to the family and explained that they were looking at palliative care. He said the family agreed. [* **Note that there is no reference to Dr Barton being involved in this conversation, contrary to what she says in her statement.**]

149. Page 25 -Witness says that a lot of time was spent dealing with the patients' daughters and a much larger amount of time was being spent with them than would be spent with other relatives.

150. Page 26 - Witness says that the patient's condition gradually went down hill over the next five days, before the patient eventually passed away. He says that the family wanted to get involved in laying out the patient and taking her to the mortuary. He says that time spent with the family made it difficult to keep the nursing records up to date. Witness also states that the ward was very busy at the time and that there was staff on annual leave and people going off sick as well which made it very hard work.

Section 3

151. The Witness is asked about a date of the patient's admit to GWMH on 11 August.

152. On page 2, the witness confirms that before the patient arrived, a letter would have been received on the Ward from Dr. Reid. The Witness summarises the contents of Dr. Reid's letter.

153. Page 4 - The Witness says that the patient's room was immediately adjacent to the Ward Office and the Nursing Station.

154. Page 4 - The Witness says that it usually takes an minimum of 2-3 days for a new arrival to settle into the Ward and to make an assessment/plan for rehabilitation.

155. Page 6 - The Witness cannot recall whether the patient arrived in a wheelchair on the day of her transfer, but he thinks this is likely.

156. Page 6 - The Witness confirms that he would have seen the patient within a few hours of her arrival and he would have found out whether she had any immediate needs that needed to be addressed. The Witness says that Dr. Barton would then have been notified of the patient's arrival.

157. On page 7 - The Witness says that usually within half an hour of being contacted of a notification of a new arrival, Dr. Barton arrives to write up the patient's notes and medical chart. The Witness says that in the case of Mrs. Richards, Dr. Barton arrived fairly promptly.

158. On page 7 - The Witness says that he gave the patient a dose of analgesia at 14:40 - he says that Dr. Barton must have seen the patient and left by that time because the Witness could not have given the medication without the chart being written up.

159. Page 7 - The Witness indicates that when the patient arrived, she was very anxious, very confused and "appeared to be in pain from the hip that she had been operated on". The Witness acknowledges that it was difficult to know what was going on exactly because the patient was so confused. The Witness felt that she was in pain and was very difficult to communicate with.

160. Page 8 - The Witness acknowledges that it is sometimes difficult to distinguish between pain and dementia.

161. Page 9 - The Witness is asked whether the patient's agitation was due to pain or dementia. The Witness acknowledges that it can be difficult to differentiate, but he says that because he had difficulty in transferring the patient, her agitation was a combination of dementia and pain.

162. Page 11 - The Witness says that because he felt the patient was in pain, he administered 10mgs of Oramorph at 2:15p.m. The witness says this is "a fairly small dose" **[again no reference to the fact that when Dr. Barton saw the**

patient on admission, she noted that the patient was "not obviously in pain"].

163. Page 11 - The Witness is asked about the choice of analgesia and gauging the appropriate levels. The Witness says the choice depends on the amount of pain ranging from minor discomfort to very severe pain and intolerable pain. The Witness says that Oramorph is used for "more severe pain". The Witness confirms that at that stage, he believed the patient was in severe pain. He is asked whether the Haslar Hospital would have let her be transferred if her pain was severe. The Witness says that the police should ask the Hospital.

164. Page 12 - The Witness says the transfer itself can cause discomfort and pain. He says that this happened on numerous occasions in connection with patients transferred from Haslar. The Witness says that in the past the Haslar has been challenged about this.

165. On page 13, the Witness says that on about 5 or 6 occasions, he has had to write memos raising different issues about the way patients are being transferred. The Witness is asked whether he made a complaint in respect of the way Mrs. Richards was transferred. The Witness said that on the first occasion, the amount of pain was "appropriate" **[consistent?]** for somebody who had had a hip operation. On a second transfer, he says there was a lot of pain and there was an issue as to the way that she was transferred - left on a sheet rather than by "canvas" **[?]**. **[*This is a possible weak area in the case against Dr. Barton. Is there any evidence to suggest that when she first arrived at GWMH, the patient was suffering pain as a result of the transfer itself - i.e., is it possible that when she left the Haslar Hospital, she was fine, but suffered pain during the course of being transferred.]**

166. On page 14, the Witness says that when the patient was examined by Dr. Barton when the patient first arrived on 11 August, the patient was not actually in pain because Dr. Barton wrote up a prescription for analgesia to cover the possibility that the patient may need pain relief in due course.

167. Page 14 - The Witness then says that the patient was not in pain "immediately on arrival". The Witness says that the pain set in "a little while later". The Witness says that it is not unusual for patients to present differently when they are examined by a doctor.

168. Page 15 - Beed confirmed that the patient wasn't obviously in pain when she was seen by Dr. Barton. The Witness indicates that pain set in in a period of about an hour after Barton's examination.

169. Page 15 - The Witness was asked whether Barton would have written up a prescription for somebody who wasn't in pain. The Witness says that patients who had hip repairs can suffer pain even several days after the operation,

particularly if attempts are made to mobilise them (moving them from a chair to bed or from a chair to the toilet) or transferring. In the Witness' view, it was appropriate to prescribe analgesia to cover the possibility that the patient would require it.

170. The Witness says that Michelle Cawford **[Crawford]** wrote up the patient's care plan. **[Check to see if a statement obtained by police.]**

171. Pages 18/19 - The Witness is asked about Dr. Barton's note stating "I am happy for nursing staff to confirm death". The Witness explains that the patients' conditions can worsen and there are no doctors on call to confirm death. Nursing staff can do this. The doctor then certifies death at a later stage. By way of clarification, the Witness says that in very elderly and frail patients, you don't necessarily need the support of a doctor because "you can see what is going on". The Witness says also that if a patient's condition deteriorated unexpectedly, or if a patient's condition had worsened over a period of a few days and the doctor had been notified of the deterioration, the it was expected that a doctor would not be called out in the middle of the night to confirm something which was expected to happen. It is put to the Witness that it seems strange to relate to a person in a case where a patient is admitted with a hip operation, the doctor records in the notes that she is happy for nursing staff to confirm death. The Witness acknowledges that this may seem strange to a lay person.

172. The Witness seeks to explain the practicalities of the situation, i.e., for instance, if the patient's health deteriorates over a period of a few days and death is anticipated, he explained why the nursing staff do not need to call a doctor out in the middle of the night to confirm death. "I would see it in the context of the patient's overall care and the likelihood of what may or may not happen...given their overall condition."

173. Page 23 - The Witness is questioned about the first dose of Oramorph on the afternoon of 11 August. He said that they kept the patient comfortable. The Witness is certain that at the time the patient was not over-sedated. The Witness says that she was conscious and able to eat and was communicating as much as she was able to do.

174. Page 24 - The Witness says the patient was more settled and noticeably less agitated. He says that this could be due to a combination of the Oramorph, which keeps a patient pain free, but also helps a patient to relax, and Haloperidol **[a sedative?]**.

175. Page 25 - The Witness is referred the prescription for Diamorphine and Midazolam via a syringe driver - it is stated to be written up on 11 August. The Witness is asked whether this indicates that Dr. Barton was amenable to the use

of a syringe driver very early on. The Witness says that a syringe driver often gets written up if the patient looks overall to be very poor and the syringe driver can be used in the judgment of nursing staff if the patient condition deteriorates and it is required to keep them comfortable.

176. Page 26 - The Witness confirms that by writing up a prescription in this way, the nursing staff were given flexibility to commence using a syringe driver if, for example, a patient's condition worsened in the middle of the night. It meant that there would be no need to call out a doctor or, alternatively, it would mean that the patient would be left in pain until the following morning. **[*Important point when considered in connection with the wide dosage of drugs which was written up. What would prevent a nurse from giving a patient an excessive dose of Diamorphine?]**

177. Page 26 - The Witness confirms that at this stage, the patient was capable of eating and drinking, but only with assistance. This confirms that the patient's swallow reflex was fine.

178. Page 28 - The Witness is asked whether he had any discussion with the patient's relatives concerning the cause of the patient's agitation, i.e., whether it was due to dementia or pain. The Witness said the daughter felt that the agitation was due to another needing to use the toilet. The Witness says he has a recollection of putting the patient on the toilet when she was agitated and the Witness infers that the patient was still agitated.

179. Page 29 - The Witness confirms that Oramorph was used to keep the patient pain free for a couple of days. Then - i.e., on or about 13 or 14 August - one of the staff nurses, Nurse Joyce, discontinued the Oramorph. Dr. Barton had written up in the records that the patient was "sensitive" to Oramorph. The Witness is asked to explain what this means. The Witness says that a drug has more of a sedating effect on some people than it does on others. It can also build up in the system. He says that Staff Nurse Joyce felt that the patient had been given a little bit too much Oramorph and that it should be stopped.

180. Page 30 - The Witness confirms that further doses of Oramorph were given on 11 and 12 August (i.e., before the decision was made to stop using it for a period). The Witness is asked whether on 11 and 12 August any member of staff reviewed the patient to determine if the level of pain had been reduced. The Witness confirms that there would have been a review during this period.

181. Page 30 **[or 31(?) cut off on tape]** - The Witness is asked whether a record is made in the notes on each and every occasion that the effects of the previous dose has worn off and the patient needs a further dose. The Witness says that a record of this would not necessarily be made.

182. Page 31 - The Witness is also explains that an analgesia is usually given on a regular basis, every four hours, to prevent pain from re-occurring. Alternatively, it can be given on an "as required" basis. Looking at the _________ records, the Witness notes that in effect, more than four hours elapsed between doses, which suggests to the Witness that the Staff Nurse gave the patient a further dose when the previous dose had worn off. **[Check to see whether the police have identified and taken a statement from the Staff Nurse in question.]**

Section 4

183. Pages 1-2 refers to the position on 12 August. The Witness confirmed that a prescription for Oramorph was on an "as required" or "PRN" basis. The Witness says that only one dose of Oramorph was administered on that particular day and that was sufficient to stabilise the patient's pain.

184. Pages 2-3 deal with 13 August patient's fall. The patient received a further dose of Oramorph at 10 to 9:00 in the evening following the discovery that she had dislocated her hip. She had not received any Oramorph or pain killers since the last dose on 12 August.

185. Page 4 - The Witness was not present when the patient dislocated her hip. The Witness says that the dislocation may have occurred when the patient fell; alternatively, it could have occurred subsequent to the fall in the process of transferring the patient back into bed. However, the interviewing officer acknowledged that there is not much the Witness can say on this because he was not actually on duty at the time.

186. Page 5 - The Witness says that the pattern of analgesia administered (on 12/13 August?) is not unusual. He explains that pain killers are only administered when someone is in pain. The amount of pain does vary from time to time depending on the exact circumstances, e.g., there may be more pain involved when a patient is transferred (moved) **[the experts need to consider this with regard to the analgesic ladder. It does not appear that the patient was in a great deal of pain prior to the dislocation and query whether a weaker analgesic should have been used]**.

187. Pages 5-6 - The Witness deals with events on 14 August when he was on duty. He refers to being present when Dr. Barton examined the patient. A dislocation was suspected and an x-ray was arranged. A further dose of Oramorph was given in the morning prior to transferring the patient to the Haslar Hospital by ambulance. The dose was given in anticipation that the patient would need some pain relief to deal with the dislocation. The dose administered was the same as the doses previously administered.

188. Pages 9-10 deal with the patient's re-admission to GWMH on 17 August. The Interviewing Officer refers to the statement from Flight Lieutenant Edmondson

(who presumably was involved in dealing with the dislocation at the Haslar Hospital). **[Check to make sure that we have a copy of the letter attached to the statement.]**

189. Page 10 - The Interviewing Officer says that the statement records that the patient was "ready for further rehabilitation". The Witness confirms that Edmondson's statement/letter accompanied Mrs. Richards on her re-admission to GWMH.

190. Page 11 - The Interviewing Officer refers to the last sentence in Edmondson's statement which says that the patient was able to mobilise and was fully weight bearing. The Witness explained that whilst this is the opinion expressed in the letter, nurses at GWMH would need to assess the patient to determine her ability to stand up.

191. Page 12 and sequence - The Witness refers to events following the patient's re-admission to GWMH on 17 August. It says that the patient was in "obvious pain and discomfort" when she arrived.

192. Pages 13-14 - The Witness explains how a patient is transferred by stretcher. Usually a length of canvas is placed over the stretcher. The canvas has holes in it through which poles can be placed. These can then be used to lift the patient from the stretcher onto the bed. However, in this case, there was a shortage of canvas and, instead, the patient had been placed on a sheet on top of a stretcher. The Witness explains that this does not give the same level of support. The sheet can sag and the transfer may be uncomfortable. Canvas, on the other hand, is firm and rigid. In other words, the ambulance had to improvise and use a sheet because of a shortage of canvas.

193. Page 15 - The Witness explained that he was not present when the patient arrived at GWMH. He was not involved in the transfer of the patient onto her bed.

194. Page 16 - The Witness says that ambulance crews are always under pressure to get on with the next job. Although the Witness was not present at the time, he says that speaking to others, he gathers that the crew were in a rush to get away.

195. Pages 17-18 - The Witness confirms that he administered pain relief at 1:00p.m. when the patient "really started to demonstrate the signs of being in pain".

196. Page 18 - The Witness confirms that this was administered with reference to the existing prescription - no new prescription was written up by Dr. Barton.

197. Page 18 - The Witness confirms that the patient is able to take oral medication at this stage - her swallow reflex is still working. However, on the following

page, the Witness says that patient refused to eat. The Witness says this may have been due to pain or the fact that the patient was unsettled or may have been down to her general dementia.

198. Page 19 - The Witness refers to the fact that Nurse Couchman re-positioned the patient's leg because she thought it was in a very uncomfortable position. Witness appears to be reasonably confident that, at that stage, no re-dislocation had occurred. An x-ray would be needed to verify.

199. Page 20 - The Witness is questioned with regard to the drug regime for the remainder of the day on 17 August. He refers to the slightly lower dose of Oramorph being given because it was thought that the patient was sensitive to Oramorph. He refers to doses given at 1:00p.m. and then 3:15p.m. He says that the latter dose was "obviously not enough" so a second dose was given at 4:45p.m. (10mgs). A further dose was given at 8:30p.m. (10mgs) and more was given in the early hours of the morning.

200. Page 21 - The Witness is asked if the family understood, at this stage, that their mother was, in fact, in pain (as opposed to confusing her distress/agitation with dementia). The Witness confirmed that both the patient's daughters were very concerned about the level of pain and the need to get this under control. **[I think the evidence of the two daughters' confirms by this stage that they both understood that their mother was in pain. Query whether the experts have attached sufficient weight to this.]**

201. Page 22 - The Witness refers to his assessment as to whether or not the doses or Oramorph were adequate to deal with the level of pain. He says that you need to give the dose sufficient time to take effect. He refers to giving the patient a further dose of Oramorph at 4:45p.m. (10mgs). He says that if she had not been comfortable by the time he left work at 8:30p.m., he would have considered the use of a syringe driver at that stage. He refers to this as "the next logical step".

202. Page 23 - The Witness confirms that he was on duty again on the morning of 18 August. The patient was reviewed by Dr. Barton. The Witness confirms that during the night of 17/18 August, the records show that that patient was receiving Oramorph every four hours.

203. Page 24 - The Witness says that night staff "would have told me that they needed to give the Oramorph every four hours and that she had not been completely comfortable on that". **[*Note that there is no reference in the records to confirm that this was actually the case and the Witness does not appear to have a direct recollection of the actual circumstances - "they would have told me".]** The Witness confirms that the lack of information in the records is purely an oversight. **[Check to see whether the**

police have interviewed the nurse or nurses who were on duty overnight. We need to check whether there is any evidence that the patient was still in pain and that the doses of Oramorph administered were not sufficient to deal with this adequately. If there is evidence to this effect, query whether the experts have attached sufficient weight to it.]

204. Page 25 - The Witness claims that the patient's overall condition is deteriorating and says her fluid and diet intake were poor and the pain was not being controlled even with the regular dose of Oramorph. **[The Witness says this, but there is no evidence in the notes to support him.]** The Witness also says the patient is agitated and uncomfortable and difficult to nurse.

205. Page 25-26 - The Witness says that he discussed the patient with Dr. Barton **[presumably on 18 August?]** and that Dr. Barton's view was that there had been a significant deterioration in her overall condition. Also, that the patient's wasn't being controlled and that a syringe driver should be used. The end result was to keep her pain free, but she was in such poor health that she was actually dying. The Witness acknowledges that by this stage, rehabilitation was unachievable and that the patient was going to die fairly shortly.

206. Page 27 - The Witness says that he met with relatives around mid-morning on 18 August and they discussed the patient's overall condition - including the need to use a syringe driver to control pain and explained that her prognosis was very poor. He says that they were upset. The Witness says that they had concerns about the use of strong analgesics from his previous discussions with them.

207. Page 28 - The Witness says that the relatives understood the position and agreed with the suggested plan. They did not disagree with the plan. If they had disagreed, the Witness would have taken advice from a nurse manager or a consultant.

208. Page 28 - The Witness acknowledges that an alternative to a syringe driver would be to continue to use Oramorph, but with higher doses. The problem with the latter alternative was that it was not keeping the patient pain free for the whole of the interval between the doses, i.e., it was not adequately controlling the pain. **[Again, the question arises as to whether or not the experts have attached sufficient weight to this.]**

209. Page 30 - The Witness explains that by giving a continuous dose of analgesic, the pain never breaks through.

210. Page 30 - The Witness is in no doubt that the pain was "from the hip". The Witness also says that she also gave the impression that she was in general discomfort and agitation because everything that was causing the patient to get upset and distressed. The Witness claims that this is quite common with people

who are dying - they have a specific pain somewhere, but also generalised pain and discomfort. **[Comments needed from experts.]**

211. Page 31 - The Witness said those involved in the review of this patient were: himself, Dr. Barton and Staff Nurse Couchman (Mrs. Richards "named" nurse).

212. Page 31 - The Witness says that he and Nurse Couchman began using the syringe driver at 11:45 on 18 August with the following medication: Diamorphine 40mgs, Haloperiodol 5mgs and Midazolam 20mgs.

213. Page 32 - The Witness explains that the dose of Diamorphine was calculated with reference to the previous doses of Oramorph, i.e., doses of Oramorph given in the last 24 hours. The Witness explains that if the dose of Oramorph kept the patient completely comfortable, a lower dose of Diamorphine would have been used. As the patient had been getting periods of discomfort, a slightly higher dose was used to make sure that she was pain free.

214. Page 33 - The Witness confirms that Hyoscine was first used the following day, 19 August.

215. Page 34 - The Witness confirms that the drugs used in the syringe driver are known to cause some degree of respiratory depression and on page 35, the Witness explains that Midazolam is used to produce anxiety.

216. Page 36 - The Interviewing Officer puts it to the Witness that Midazolam is not licensed for subcutaneous use, but the Witness claims that its use in this way is, nevertheless, established practice in palliative care.

217. Page 37 - The Witness confirms that the use of the syringe driver would continue until the patient passed away because if the analgesia was withdrawn, the level of pain would return. However, the Witness claims that the use of the syringe driver was "constantly under review" to make sure that the dose was "appropriate to the patient's needs". The Witness says that this would be reviewed every 24 hours and every time the syringe driver was changed, i.e., checking to see whether the patient was comfortable or uncomfortable.

218. Page 37/38 - With regard to hydration, the Witness said that the patients are encouraged to take food and fluid if they are conscious. If patient are unconscious, patients are not hydrated unless there is specific indication that it is the appropriate course.

219. Page 38 - The Witness confirms that they stopped actively treating the patient and moved to palliative care on the morning of 18 August.

220. Page 38 - The Witness is asked about checking the levels of pain in the three day period after palliative care was commenced. The Witness says that this would

have been monitored when a patient was washed and changed and checked to see whether there are any signs of pain. He claims that if there were no signs of pain whatsoever, lower doses may be appropriate. However, the Witness said it is usual to see indications of pain when you start to move patients in these circumstances. If pain is noted, the appropriate course is to increase the dose of pain killers.

221. Page 39 - The Witness is asked if there are any indications in the patient's notes that these checks were carried out. He said that on the 18th, during night care, the patient was comfortable. Also on 19th, she had a night change and a wash and was re-positioned and was apparently pain free.

222. Page 40 - It was put to the Witness that in this case, was the proper course not to reduce the dose. The Witness says that the difficulty with reducing the dose is that pain can break through and that the patient is "back to square one". Where the patient is dying and is pain free, there is no alteration in the dose.

Section 5

223. Pages 1-2 - The Witness refers to an entry in the notes by Nurse Joyce at 8:00 on 18 August, i.e., 36 hours after the syringe driver was commenced. The notes state that the patient was sleeping in peace, but reacted to pain when she was moved and the pain appeared to be in both legs. The Interviewing Officer then points out to the Witness that it was not, in fact, 36 hours, but 12 hours after the syringe driver had been commenced. **[*Have experts attached sufficient weight to this - particularly Professor Livesley and Professor Ford.]**

224. Page 2 - With regard to the dose of Morphine administered, the Witness claims that this was at the "bottom end of the scale". The Witness says "we could have gone up to 200mgs of Diamorphine and 80mgs of Midazolam". The Witness claims that in some patients, he has known the doses of Diamorphine have even higher - 500mgs which he describes as being not an "uncommon dose to give someone who is in that much pain".

225. Page 3 - The Witness says that on 19 August, the patient had a "very rattley chest". Due to secretions. The patient was started on Hyoscine at this point.

226. Page 4 - The Witness is asked whether the chest infection is caused by the medication. The Witness said that the medication would have an effect on aspiration, but that the patient's overall condition would have affected her respiration as well.

227. Page 5 - Question further on the decision to move to palliative care on 18 August. The Witness confirms that the patient is very frail. She wasn't eating and that she was in pain which was not being controlled. She was not able to mobilise or anything to meet her own needs.

228. **[A KEY POINT THEREFORE WITH THIS PATIENT IS WHETHER PALLIATIVE CARE WAS INTRODUCED PREMATURELY.]**

229. Page 8 - The Witness recalls having a conversation with the patient's daughter, Mrs. McKenzie, about Euthanasia. Witness is asked about the distinction between palliative care and Euthanasia. He says that the former is aimed at making death a comfortable and dignified experience and meeting a patients nursing needs. Euthanasia is actively assisting someone in the process of dying.

230. Page 8 - The Witness is asked about the suggestion that the patient had a "massive haematoma". The Witness says that this was the view of Dr. Peters (one of Dr. Barton's partners?) when he examined the patient's x-rays. **[Check to see whether a statement was taken from Dr. Peters. Check to see if Dr. Peters queried the medication prescribed by Dr. Barton.]** The Witness' understanding is that a haematoma may have been caused as a result of the dislocation and the manipulation required to deal with the dislocation. The Witness said this can be quite painful. The Witness also believes that the level of pain indicated that it was more than the pain from the haematoma. "She was in an awful lot of uncontrollable pain and distress from the pain as well." The Witness said that he had seen other patients with dislocations which had been put back. The level of bruising and discomfort was not on the same level that Mrs. Richards was experiencing. **[Have the experts attached sufficient weight to this?]**

231. Page 9 - The Witness is asked why the patient did not receive fluids subcutaneously after 18 August. The Witness said that this is not considered an appropriate course of action with palliative care as it does not change the outcome. Also claims that it makes patients feel uncomfortable because the fluids do not get absorbed properly.

232. Page 11 - Towards the end of the interview, the Witness comments that he spent a lot of time with the patient's daughters. He talked to them and answered a lot of questions. He says that he finds it strange that they are now raising issues which they did not raise at the time. The Witness finds this "puzzling".

233. Pages 11-12 - The Witness is asked whether anything could have been done differently with hindsight? The Witness says it would have been better for the patient to be transferred earlier after her fall, but the Witness said that would not have altered the outcome with regard to the care the patient received following her re-admission. The Witness claims that all the decisions were appropriate "so I can't see, in terms of overall care, that there was anything we could have done differently now if we were in the same situation again".

234. Pages 12-13 - The Witness is asked whether any consideration was given to sending the patient back to the Haslar Hospital. It appeared after her re-

admission to GWMH. The Witness said that Dr. Barton felt it was inappropriate for a 91 year old who had been through two operations to go back to the Haslar Hospital. In Dr. Barton's view, the patient would not have survived any further surgeries. Also, Dr. Barton has not been able to find any specific cause of pain to warrant a transfer - therefore, the most appropriate course was to keep Mrs. Richards at the GWMH.

235. **That is the end of the police interview. Check to see whether Mr. Beed made any separate statements. His evidence highlights a problem in dealing with this particular case. He is clear, in his own mind, that the use of opiate analgesics was appropriate given the degree of pain experienced by the patient. He has acknowledged that there are deficiencies in the nursing records. He may be slightly defensive as to his own position and any consideration of his evidence must bring this into account.**

File 62 - Tab 2 - Police interview with Nurse Couchman

236. Witness interviewed on 29 June 2000 - just under two years after Mrs Richards' death.

237. Page 4 - Witness confirms that she is an E grade staff nurse in charge of the ward (said she worked on Daedulus Ward - had worked there for 12 years up to the date of the interview).

238. Page 6 - A witness confirms that she was Mrs Richards' "main" (named?) was on leave when Mrs Richards was first admitted. Witness' first day back after leave was the day that the patient was readmitted from the Haslar Hospital.

239. Page 6 - Witness is aware that there were concerns about the patient being transferred from the Haslar Hospital on a sheet. Witness says that a canvas should have been used.

240. Witness saw the patient shortly after she arrived. Confirms that the patient was in pain. Mrs Richards was in bed. Witness pulled back the covers and found that the patient was not lying properly. With the help of one of the patient's daughters, the witness put the patient in the correct position and this made the patient more comfortable.

241. Page 7 - Witness says that "somewhat later" she heard the patient in pain and distress. Went into the patient's room. The patient was "crying out in distress".

242. Witness says that she spoke to one of the daughters to explain that she would like to give the patient something to relieve the pain. The witness spoke to the manager, Mr Beed - presumably to get authorisation - to give the patient some Oramorph. Says that the patient was then given a very small dose.

243. Page 8 says the witness did appear more comfortable after this was administered.

244. Page 9 - witness gives a more detailed description of the position which she found the patient in when she first saw her. Said that the patient should have been lying with her legs stretched out and a pillow in between to keep her hip in the right position. However, witness describes the patient lying flat on the bed with one leg bent. Witnesses asked who was on duty at the time of the transfer. The witness says that apart from her there was one other plain member of staff. She was engaged elsewhere when the patient arrived (**the inference therefore is that there was no trained member of staff available when the patient was re-admitted).**

245. Page 11 - Witness agrees that it was likely that the ambulance crew put the patient into bed.

246. Page 12 - Witness gives a further description of the position of the patient's legs when the witness first saw the patient. She says that one leg was tucked under the other in a "figure 4" shape.

247. Page 12 - Witness says that she was told that the patient's daughters were suing the nursing home where the patient originally broke her hip. Witness says therefore that the staff at the Hospital bent over backwards to try and prevent a complaint.

248. Page 13 - The Witness says that one of the other staff members became quite friendly with Mrs MacKenzie, one of the daughters. Mrs MacKenzie said that she was a lawyer and had then worked as at TV producer. She had also written books. The witness says that she and some other staff members had attended a meeting with Mrs MacKenzie to hear people speaking about spiritual healing. The speaker was the President of the National Federation of Spiritual healers. However, during the meeting, Mrs MacKenzie criticised the quality of nursing care and said that she was unhappy about the circumstances in which her mother had died. A witness says that Mrs MacKenzie was very derogatory about her mother's death and believes that she wanted to make the point publicly in front of the nurses at the meeting.

249. Page 16 - Witness says that she was shocked to hear about the complaint at the meeting. The witness had not been aware that Mrs MacKenzie had a complaint before then (**bear in mind when considering Mrs MacKenzie's evidence. It does seem an unusual way of going about things).**

250. Page 16 - Witness describes her role as "the main" nurse for Mrs Richards. It was the witness's duty to look after the patient and her relatives - keep the relatives informed of the patient's progress and deal with medication.

251. Page 18 - Talking about the patient generally, the witness refers to her dementia and the fact that she cried out frequently. The witness put this down to the patient's dementia.

252. Page 19 - Witness confirms that she has signed a number of entries in the controlled drug register for this patient. The Witness signed the entry at 11.45 on 18 August and 10.45 on 20 August.

253. Page 21 - Witness appears to have signed for the first dose of Diamorphine used in the syringe driver although she says that she has got no specific recollection of this. The witness believes that her manager, Mr Beed, had already spoken to the patient's relatives and to the doctor (Barton) about the first use of the syringe driver. The witness is not involved in these discussions.

254. Page 24 - Witness confirms that the decision to prescribe controlled drugs is Doctor Barton's responsibility, although she will consult with nursing staff concerning the patient's condition as staff had much more contact with the patient.

255. Page 30 - Witness clarifies Mr Beed's role - he is the Clinical Manager which in old terminology would have meant the Ward Sister - in charge of the ward.

256. Page 32 - Witness says that the nurses would not administer a drug if they did not feel it was necessary. **(However, the nurse is not saying that they would ignore the instructions given by doctors. If they had reservations about a particular prescription, they could speak to others about their concern - there was a very good support system)**. The witness said that during her time at the hospital she never had any disagreements with a doctor over treatments.

257. Page 34 - Witness confirms that patient was very distressed and in a great deal of pain when she was first put on the syringe driver. However, the witness also says that at the time a syringe driver was first used, she did not feel that the patient was dying. Witness says she only came to realise that a couple of days before the patient died. **(As the witness was first put on a syringe driver only three days before she died, there may not be very little in this observation by the witness)**.

258. Page 34 - Witness says that the patient had multiple problems. The witness refers in particular to a haematoma - witness describes this as a blister on her hip which had broken. - "so we knew that caused a lot of pain".

259. Page 35 - Witness also says that patient probably had a chest infection because her chest was "rattling".

260. Page 35 - witness refers again to the date of re-admission. Says that the possibility that the hip had slipped out again was considered, but an x-ray confirmed that this was not the case. The witness thinks that the haematoma was discovered later.

File 62 - Tab 3 - Continuation of interview with Nurse Couchman

261. Page 6 - Witness confirms that once Dr Barton has issued a prescription with a range of doses, the nurse has a discretion to increase the dosage. On page 7, the witness confirms that an increase in dosage would not necessarily involve any further consultation with Dr Barton. If the witness and another nurse had decided that the patient was in distress and pain, they could have increased the dose within the set parameters **[*this is an important point. Check that the experts considered it fully. Also check Barton's evidence. I think that she accepts that nurses could use their discretion to increase the dose within the range if a doctor was not on duty and could not be consulted, provided that the nurses notified the doctor of their decision as soon as the doctor was next on duty]**

262. Page 8 - Witness considers that the patient was given a "normal" dose of medication through the syringe drive. The witness also considers the combination of drugs to be appropriate for somebody in Mrs Richards' condition.

263. Pages 14/15 - The interviewing officer refers to a statement in which the witness appears to have provided in connection with an internal/hospital enquiry relating to the patient's death. The witness says that she hadn't been given a chance to check it and indicates that it is not an accurate reflection of what she said on a different occasion **[*evidence of additional material held by the police which we do not appear to have in our papers]**

264. Pages 17-19 - The witness gives some background information about the content of care plans, making it clear that Mrs Richards was highly/totally dependent.

265. Page 26 - The interviewing officer refers to the patient's care plan and the lack of entries between 14 and 21 August. The officer points out that from 14 to 17 August, the patient was at a different hospital. The witness cannot explain the lack of entries between 17 and 21 August. She acknowledges that she herself should have made an entry on 17 August with regard to nutrition because she can recall sending the patient's lunch back to the kitchen to have it minced. This is not mentioned on the nutrition form. The witness says that she was probably too busy sorting out the patient's pain relief to make the proper entry.

266. Page 31- Witness confirms that on the morning of her re-admission, the patient was in a lot of pain and distress. The witness indicates that she never saw the patient in a position where she would be able to be mobilised.

267. Page 34 - Witness alludes to the behaviour of the daughters towards staff after her mother's death. Witness says she finds it difficult to come to terms with the fact that relatives could be so friendly; at one stage they were sending gifts etc. and making complaints subsequently.

268. **[*ALTHOUGH THIS WITNESS WAS INTERVIEWED AT LENGTH BY THE POLICE, THE POLICE DO NOT APPEAR TO HAVE QUESTIONED HER SPECIFICALLY OR AT LEAST IN ANY GREAT DETAIL ON THE PATIENT'S STAY ON EACH OCCASION THAT THE WITNESS ADMINISTERED MEDICATION. THE WITNESS CAN ONLY GIVE EVIDENCE RELATING TO THE PERIOD BETWEEN 17 AUGUST AND THE PATIENT'S DEATH. SHE DOES SAY THAT WHEN THE PATIENT WAS RE-ADMITTED, SHE WAS EXPERIENCING A LOT OF PAIN, BUT THERE IS NO DETAIL ABOUT HOW THIS PAIN IS MONITORED BETWEEN 17 AND 21 AUGUST. IN CONCLUSION, THEREFORE, THE EVIDENCE IS NOT PARTICULARLY HELPFUL IN TERMS OF CLARIFYING THE DEGREE OF PAIN WHICH THE WITNESS SUFFERED IN THIS PERIOD. THE WITNESS DOES, HOWEVER, CONFIRM THAT NURSES HAD A DISCRETION TO INCREASE DOSAGES WITHIN A PRESCRIBED RANGE WITHOUT NECESSARILY SEEKING PRIOR AUTHORISATION FROM HER DOCTOR]**

File 61 - The statements of Mr Warren and Mr Tanner (10th and 11th statements in the file)

Warren

269. Witness is a leading ambulance man. He has no personal recollection of transferring Mrs Richards to GWMH from the Haslar Hospital on 17 August, but his job record card shows that he did the transfer. (To put the transfer in context, he says that he does approximately 24 transfers a day, five days a week and that since 17 August 1998, he would have transferred approximately 9,000 patients).

270. Referring to his record, he points out the reference "ST" which he says indicates that the patient was moved by stretcher. He says that this "would have been" on a canvas sheet, being the only recognised method of moving a patient by stretcher. **(Note, however, statements from other witnesses - Beed/Couchman which indicates that there was no canvas available and a sheet was used instead.)**

271. Witness also refers to the fact that the job sheet makes no reference of there being any complications during the transfer. The witness said that if there had been complications, this would have been noted.

Tanner

272. Assistant ambulance man also has no recollection of moving this particular patient. Confirms that reference to a job sheet does show that he was involved in the transfer of the patient to GWMH on 17 August. He refers to the usual method of conveyance by stretcher, i.e. using a canvas sheet. Says that this is the only method that would be used to move a stretcher patient. Also confirms that if there had been any complication, these would have been noted on the record sheet. He therefore assumes that there had been a straightforward transfer.

273. **(Neither ambulance man is able to give any useful evidence in connection with the transfer and/or confirm that the patient suffered pain during the transfer).**

File 56 - Tab 9 Police interviews of Dr Lord - Date of interview 27 September 2000 (just over two years after Mrs Richard's death)

274. Page 2 - Confirms that at the date of interview, the witness has been a Consultant Geriatrician since 1992.

275. Page 3 - Witness usually responsible for patients on Daedalus Ward, but in about July 1998 whilst Dr Tandy was on maternity leave, the witness also covered Dryad Ward.

276. Page 8 - Witness said she did ward rounds once a fortnight for both wards, i.e. Dryad Ward one Monday and Daedalus the following Monday. On page 10, witness says that due to the demands of the job, she was also having to pop into the wards on a weekly basis to deal with particular problems notified by nursing or medical staff.

277. Page 13 - Witness said that she had every confidence in Dr Barton, but witness accepts that there is a joint responsibility with regard to prescribing drugs. Dr Barton had authority to prescribe drugs in her absence, but this would be subject to a review by Dr Lord.

278. Page 15 - Lord cannot recall any occasion when she had to question Barton's actions over a particular patient in terms of either level of treatment or type of treatment.

279. Page 16 - Witness refers to Barton as a "very dependable, sensible GP."

280. Page 18 - Witness confirms that she had no contact at all with Mrs Richards during either period that she was admitted.

281. Page 19 - Witness says that she did a ward round on 10 August, the day before the first admittance. She said that she would have been on the ward shortly before the patient fell on 13 August, but she was not alerted to the fact that

there was a problem. The ward round on the 13th was to deal with stroke patients and so Mrs Richards wouldn't have been scheduled for a review.

282. Page 20 - Witness says that on 17 and 18 August, she was on study leave. She would have attended the hospital on 19 August - again to see stroke patients. Mrs Richards would not have been up for a review on that ward round and nobody alerted Dr Lord to the fact that they wanted to see her.

283. Page 21 - Witness appears to be saying that there would have been no consultant cover on 17 or 18 August, but if there had been a problem, a geriatrician at the Queen Alexandra Hospital could have been contacted.

284. Pages 24 and 25 - Lord deals with the prescriptions for Mrs Richards. She refers to prescriptions of Oramorph - 45mg over a 24 hour period.

285. Page 25 - Lord refers to the dose of Diamorphine at 40mg per day in the 4 day period from the 17 August as being "almost static" (presumably meaning no increase in dose).

286. Page 28 - Lord refers to the maximum dose of Diamorphine being up to 250 (mgs?). The witness says it depends on clinical judgement as to how much pain and distress the patient is in as to how much should be prescribed. **[Because the witness did not see Mrs Richards at any stage, she is not in a position to say how agitated or distressed she was.]**

287. Page 32 - The witness is asked as to who is responsible for making the decision as to whether or not a person is dying. The witness says that on a day to day basis, it would be between the nursing staff and Dr Barton. If they had any concern, they could seek advice by telephone. The witness can not recall an incident when it required her to attend in person to deal with such a decision.

288. Page 34 - The witness is asked whether the drugs prescribed would have been a direct cause of the patient's death. The witness does not think that death would have been caused directly, but makes the point that once a patient is sedated they end up with things like chest infection - "it is not a healthy environment to be in".

Tab 9 includes a second transcript of an interview with Dr Lord which starts again at page 1

289. Page 3 -Witness seems to be saying that it is possible to hydrate a patient in a palliative care setting by using a subcutaneous supply of fluids. This can be done if it is felt that hydration was going to benefit the patient. "It is a clinical issue". **(*This raises the question as to whether or not Mrs Richards could have benefited from subcutaneous hydration. Something which the experts may not have considered in any detail).**

290. Page 4 - Witness is asked whether there are any scenarios which would justify not hydrating a patient. Witness says that is justified if the patient is very poorly and not expected to survive very long.

291. Page 12 - Witness says that if it was felt that someone was unlikely to survive more than a few days then she would not necessarily give the patient fluids.

292. Pages 15 and 16 - The interviewing officer shows the witness a copy of the report which she prepared in December 1998 [**I am sure that we have a copy of this elsewhere in the papers - check**].

293. Page 17 - Says the report was prepared quickly over a couple of days.

294. Page 19 - Witness confirms that as her report was prepared with reference to the patient's notes and discussions principally with Dr Barton and Mr Beed.

295. Page 21 - Witness says that for the benefit of hindsight, she would have preferred the nurses or Dr Barton to have contacted her about Mrs Richards when the patient was still alive to notify her that there was some concerns.

296. Page 23 - Witness confirms that sometimes a patient's condition can deteriorate significantly during a transfer from one hospital to another.

297. **Note page 29 is missing from the bundle.**

298. **(WE WILL NEED TO LOCATE A COPY OF DR LORD'S REPORT TO GET A CLEARER UNDERSTANDING OF HER VIEWS AS TO THE MANAGEMENT OF THIS PATIENT. THE POLICE IN THIS INTERVIEW DO NOT APPEAR TO HAVE FOCUSED IN ANY DETAIL ON THE KEY ISSUE OF WHETHER OR NOT THE USE OF THE SYRINGE DRIVER WAS JUSTIFIED, ALTHOUGH THE INFERENCE SEEN FROM DR LORD'S EVIDENCE IS THAT SHE BELIEVES THIS TO BE THE CASE).**

Statement of Nurse Giffin - FILE 56 - Tab 5

299. Staff nurse who worked mainly on night duty on Daedalus Ward, confirms that she was working on Daedalus Ward in August 1998. Specifically, she worked on 20 and 21 August (Mrs Richards died on 21 August) says that on 20 August, Senior Staff Nurse Turbritt was also on duty as were Anne Fletcher and Monique Gallacher, both Health Care Support Workers. (The police interviewed and/or took a statement from Nurse Turbritt to check whether evidence has been obtained from the 2 Heath Care Support Workers).

300. Witness said that when she started her duties on the evening of 20 August, she was aware that Mrs Richards was on the ward and that Mrs Richards was on a syringe driver.

301. Page 3 - Witness says she recalls Mrs Richards being on the ward on a previous occasion, before the patient was sent back to the Haslar Hospital for more treatment. **[The Witness' statement does not deal with this earlier period. Query why the police didn't deal with the earlier period.]**

302. Page 3 - Witness does not recall administering any drugs to Mrs Richards. She said it would be unusual to administer drugs overnight.

303. Page 3 - Looking a the relevant records, the Witness notes that the patient's syringe driver was loaded in the morning on 20 August (whilst the Witness was not on duty). As the driver lasts for 24 hours, the Witness would not expect to have reloaded the syringe driver whilst on night duty.

304. Page 4 - Witness confirms that the patient was not conscious. The Witness did not therefore give the patient any fluid, either orally or subcutaneously.

305. Page 4 - Witness says that she was "not concerned" about the drugs that were administered to Mrs Richards. Witness says that she checked regularly on the patient and the patient appeared comfortable.

306. Witness was present when Mrs Richards died - at 4am on 21 August. The witness pronounced the patient's death.

307. **Firstly, we need to cross-check to see whether this Witness gave any other statements to the police. The evidence in this statement does little to assist in clarifying the main issues, i.e. whether or not Mrs Richards was actually in pain at any stage during her stay at GWMH. All that this statement says is that the Witness was on a syringe driver on 20 and 21 August - which is not in dispute and that the Witness appeared comfortable during this period until she died.**

Notes of Police Interview with Nurse Giffin - FILE 56 - Tab 6

308. The police interviewed Nurse Giffin on 19 June, approximately 2 weeks after she made her statement, referred to above.

309. The first transcript of interview runs to 33 pages. The second part of the transcript starts again at page 1 and runs for 25 pages.

First Section of the Transcript

310. Page 4 - Witness is referred to a statement which she made earlier (see above). She is asked whether she wishes to clarify anything. She says that Nurse Tappett (Turbitt) was not actually based on the ward - she visited the ward at various times during the night.

311. Pages 12/13 - Witness is asked whether she recalls any treatment programme (instigated by Dr) with which she did not approve. She says she cannot recall an example of this.

312. Page 15 - The interviewing officer says this investigation is concentrating on the period between 17 and 21 August.

313. Page 18 - Witness is asked about her recollection of Mrs Richards during this period - "I cannot honestly remember her".

314. Pages 18/19 - Witness does have some recollection of the patient's daughter and having several conversations with the daughter when checks were being made on the patient.

315. Page 19 - Witness confirms that the syringe driver was already in place when she went on duty.

316. Page 20 - Witness explains that syringe driver delivers a steady flow of medication which is more effective at controlling pain than giving the patient injections every 4 or 6 hours. With injections there are "peaks and troughs" in the effectiveness of medication.

317. Page 23 - Witness says that Diamorphine is used principally for pain relief although it can also be used on patients who suffer dementia and scream - "you are never sure whether it is pain or just agitation of mind and Diamorphine does help to address both things at once".

318. Page 25 - Witness appears to regard a dose of 40mgs of Diamorphine as being a "low dose".

319. Page 26 - Witness says that when she was on duty, patient did not show any signs of pain and therefore believes that the dose was appropriate.

320. Page 26 - Witness confirms that she had no discussions with Dr Barton concerning the prescribing of Diamorphine.

321. Page 27 - Witness is asked whether there was anything which made her feel that the patient was dying. Witness says that she doesn't think that anyone would have told her the patient was dying - "they would probably have said that she was not very well' and that she was put onto a syringe driver for "continuing care". However, on page 28, Witness elaborates by saying that she did not expect the patient to recover. She expected a slow deterioration in the patient's condition. When questioned in more detail, Witness seems to accept that the drugs were prescribed for palliative care.

322. Page 29 - Witness confirms that she did not see the patient before 20 August **[*It is doubtful whether this Witness is going to give any real assistance in this case.]**

323. Page 32 - Witness is asked whether anyone ever mentioned what the patient was dying of. Witness says that nothing specific was said.

Section 2 of Police Interview with Nurse Giffin

324. Page 2 - Witness appears to agree that she was not hydrating the patient with a needle because that could affect the patient's capacity to absorb the drugs.

325. Page 4 - Witness is asked to comment on the patient's notes notwithstanding the fact that the patient was not involved in preparing the notes. Witness notes the reference in the notes on 21 August to the patient's rattley chest. The Witness does not recall the patient having a rattley chest, although she does not appear to be saying definitely the patient did not have a rattley chest.

326. Page 7 - The Witness confirms that the daughters prepared their mother to go to the mortuary.

327. Page 21 - The Witness is questioned again about the fact that she has no recollection of the patient having a rattley chest. She says that as the patient had been receiving Hyoscine for a few days this might have sorted out the rattley chest, i.e. the medication may have dealt with the problem before the Witness came on duty.

328. **NURSE GIFFIN PROVIDED ANOTHER STATEMENT WHICH IS INCLUDED IN FILE 2. I HAVE SUMMARISED THE CONTENTS OF THAT STATEMENT IN PARAGRAPHS 20 - 27 OF MY GENERAL NOTES. GIFFIN REFERRED TO BARTON AS A COMPETENT DOCTOR, BUT CRITICISED HER FOR AUTHORISING THE USE OF SYRINGE DRIVERS AS A MATTER OF COURSE. ALSO SAID IN HER EARLIER STATEMENT THAT IT WAS OPEN TO NURSING STAFF TO USE THE DRIVERS AT THEIR DISCRETION. SHE AND HER COLLEAGUES ARRANGED A MEETING WITH MANAGEMENT TO EXPRESS THEIR CONCERNS. CHECK TO SEE WHETHER THE STATEMENT WAS MADE BEFORE OR AFTER THE STATEMENT REFERRED TO IN THESE NOTES.]**

Transcript of Interview with Nurse Tubbritt - FILE 57 - Tab 17

329. Nurse Tubbritt was interviewed on 28 June 2000. She is a Senior Staff Nurse, working on night duty. **[*Check to see whether this Witness gave any previous statements to the police regarding concerns expressed by staff in 1991.]**

330. Page 7 - Witness has only a vague recollection of the patient. Recalls the night that she died. Remembers that one of the daughters asked her if she could pass on a book from the daughter to a colleague. Apart from this, Witness says she had no further contact with the patient or her family.

331. Page 7 - The book in question was something to do with spiritualism and it was to be passed to Staff Nurse Jeannette Florio **[It would appear that this Nurse had some dealings with the patient and/or her relatives. Check to see whether the police interviewed her.]**

332. Page 9 - The Witness has no recollection of the relatives expressing any concerns about their mother's treatment.

333. Pages 17/18 - Witness seems to be saying that where a range of dosage has being indicated by a doctor, the nurse has some leeway as to the actual dose. However, the nurse would usually try and contact the doctor to discuss any variation in dose. There is an inference that if the doctor is unavailable, for example during night duty, a nurse may vary a dose, but discuss this with the doctor in the morning. Witness says that at some point during the patient's care, the doctor would give an indication to the Nursing Staff as to the requirements.

334. Page 20 - Witness confirms that Nursing Staff did not have "carte blanche" to vary dosages. She gives an example of increasing doses of Oramorph to deal with breakthrough pain and with the dose being calculated with reference to the dose which the patient received the previous day. [Presumably the calculation would be made with reference to the BMF. ***The Witness refers specifically to Oramorph, would the same apply to Diamorphine?]**

335. Pages 22/23 - Witness cannot remember any time during her career where she had a problem with a course of treatment which had been prescribed by someone else.

336. Page 23 - However, the Witness does refer to concerns ____________ as previously when syringe drivers were first introduced. **[Cross-refer to the statement which she made separately which is included in File 2. The summary of her evidence appears at paragraph 34 of my general notes. In that statement, the Witness expressed a concern that staff had not been properly trained to use syringe drivers. She refers to a staff meeting in connection with this without specifying the date of the meeting. She is not critical of Dr Barton in her earlier statement.]**

337. Page 28 - Witness confirms that she did not make any of the notes in the nursing records relating to this patient. On page 29, she is asked about gaps in the Care Plan Record. She puts this down to staff not having sufficient time to complete them.

338. Page 34 - Witness says that patients were not given fluids subcutaneously if it was not going to make any difference to the patient's condition.

339. Page 35 - Witness confirms that it would be inappropriate to hydrate a patient who was dying where the hydration would make no difference to the outcome.

340. Page 38 - Witness confirms that her contact with Mrs Richards was minimal. **[The Witness does not appear to be in a position to give any relevant evidence in the GMC case.]**

Statement of Anne Funnell - FILE 56 - Tab 4

341. Witness is the Medical Records Manager at the Haslar Hospital. She produces a copy of the patients' medical records whilst at the hospital including x-ray images.

Statement of Lesley Humphrey - FILE 56 - Tab 7

342. Witness is a Quality Manager employed by Portsmouth Healthcare NHS Trust.

343. The Witness produces various records relating to the patient. **[Note in particular, reference to the contact record on page 5 which lists various members of staff who made entries on the record - Brewer, Beed, Joice, Couchman, Florio and Giffin. The majority of the entries are by Beed and Couchman.]**

344. Page 6 - The Witness produces, inter alia, copies of the nursing care plan and prescription sheet for the patients. **[We need to check that copies of these documents are included in our papers.]**

345. Page 7 - Witness produces some additional documents including letter of complaint from Mrs Lack and dated 20 August 1998; also a copy of an internal enquiry undertaken by Mrs Hutchins in response to the complaint and dated 11 September 1998; a letter dated 22 September 1998 sent by the Trust to Mrs Lack in reply to her letter of complaint referred to above. **[*Check to make sure that copies of all these documents are in the papers.]**

346. Pages 7/8 - Witness produces a copy of a report prepared by Dr Lord on 22 December 1998 **[Check to make sure we have a copy of the report in the papers.]**

Police Interview with Catherine Marjoram - FILE 57 - Tab 11

347. Pages 4/5 - Witness was a night duty Staff Nurse in August 1998 **[Witness does not appear to have given a previous statement but I'll double-check previous notes.]**

348. Page 5 - Referring to a duty rota confirms that she was on duty on the nights of 16/17 August 1998.

349. Page 6 - Witness says that she was on duty previous week when the patient was admitted.

350. Page 7 - Witness appears to be saying that she was on duty on the day that the patient was first admitted to GWMH (11 August?) and that she was also on duty the following week when the patient was re-admitted (on 17 August?). However, her evidence as outlined in the transcript is not very clear.

351. Page 8 - Witness says she cannot remember Mrs Richards, or her daughters.

352. Page 9 - Witness says that she worked with 2 Care Support Workers whilst on night duty i.e. a total of 3 staff worked on night duty. These Support Workers do basic nursing under instruction from the qualified nurse.

353. Page 18 - Witness refers to a dose of 40mgs of Diamorphine as "minimal".

354. Pages 18 - 20 - Witness appears to be saying that a nurse has a discretion to increase the dose if the patient's pain is not being controlled with a lower dose **[There is no reference to the nurse having to seek prior authorisation from a doctor to do this.]**

355. Pages 20 - 22 - With reference to the prescription record confirms that she gave the patient some Oramorph at 12.30am on 18 August. On page 22, Witness points out that this is an usual time to give a patient medication and the Witness therefore concludes that the patient was "obviously in pain" by way of clarification, she says that the drug rounds are usually done at 10 o'clock (10pm?) and was therefore unusual to administer medication at 12.30am.

356. Page 23 - Witness appears to be saying that it is not actually right in the notes that Mrs Richards was in pain at the time that the Oramorph was administered, although the Witness plainly believes this to be the case. **[*HAVE THE EXPERTS CONSIDERED THIS EVIDENCE AND/OR ATTACHED SUFFICIENT WEIGHT TO IT?]**

357. Page 24 - Witness also conclude the patient was probably not it pain when the Witness did her drugs round at 10pm, i.e. the pain developed between 10pm and 12.30am **[CHECK TO SEE WHETHER THE POLICE ASKED THE WITNESS LATER IN THE INTERVIEW WHETHER THE DOSE ADMINISTERED AT 12.30AM ON 18 AUGUST WAS SUCCESSFUL IN CONTROLLING THE PATIENT'S PAIN.]**

358. Page 26 - Witness confirms that the combination of drugs prescribed to be used in the syringe driver can be used when a person is very ill and close to death,

but in the case of this particular patient, the Witness believes that the drugs were administered to make her "less distressed and more comfortable."

359. Pages 26/27 - Witness is asked whether she recalls any signs of the patient's dementia. The Witness says that when the patient was first admitted, she seemed to call constantly, she was distressed and "obviously, she'd had the hip done, which is very painful." **[Is not clear whether the Witness is speaking from her direct recollection here or telling the police what she believed was the case. In summary, she seems to be saying that the calling out and distress may have been a combination of dementia and pain. However, there seems to be some confusion about the timing as the Witness appears to be describing pain following the procedure to deal with the dislocation as opposed to the residual pain from a hip replacement operation. When the patient was initially admitted to GWMH, she had had the hip replacement. She then suffered a dislocation and had to go back to the Haslar Hospital.]**

360. Page 27 - The Witness says that she gave the patient Oramorph on the second to last occasion. It is not clear who gave the patient her last dose of Oramorph before she went onto the syringe driver.

361. Page 27 - Witness is asked whether she did anything to try and locate the source of the pain.

362. Page 28 - Witness says that a Nurse would try to make a patient comfortable before resorting to the use of drugs.

363. Page _____ - Witness says that attempts would be made to reposition a patient and give the patient a drink as part of an assessment practical before deciding whether "major analgesia" was necessary. **[However, it is clear that the Witness is talking about the position generally here and not specifically about this particular patient because when she is asked whether she can recall trying to reposition Mrs Richards, she has no recollection of this.]**

364. Page 32 - Witness says that the patient's treatment would be reviewed on a daily basis.

365. Page 34 - Witness is asked whether she's ever had any problem or issue with the patient's treatment regime. The Witness said she's never had a problem.

366. Pages 36/37 - Witness explains that there is a difference between the sort of cry made by somebody who is demented and someone who is in pain. A demented person often wails, whereas if they've hurt themselves, they tend to sob. Witness also says there are other signs that a person may be in pain as they may, for example, hold part of the body that is hurting them and seek to protect that part of the body. Witness says that it is difficult to distinguish the two.

[*The interviewing officer does not go on to seek clarification as to how the witness found the patient at 12.30am on 18 August when she administered a dose of Oramorph. However, the Witness has said earlier in the interview that she believed that the patient was in pain at the time.]

Section 2 of the Transcript of Interview with Catherine Marjoram

367. Pages 3/4 - The interviewing officer questioned the Witness again about the decision to administer Oramorph (12.30am on 18 August (?). Earlier in her interview, the Witness refers to the fact that the patient was in pain at the time.) On further questioning, it is clear that the Witness cannot specifically recall the circumstances in which she gave the patient some Oramorph. She has no specific recollection. **[Therefore, what the Witness said earlier about the patient being in pain at the time appears to be an assumption on her part.]**

368. Page 7 - Witness says that if a patient is dying, you would not take steps to re-hydrate them as it would not be in their best interest.

369. Page 9 - Witness says that on the nights of 17 and 18 August, she cannot recall whether she attempted to give the patient a drink. All the Witness can say is that if it had been possible to give the patient a drink, she would have done so.

370. **[*THE EVIDENCE THAT THIS WITNESS HIGHLIGHTS IS A DIFFICULTLY WE ARE LIKELY TO ENCOUNTER GENERALLY IN THIS CASE - SHE CANNOT SPECIFICALLY RECALL THE PATIENT IN QUESTION AND CAN ONLY REALLY REFER TO THE NURSING NOTE AND GENERALISED COMMENTS ABOUT PATIENT CARE. THE WITNESS CLEARLY BELIEVES THAT THE REASON SHE GAVE THE PATIENT ORAMORPH AT 12.30AM ON 18 AUGUST WAS DUE TO THE PATIENT'S PAIN. THE EXPERTS NEED TO CONSIDER THIS WITH OTHER REFERENCES TO THE PATIENT BEING IN PAIN WHICH IS INCLUDED IN WITNESS STATEMENTS AND INTERVIEWS WITH OTHER NURSES, PRINCIPALLY BEED AND COUCHMAN.]**

Statement of Geraldine McCarthy - FILE 57 - Tab 12

371. Witness is a Healthcare Support Worker. Worked on Daedalus Ward in August 1998. With reference to a duty rota, Witness confirms that she was on duty between 7.30am and 1.30pm on 18 and 19 August and between 1.15pm and 8.30pm on 21 August. She cannot recall any details of Mrs Richards' care whilst she was in Daedalus Ward.

372. **[Doesn't appear that this Witness can give any useful evidence in this case.]**

Transcript of Interview with Jean Moss - FILE 57 - Tab 13

373. Witness was a nursing Auxilliary also described as a Healthcare Support Worker, i.e. principle role is to assist the nursing staff in the care of patients.

374. Page 9 - Witness refers to circumstances relating to the patient's re-admission to GWMH (on 17 August(?)). Witness has no recollection of the first occasion on which the patient was admitted.

375. Witness says that the patient was crying out and moaning as she was brought into the Ward on a trolley by the ambulance men. Ambulance men apologised because they did not have any canvas to use for the transfer (elsewhere other witnesses have described how canvas is used to transfer patients from a stretcher to a bed, being the preferred option for transferring patients in terms of patient comfort.)

376. Page 10 - Witness describes the patient being lifted on a sheet by the ambulance men onto the bed. The patient was then rolled gently onto her side and the sheet used to transfer her was removed. The Witness says that the patient's leg was "crooked" and that she was crying out in pain. Someone went to fetch Nurse Couchman. She straightened the patient's leg and placed a pillow between her legs.

377. Page 10 - Witness explains that if canvas is used, poles can be inserted in holes and this make the canvas more rigid and therefore offering more support.

378. Page 12 - Witness understood that the patient was in pain when she was moaning and crying out **[Need to check that the experts have considered this evidence and/or attached sufficient weight to it.]**

379. Page 14 - Witness cannot recall whether she had any further contact with Mrs Richards in the days following the incident referred to.

380. Page 15 - Witness is asked about the patient's condition from 17 August onwards. **[It is not clear why the police have asked the question when the Witness has said earlier in the interview that she had no further recollection of her.]** However, in answer to the question, Witness says that the patient was not a "well lady" - "to my mind she was just a poorly lady."

381. Pages 21/22 - The Witness' attention is drawn to the fact that there are no entries in the nursing record between 17 and 21 August. Witness appears to be saying this may be due to the fact that there was nothing to recall of any significance in that period. She is asked if the patient's relatives cared for the patient in that period of time. Witness believes that the patient was fed by her relatives on occasions, but she is not entirely sure.

382. Pages 23/24 - Witness indicates that the patient's daughters were rather demanding. On page 24, she refers to an invitation which she received after the patient's death from Mrs McKenzie. This was to attend a spiritual meeting in Chichester with Margaret Couchman and Lynda Boldecino. Witness says she attended the meeting. Witness says there was no indication whatsoever that Mrs McKenzie had a problem with the way that her mother had been dealt with. The Witness also said that the relatives gave gifts of books to certain members of staff.

383. Page 25 - Witness also recalls that the daughters made a gift of a chair to the Ward.

384. Page 26 - Witness confirms that she had no role in administering drugs.

385. Pages 33/34 - Witness has obviously seen a copy of a witness statement prepared by Mrs McKenzie. Witness disagrees with some of the detail in the statement - says that there is no was a member of staff would have said "Well, thank goodness you've come because she won't eat, while I'm trying to make her eat". Witness also disputes that on the transfer, the patient was rolled off the stretcher onto the bed. The Witness says that the patient was lifted from the stretcher and put onto the bed.

386. On page 35, Witness says that she cannot recall either daughter being present at the time although he does not seem to be absolutely clear about his.

387. Page 37 - Referring to Mrs McKenzie's statement, it appears to become clear that in fact she was not present when her mother was transferred from the stretcher to the bed. Her account is based on information received from someone else - Lynda (the other Auxilliary Nurse(?)).

388. Pages 38/39 - Witness disputes that Philip Beed would have told the relatives that the pain relief was to "aid" the patient in dying. The Witness believes that Beed would have told them that the medication was to help with the pain, but there was no way, in the Witness' view, that Beed would have said that the medication was to help Mrs Richards to die. **[Apparently, this is stated on page 19 of Mrs McKenzie's statement.]**

389. Page 39 - Witness refers to Dr. Barton as a good doctor - "I would trust her with my life".

390. Page 40 - Referring to page 7 of Mrs Lack's statement which alleges that her mother's crying out was misinterpreted by staff, i.e. that her mother was shouting out because she was suffering from dementia rather than being in pain - Witness says that on this page and on the subsequent page, that whilst the patient was anxious, she was also in pain.

391. Page 41 - The Witness notes the different accounts of Mrs McKenzie and Mrs Lack concerning the feeding of their mother. Mrs Lack says in her statement that a Care Assistant told her that it was not possible to feed her mother because she was screaming all the time. Witness points out that that is a different account to the account given by Mrs McKenzie (referred to earlier).

392. ***THE WITNESS CHALLENGES THE CREDIBILITY OF MRS MCKENZIE. IN PARTICULAR, THE WITNESS CAN GIVE EVIDENCE RELATING TO THE MODE OF TRANSFER FROM STRETCHER TO BED ON THE PATIENT'S READMISSION AND WILL SAY THAT THE PATIENT WAS IN OBVIOUS PAIN AT THE TIME. BEYOND THIS, THERE IS VERY LITTLE ELSE WHICH THE WITNESS CAN CONTRIBUTE.**

GENERAL MEDICAL COUNCIL AND DR. BARTON

CASE SUMMARIES AND COMMENTS

1. **Pittock**

1.1 Aged 82 on admission. One of the experts - Black - believes patient was probably terminally ill on admission.

1.2 Patient was assessed by Dr. Lord on the day before his admission - assessed his prognosis as being poor. Chances of survival slim. Unlikely to survive for long.

1.3 On transfer to Dryad Ward, Dr. Tandy, Consultant Geriatrician, had overall medical responsibility. (She worked on the Ward until late 1996.) Her responsibilities included a Ward Round once a fortnight.

1.4 Dr. Tandy saw the patient on 10 January 1996, five days after he was admitted. She prescribed 5mg Oramorph to alleviate pain and distress.

1.5 Dr. Barton, in her witness statement, "believes" (emphasis added) that she reviewed the patient on 15 January 1996 and "believes" that his condition had deteriorated with significant pain and distress.

1.6 It appears that Barton prescribed Diamorphine on 15 January 1996 - it also appears that this was without reference to Dr. Tandy.

1.7 Dr. Tandy, in her witness statement, comments that she would have used a lower dosage of Diamorphine and Midazolam - her practice being to use the lowest dose to achieve the desired outcome, and to reduce adverse effects.

1.8 Nurse Hamblin, the Sister, refers to an increased dosage of Diamorphine on 18 January, six days before the patient died. **[Check to see whether the increase in dosage was authorised/sanctioned by Dr. Barton.]**

1.9 The key clinical team observed that the patient was physically and mentally frail. The team concluded that the patient was probably Opiate toxic, but notwithstanding this, the dose was not reduced. Cause of death - unclear. Opiates "could" have contributed.

1.10 Two experts have reviewed the case, Dr. Wilcock, expert in Palliative Medicine, Dr. Black, a specialist in Geriatric Medicine.

1.11 As a general observation in this and the other cases, Dr. Wilcock tends to be more bullish in his conclusions compared to Dr. Black who is more circumspect.

1.12 Wilcock refers to Barton's poor medical note keeping. In her witness statement, Barton admits to this, but seeks to explain the deficiency with reference to

substantial work place demands. Says that a choice had to be made between detailed note making or spending more time with the patients. Also seeks to explain the policy of "pro-active prescribing" with reference to the demands of work. **[This is a reference to prescribing doses of Diamorphine and other drugs within a range of doses to be administered on an "as required" basis. This needs to be fully investigated to determine whether or not nurses sought authorisation from Dr. Barton before administering medication which had been prescribed in this fashion, and/or when increasing a dose. It is also not clear why it was necessary to prescribe in this way given that Dr. Barton attended the hospital every weekday.]**

1.13 Wilcock says that the patient's pain was not appropriately assessed. We need to check how he reached this conclusion. Is it a case that there was no written assessment? Is there any evidence that a proper assessment was made, but not recorded in the notes?

1.14 Wilcock refers to the inappropriate administration of Opiates to relieve anxiety and agitation. **[Check records to identify day/days on which this occurred. Also check to make sure that at the same time the patient was not suffering pain at the same time which would justify the prescribing of Opiates. Also check whether this criticism is directed solely at Barton or whether it includes the prescription of Oramorph issued by Dr. Tandy on 10 January1996.]**

1.15 Wilcock refers to doses of Diamorphine in the range 40-120mgs as being excessive to the needs of the patient and far in excess of an appropriate starting dose. Says that an appropriate dose would be 10-15mgs. **[We need to check what dosages were actually administered as opposed to being prescribed.]**

1.16 Wilcock's overall conclusion is that Barton breached her duty of care to the patient by failing to provide treatment with skill and care, but "it is difficult to exclude completely the possibility that the dose of Diamorphine that was excessive to his needs may have contributed more than minimally, negligibly or trivially to his death".

1.17 Wilcock also believes that the certified cause of death - Bronchopneumonia appears to be the most likely cause of death.

1.18 Dr. Black, in his report, refers to the patient's condition being extremely frail. The patient was at the end of a chronic period of disease spanning more than 20 years. The patient suffered from depression and drug related side effects.

1.19 Black refers to a problem in assessing the standard of care due to a lack of documentation. He agrees with Wilcock in that the lack of notes represents poor clinical practice.

1.20 Black refers to "suboptimal" drug management. **[Check to see this is directed solely at Barton or whether it also includes Dr. Tandy.]**

1.21 Black notes that the starting dose of 80mgs of Morphine was approximately three times the dose that is conventionally applied. Black also says that the combination of drugs (Diamorphine and Midazolam/Noizinan) are likely to have caused excessive sedation and may have shortened the patient's life by a short period of time - "hours to days" - "medication likely to have shortened the patient's life, but not beyond all reasonable doubt".

1.22 Other features noted include the following: the patient's own GP, Dr. Brigg, was consulted about the patient on 20 January 1996 - four days before the patient died. **[We need to check the circumstances in which Dr. Brigg became involved. To what extent did he review his patient's medication as prescribed by Dr. Barton. It appears that he did not vary the prescription for Diamorphine and therefore presumably believes it was appropriate.]**

1.23 Police have taken a statement from the patient's daughter, Mrs. Wiles, who is also a retired Registered Mental Nurse. Her understanding is that her father was transferred to Dryad Ward for terminal care. She believes that he died through "self neglect" - he was extremely frail and had lost the will to live. She did not take issue with the fact that her father was prescribed Morphine and she considered this to be appropriate.

Initial View

1.24 There is sufficient evidence to pursue the charges relating to inadequate note keeping, inadequate assessment (possibly) and prescribing/administering medication, including Diamorphine, in excess of the patient's needs. The conclusions of the two experts are not strong enough to sustain a charge that the standard of care resulted in premature death. Further work needs to be done with the experts to particularise the charges and to clarify whether Dr. Tandy is also culpable.

1.25 The police file contains 19 statements taken from witnesses of fact. Approximately ten of these would appear to be "key witnesses".

1.26 Our overall assessment is that this case is possibly suitable for a referral to the Fitness to Practice Panel, but is not one of the strongest cases.

2. **Lavender**

2.1 The patient was aged 83 when she was admitted to Daedelus Ward on 27 February 1996.

2.2 Her son refers to the fact that she was transferred to Daedelus from the Haslar Hospital where she had been recovering from a fall. The son says she was making an excellent recovery and the Occupational Therapist was considering a possible return of the patient to her home. She was coherent and walking with the assistance of a frame. A couple of days after admission to Daedelus Ward, Dr. Barton told the son that his mother had "come here to die". His mother deteriorated rapidly. The witness was not aware that Diamorphine was being administered by a syringe driver until the day prior to her death.

2.3 The patient was seen by Consultant Geriatrician, Dr. Tandy a few days before she was transferred to Daedelus Ward. The Doctor recorded that the patient had most likely suffered a brain stem stroke leading to the fall. Agreed to transfer of the patient to Daedelus Ward for rehabilitation. **[Check whether Dr. Tandy had any further involvement in the patient's care. Note that the other Consultant, Dr. Lord, was on annual leave between 23 February and 18 March 1996 and had no input into the treatment or care of this patient. She also says in her statement that no locum cover was arranged in her absence.]**

2.4 Barton's statement confirms that she did an assessment on the patient's transfer to Daedelus Ward. It says that the prognosis was not good. The patient was blind, diabetic, had suffered a brain stem stroke and was immobile.

2.5 Morphine was first prescribed on 24 February. The dose was increased on 26 February because the patient's bottom was very sore (pressure sores).

2.6 Barton wrote up a "pro-active prescription" for further pain relief which included Diamorphine. It was "pro-active" on the basis that nursing staff could contact her if necessary and she could authorise dosages as necessary within the dosage range.

2.7 Barton saw the patient again on 29 February and 1 March and noted that her condition was slowly deteriorating.

2.8 On 4 March, the dosage of slow-release Oramorph was increased.

2.9 Barton saw the patient again on 5 March and claims that the pain relief was inadequate. Barton authorised the administration of Diamorphine and Midazolam by syringe driver. Barton claims that the doses were appropriate in view of the uncontrolled pain. The patient died on 6 March. Barton certified death as Cerebrovascular Accident.

2.10 Dr. Black reports that it is likely that the patient was suffering from several serious illnesses and entering the terminal phase of her life when she was admitted. He notes that she was suffering constant pain to her shoulders (in addition, there were serious abnormalities in various blood tests).

2.11 He believes that the patient was mis-diagnosed (presumably both prior to her admission to Daedelus Ward (at the Haslar Hospital) and after her admission). The patient had, in fact, suffered a quadriplegia resulting from a spinal cord injury, secondary to her fall.

2.12 Black says that negligent medical assessments took place both at the Haslar and the Gosport Hospitals. In particular, her medical diagnosis was made to determine the cause of the pain, which he says is consistent with spinal cord fracture. **[From what he says, there was a joint failure to conduct a proper assessment and the doctor(s) responsible for the patient's care at Haslar are also culpable.]**

2.13 **Check to see whether Black has considered the fact that Dr. Lord, the Consultant, was on leave at the time. Should Barton have sought specialist advice elsewhere?**

2.14 Both Black and Wilcock refer to excessive doses of Diamorphine/Midazolam (Wilcock, in addition, thinks that earlier dosages of Morphine may also have been inappropriate/excessive to the type of pain experienced).

2.15 Wilcock says that the excessive doses of Morphine/Midazolam could have contributed towards her death. Black cannot say beyond all reasonable doubt that the patient's life was shortened.

Initial Views

2.16 The probability that the cause of pain was misdiagnosed, not only by Dr. Barton, but by the doctors at Haslar, before the patient was transferred to Gosport, makes this case more difficult to assess.

2.17 Further work needs to be done to determine whether a stronger case can be made relating to Dr. Barton's failure to seek specialist advice in view of the deterioration in the patient's condition leading to increased dosages of Morphine and the use of Diamorphine.

2.18 Both experts agree that at least some of the dosages of Diamorphine/Midazolam were excessive to the patient's needs. The opinions of the experts are not strong enough to sustain a charge that the patient's life was shortened.

2.19 Police took 32 witness statements and approximately 15 witnesses would fall within the category of "key witnesses".

2.20 There is sufficient evidence to refer the case on the basis of the excessive use of Diamorphine/Midazolam and possibly the failure to seek specialist advice, as part of an assessment to diagnose the underlying cause of a patient's pain.

2.21 The inappropriate prescribing of Diamorphine/Midazolam may only relate to one or two particular occasions. There may be other cases where prescribing took place over a longer period and where a stronger case may be made out.

3. **Lake**

3.1 The patient was aged 84 when she was admitted in August 1998. She had suffered a fall and broken a hip. She spent 2-3 weeks at the Haslar Hospital where she received a new hip. She was transferred to Gosport to recuperate and was expected to be discharged at some stage.

3.2 Patient died within 3 days of admission. On the first day at Gosport, she was able to talk to her family. On the second day, she became agitated and distressed. The next day, she was asleep and unable to respond either orally or through hand gestures. During the last two days of her life, she was receiving medication through a syringe driver. **[The case summary gives the (perhaps misleading) impression that there was very little wrong with her general health when she was first admitted to the Hospital following her fall. However, the notes later refer to an earlier admission to hospital in June where there is a record of her suffering from chronic renal failure and irregular heart beat. There is also reference in her medical history to a heart attack, irregular heart beat and raised blood pressure. In addition, she had poor circulation in her fingers and difficulty in swallowing.]** Despite these and other ailments, at the time of her fall, she was usually mobile, independent, and self caring. Following her hip replacement operation, she had problems with vomiting and shortness of breath. Blood tests revealed on-going renal impairment. On 10 August, she was reported to be unwell, drowsy and experiencing vomiting and diarrhoea. Her pulse increased and became irregular.

3.3 An x-ray revealed an infection at the base of the left lung and no heart failure. She was given antibiotics intravenously and started to improve.

3.4 Her improvement continued and on 12 August, antibiotics and intravenous fluids were discontinued. Her post-operative recovery was slow.

3.5 She was assessed by Dr. Lord who recorded "It is difficult to know how much she will improve" and she was referred to Gosport for continuing care. The summary in Dr. Lord's assessment recorded the patient as being "frail and quite unwell" and it uncertain as to "whether there will be a significant improvement".

3.6 Nursing records for 15 August record some pain due to arthritis.

3.7 On 17 August, the medical notes record that she was well, did not have a raised temperature or chest pain, that she was mobilising slowly and awaiting transfer to Gosport.

3.8 Her transfer letter written for staff at Gosport noted that she had made a slow recovery from the operation, exacerbated by bouts of angina and breathlessness.

3.9 Dr. Barton made an entry in the patient's medical notes on the day of transfer. This included reference to her operation, and past medical history including angina and congestive heart failure.

3.10 Nursing notes confirm that Morphine was administered on 18 August (5mgs) and 19 August (10mgs). The reason for the dose of Morphine on 18 August is not apparent. The nursing notes indicate that she had settled quite well and was fairly cheerful. On 19 August, she awoke very distressed and anxious and the nursing notes record that the Oramorph that had been given to her had very little effect.

3.11 The nursing notes on 19 August indicate that she was walking, albeit unsteadily. There is also reference in the notes of the patient being very breathless and complaining of chest pains.

3.12 There are various references to prescriptions for Diamorphine. The dosages ranging between 20mgs and 60mgs.

3.13 Dr. Wilcock and Dr. Black highlight a lack of information recorded in the patient's notes. Black regards this as a major problem in assessing the level of care. Both experts make assumptions that the patient was not adequately assessed by Dr. Barton, because there is no indication in the records that a proper assessment took place.

3.14 Dr. Wilcock also assumes that a further assessment did not take place when the patient complained of chest pain.

3.15 Both Doctors are critical of the lack of justification given for the prescription of Morphine and the decision to commence the use of a syringe driver.

3.16 Dr. Wilcock states that the lack of documentation makes it difficult to understand why the patient may have deteriorated so rapidly. He says that a thorough medical assessment when the patient complained of chest pain <u>may have</u> (emphasis added) identified treatable causes of the pain, e.g., chest infection.

3.17 Wilcock also says that it is <u>possible</u> (emphasis added) that the patient's deterioration was temporary/reversible.

3.18 Wilcock refers to the <u>apparent</u> (emphasis added) inappropriate use of medication.

3.19 There is evidence to show that whilst this patient suffered complications following the hip replacement operation, at the time she was transferred to

Gosport, there is a possibility that she would make a recovery. The experts are not able to explain the rapid deterioration in her condition leading to her death, within 3 days of transfer. The experts are hindered by the lack of documentation. They assume that thorough medical assessments have not taken place. Dr. Barton may disagree with this, but in any event, she will admit that she failed to keep proper notes.

3.20 The police took 41 statements from witnesses of fact. The statements will need to be analysed to identify the key witnesses. For present purposes, assume that approximately 15 witnesses will fall into the key witness category.

Initial Views

3.21 Lack of documentation in this case has made it difficult for the experts to reach any firm conclusions. There is certainly sufficient evidence to bring charges in relation to inadequate note keeping and possibly inadequate assessment of the patient's condition on transfer and after the patient complained of chest pains. On the available evidence, it would be more difficult to pursue charges relating to excessive use of Morphine/Diamorphine.

3.22 Further investigation will need to be undertaken to assess the role of Dr. Lord. It is possible that as the patient was only at Gosport for three days, she was not seen by Dr. Lord and Dr. Lord did not review the medication prescribed by Dr. Barton.

4. **Wilson**

4.1 The patient was 74 when he was admitted to the Hospital in October 1998. He died four days after admission.

4.2 Admitted with a fracture to the left humerus. Before his transfer, whilst he was being cared for at the Queen Alexandra Hospital, he was prescribed Paracetamol and Codeine for pain relief.

4.3 On transfer to Gosport, Dr. Barton prescribed Oramorph despite the fact that the patient had liver and kidney problems **Code A** and these problems made the body more sensitive to the effects of Oramorph.

4.4 Patient deteriorated and was converted to a syringe driver and received Diamorphine. Over the next two days, the dose was increased without obvious indications.

4.5 It appears that Dr. Knapman was the GP who covered for Dr. Barton. In his police statement, he says that the prescriptions written up by Dr. Barton were not excessive.

4.6 In the days immediately preceding the patient's death, on 17 and 18 October, he was seen by Dr. Peters, a Clinical Assistant at the Haslar Hospital. Dr. Peters was covering for Dr. Barton **[the police summary of Dr. Peters' evidence does not say whether he agreed with and/or varied the prescriptions written by Dr. Barton.]**

4.7 Dr. Barton, in his statement, justifies writing up a "pro-active regime" of Diamorphine in the event of the patient's deterioration. She states further that it was her expectation that the nursing staff would endeavour to make contact with her or the duty doctor before starting the patient on Diamorphine at the bottom end of the dose range.

4.8 Dr. Wilcock refers to the patient's multiple medical problems - cirrhosis/liver failure, heart failure and kidney failure. Patient also suffered from dementia and depression.

4.9 Wilcock notes that the pain he experienced following his fracture progressively improved during his stay at the Queen Alexandra Hospital. The doses of Morphine given there were reduced to 3mgs.

4.10 On his transfer to Dryad, he was prescribed 5-10mgs of Morphine, as required for pain relief. He received doses of Morphine despite the general expectation that the pain from the fracture would continue to improve over time.

4.11 Dr. Wilcock refers to a lack of clear note keeping and an inadequate assessment of the patient and he places blame for this on Dr. Barton and Dr. Knapman, the Consultant.

4.12 Dr. Wilcock also refers to doses of Diamorphine being administered - initially 20mgs, subsequently increased to 60mgs. Dr. Wilcock states that the increase in dose is "difficult to justify" as the patient was not reported to be distressed by pain.

4.13 Dr. Wilcock cannot state with any certainty that the doses of Morphine or Diamorphine contributed to the patient's death because of the possibility that heart and/or liver failure caused the death.

4.14 Dr. Black refers to "weaknesses" in the documentation of the patient's condition on admission, when strong Opiate Analgesia was commenced.

4.15 Black says that if clinical examinations were undertaken, they have not been recorded.

4.16 Black refers, in particular, to the prescription of 50mgs of Oramorph on 15 October which he believes was not an appropriate clinical response to Mr. Wilson's pain.

4.17 Further, Black considers that the medication prescribed in the period 15-16 October more than minimally contributed to the patient's death on 19 October. **[Has Dr. Black considered Dr. Peters' involvement on 17 and 18 October and the apparent failure to correct Dr. Barton's inappropriate prescriptions?]**

4.18 Professor Baker has also prepared a report. He says firstly that the Death Certificate inaccurately recorded that Mr. Wilson died of renal failure.

4.19 Professor Baker also believes that the administration of Opiate medicine was an important factor leading to the patient's death. On the evidence available, Baker says that the initial prescribing of Opiate medication was inappropriate and the starting dose was too high.

4.20 Baker refers to the reasons for not using non-opiate drugs for pain relief are not given in the medical notes.

4.21 A further expert report has been obtained from Dr. Marshall, a Gastroenterologist. He describes the administration of high doses of Morphine as "reckless". This is because warnings about using Morphine in the context of liver disease are readily available in the Standard Prescribing Guides.

4.22 Dr. Marshal considers that the impact of regular Morphine administration is likely to have hastened the patient's decline.

4.23 Note that this patient's case was investigated by the police as part of their initial investigation into four other patients. At the earlier stage in the investigation, the police instructed two different experts, Dr. Mundy and Dr. Ford. The former is a Consultant Physician and Geriatrician, the latter is a Professor of Pharmacology.

4.24 Mundy is critical of the standards of care given in this case - in particular, the fact that non-opiate analgesia was not initially considered and the fact that there was large dose range for Diamorphine. However, Mundy does express a view that the palliative care given in this case was appropriate.

4.25 Dr. Ford's conclusions concerning this patient need to be checked.

4.26 The summary of police evidence refers to a statement taken from Dr. Lord, the Consultant Geriatrician. She was on leave between 12 and 23 October. **[Investigate whether there was any locum cover. Experts need to consider whether either Dr. Peters and/or Dr. Knapman are culpable.]**

Initial Views

4.27 We have the benefit of six expert reports in this case. The reports obtained from the two experts at the outset of the police investigation need to be checked.

However, the four reports obtained during the more detailed part of the police investigation, clearly support charges relating to the excessive use of Morphine which hastened the patient's death. For this reason, this is one of the strongest cases and the evidence will support a referral to the FTP Panel.

4.28 The police obtained statements from approximately 40 witnesses of fact and a detailed examination of all the evidence will be required to determine the number of key witnesses. For present purposes, we should assume that there will be at least 20 key witnesses of fact.

5. **Spurgin**

5.1 The patient was aged 92 when she was admitted to the Hospital in March 1999.

5.2 She fractured her hip as a result of a fall, and initially was admitted to the Haslar Hospital. She underwent surgery there to repair the hip.

5.3 There were complications following the surgery and she developed a haematoma.

5.4 She experienced some pain and discomfort following her operation and, as a result of the haematoma. After transfer to Dryad Ward, she was given Oramorph. The pain persisted and it appears that her wound became infected. Dr. Barton prescribed antibiotics.

5.5 There is a suggestion that the hip may have been x-rayed. However, the results of the x-rays have not been found.

5.6 The dosage of Morphine was increased, followed by a decision to use Diamorphine with a syringe driver.

5.7 Dr. Barton prescribed a range of 20-100mgs and the patient was started on 80mgs. Dr. Reid reviewed this and reduced the dose to 40mgs.

5.8 The summary of Dr. Barton's witness statement indicates that the starting dose of 80mgs of Diamorphine was discussed with her before it was administered by the nurses.

5.9 Dr. Wilcock, in his report, is highly critical of Dr. Barton and, to a lesser degree, Dr. Reid, the Supervising Consultant. Dr. Wilcock's criticisms include the following: insufficient assessment and documentation of the patient's pain and treatment; failing to seek an orthopaedic opinion when the pain did not improve over time, but instead increasing the dose of Morphine which is associated with undesirable side effects; the doses of Diamorphine were excessive to the patient's needs.

5.10 Further work needs to be done with the expert to give a more detailed analysis of dates, entries in notes in which Doctor (Barton/Reid) were responsible at a particular time.

5.11 Dr. Black refers to an "apparent" (emphasis added) lack of medical assessment and the lack of documentation relating to this patient.

5.12 Dr. Black is also critical of the use of Oramorph on a regular basis without considering other possible analgesic regimes.

5.13 Black believes that some of the management of the patient's pain was within acceptable practice with the exception of the starting dose of Diamorphine - 80mgs. Black describes it as being "at best poor clinical judgment".

5.14 A further report has been obtained from a Consultant Orthopaedic Surgeon, Dr. Redfern.

5.15 He is very critical of the doctors' failure to investigate the cause of the internal bleeding into the patient's thigh following her operation. Redfern criticises those responsible for her care at Gosport Hospital and at the Haslar Hospital.

Initial View

5.16 The findings of the experts support charges relating to poor note keeping, failure to assess the patient's pain and the use of excessive doses of Diamorphine. There is a complicating factor in that Dr. Reid is also criticised by the experts.

5.17 The police interviewed approximately 20 witnesses of fact. For present purposes, we should assume that the majority of these would be required to give evidence.

6. **Devine**

6.1 The patient was aged 88 at the time that she was admitted in October 1999. She died 32 days after her admission.

6.2 The summary of the patient's medical history prior to her admission indicates that in the summer of 1999, she was well enough to provide emotional and domestic support to her daughter, who was suffering from Leukaemia. However, by October 1999, she was admitted to Queen Alexandra Hospital where she was reported to be confused and aggressive.

6.3 On 14 October 1999, she was seen by a Dr. Taylor who concluded that it was likely she was suffering from Dementia.

6.4 On 21 October 1999, she was transferred to Dryad Ward for rehabilitation/respite care under Dr. Reid.

6.5 On the day of her admission, Dr. Barton prescribed Morphine to be taken as required.

6.6 Between 25 October and 1 November 1999, she was described as being physically independent and continent although she required supervision. She remained confused and disorientated.

6.7 On 16 November, Dr. Barton referred the patient to Dr. Lusznat due to a deterioration in the patient's renal function.

6.8 On 18 November, Dr. Taylor noted that her mental health had deteriorated and she was becoming increasingly restless and aggressive. Her physical condition, at that stage, was stable.

6.9 On 19 November, Dr. Barton recorded that there had been a marked deterioration and she was then prescribed a combination of Diamorphine (40mgs) and Midazolam. On 19 November 1999, the patient's family were also informed that the patient had suffered kidney failure and was not expected to survive more than 36 hours.

6.10 A police summary records that the Registrar refused to accept the recorded cause of death which resulted in an amendment of the Certificate by Dr. Barton.

6.11 After the patient's death, the family complained about the quality of her care and this resulted in the Health Authority setting up an independent review panel.

6.12 The Panel was asked to review, inter alia, the appropriateness of the clinical response to the patient's medical condition. Oral evidence was heard from various witnesses including Dr. Barton. **[We need to check with the police to see whether they obtained transcripts of the evidence given to the Review Panel.]**

6.13 The Panel found that the dosage of drugs given to the patient was appropriate - including the dose of 40mgs of Diamorphine. The Panel also found that the dosage and devices used to make Ms. Devine comfortable on 19 November were an appropriate and necessary response to an urgent medical situation.

6.14 In her police witness statement, Dr. Barton says that Dr. Lusznat, a Psychiatrist, recorded that the patient was suffering from severe Dementia. Barton says that this was confirmed by a CT scan on 18 November 1999.

6.15 The case was reviewed by three different experts: Dr. Wilcock, Dr. Black and Dr. Dudley, a Consultant Nephrologist.

6.16 Dr. Wilcock is highly critical of the standard of care, in particular, he refers to an inadequate assessment of the patient's condition and the inappropriate

prescribing of medication, including Diamorphine. He describes these as being unjustified and excessive to the patient's needs.

6.17 The list of criticisms made by Dr. Wilcock would form the basis of a strong case. However, the findings of the other two experts are not critical to the same degree.

6.18 Dr. Black refers to a lack of documentation, and the difficulty of deciding whether the level of care was below an acceptable standard.

6.19 He appears to criticise certain aspects of medication regime, but expresses the view that the patient was terminally ill and appeared to receive good palliatation of her symptoms. He is not able to say that Dr. Barton's prescribing had any definite effect on shortening the patient's life in more than a minor fashion.

6.20 Dr. Dudley observes that after a period of stabilisation, the patient's condition worsened and she suffered severe renal failure. He says that although it may have been possible to stabilise her condition, this would not have materially changed the patient's prognosis as death was inevitable.

6.21 Further, Dr. Dudley considers that the patient was treated appropriately in the terminal phase of her illness with strong Opiods to ensure comfort.

Initial View

6.22 It is difficult to reconcile the views expressed by the experts in this case: Dr. Wilcock is highly critical, whereas Doctors Black and Dudley - in particular, Dr. Dudley - are far less critical. Also, the Independent Review Panel findings support Dr. Barton.

6.23 The police took approximately 60 witness statements and, further evidence was given to the Independent Review Panel. It is possible that evidence given by witnesses to the Panel has been recorded and retained.

6.24 Dr. Reid, in his police witness statement, confirms that he saw this patient on three occasions: 25 October and 1 and 15 November 1999. He says that the "as required" Oramorph was prescribed by Dr. Barton on 21 October was reasonable. He also claims that the use of a syringe driver to administer Diamorphine and Midazolam was appropriate in these circumstances.

6.25 The difference in views expressed by the experts in this case and the fact that Diamorphine was used in conjunction with the syringe driver only at the very end of the patient's life, makes this one of the weakest cases.

7. **Service**

7.1 The patient was 99 years old when she was admitted in June 1997.

7.2 The patient died within two days of admission. When she was admitted, she was suffering from various medical problems, including Diabetes, heart failure, confusion and sore skin.

7.3 On transfer, she was placed on sedation via a syringe driver. She became less well the following day and Diamorphine was added to the driver. (She had not required Analgesia other than Paracetamol at the Queen Alexandra Hospital, where she had been before she was transferred.)

7.4 On the day of transfer, Dr. Barton carried out an assessment and noted that the patient was suffering from heart failure, was very unwell and probably dying. In her witness statement, Dr. Barton says that the care of the patient would have been more appropriate at Queen Alexandra Hospital and a transfer by ambulance would not have been in the patient's best interest. Barton claims that Diamorphine and Midazolam were prescribed and administered solely with the intention of relieving the patient's agitation and distress. Diamorphine was also prescribed to treat symptoms of the patient's heart failure.

7.5 Dr. Wilcock casts doubt on whether the patient was dying on the day of her admission, as alleged by Dr. Barton. He refers to blood test results to support his views; however, the summary of his evidence indicates that he is not absolutely sure as to whether or not the patient was dying. He says that if she was not dying, the failure to re-hydrate her and the use of Midazolam and Diamorphine "could" (emphasis added) have contributed more than negligibly to her death.

7.6 If, on the other hand, she was in the process of dying, Dr. Wilcock concludes that it would have been reasonable not to re-hydrate her and to use Midazolam/Diamorphine.

7.7 The police obtained a further opinion from Dr. Petch, a Consultant Cardiologist. He refers to the patient's history of heart disease and states that the patient's terminal decline in 1997 was not unexpected. Further, he says that palliative care with increasing doses of Diamorphine and Midazolam was appropriate - the patient's prognosis was "hopeless". The administration of Diamorphine and Midazolam was reasonable in the circumstances described by Dr. Barton.

7.8 Dr. Black is in no doubt that the patient was entering the terminal phase of her illness. He says that an objective assessment of the patient's clinical status is not possible from the notes made on admission. The notes were below an acceptable standard of good medical practice.

7.9 Further, Dr. Black says that the 20mgs dose of Diamorphine combined with a 40mgs dose of Midazolam was higher than necessary, and "it may have slightly shortened her life".

7.10 Police took statements from 20 witnesses of fact. Without a detailed review of the evidence, it is not possible to say, at this stage, how many of these would be regarded as "key" witnesses.

Initial View

7.11 In the light of the views expressed by the Consultant Cardiologist who considers that the use of Diamorphine and Midazolam was appropriate, there seems little prospect of success in this case.

8. **Cunningham**

8.1 The patient was aged 79 on the date of his admission in September 1998. He died within five days of admission.

8.2 When he was admitted, the patient was suffering from Parkinson's Disease, Dementia, Myelodysplasia. He also had a necrotic pressure sore.

8.3 Dr. Lord, the Supervising Consultant, prescribed Oramorph. Dr. Barton considered that this may not have been sufficient in terms of pain relief and wrote up Diamorphine on a pro-active basis with a dose range of 20-200mgs.

8.4 In her police witness statement, Dr. Barton explains that the levels of pain relief were increased as the patient continued to suffer pain and discomfort.

8.5 Dr. Wilcock is critical of Dr. Barton's practice of prescribing Diamorphine on an "as required" basis within such a large dose range, i.e., up to 200mgs. He says this unnecessarily exposes the patient to a risk of receiving excessive doses of Diamorphine.

8.6 However, in this case, Dr. Wilcock concludes that the patient was dying in an expected way and the use of Diamorphine and Midazolam were justified in view of the patient's chronic pain. The expert also concludes that although the dose range prescribed by Dr. Barton was excessive, in the event Mr. Cunningham did not receive such high doses.

8.7 Wilcock criticised Dr. Barton's lack of clear note keeping and, on the basis of the notes, he also considers that Dr. Barton failed to adequately assess the patient.

8.8 Dr. Black regards this particular case as an example of the complex and challenging problems which arise in Geriatric Medicine. He notes that the patient suffered from multiple chronic diseases and, in Dr. Black's view, the patient was managed appropriately and this included an appropriate decision to start using a syringe driver. Dr. Black has only one concern - the increased dose of Diamorphine just before the patient's death. He says that he is unable to find any justification for the increase in dosage in the nursing or medical notes. He

says that this "may" (emphasis added) have slightly shortened the patient's life, i.e., by a few hours/days.

8.9 The police took 47 statements from witnesses of fact in this case. Without a detailed analysis of the evidence, it is not possible to say how many of these can be regarded as being "key" witnesses.

Initial View

8.10 Whilst Dr. Wilcock, in particular, is critical of the large dose range prescribed by Dr. Barton, he considers that the dosages administered to the patient in this particular case were reasonable. He concludes that the patient was managed appropriately.

8.11 This case has already been referred to the FTP Panel, presumably on the basis of reports from other experts obtained earlier in the police investigation. We will need to review the earlier reports. However, on the basis of the opinions expressed by Dr. Black and Dr. Wilcock, there is no realistic prospect of proving that the doses of Diamorphine administered in this particular case was inappropriate.

9. **Gregory**

9.1 This patient was aged 99 when she was admitted in September 1999.

9.2 [This case is slightly different from the majority of the other cases in that the patient spent nearly 3 months on Dryad Ward until her death. In the other cases, apart from Mrs. Devine who was at the Hospital for about a month before she died, all the other patients died in a period of 2-18 days.]

9.3 Whilst the patient was on Dryad Ward, she was seen on various occasions in September, October and November 1999 by the Supervising Consultant, Dr. Reid. In his police statement, Dr. Reid expressed a view that whilst Dr. Barton's note keeping may have been poor, the patients were managed appropriately by Dr. Barton.

9.4 Dr. Reid, in retrospect, feels that it was inappropriate of Dr. Barton to prescribe Diamorphine as early as 3 September 1999, in the absence of documented pain or distress. However, Dr. Reid believes that it was appropriate for Dr. Barton to prescribe Opiates on 20 November, as the patient was in the terminal stages of her life.

9.5 When the patient was admitted to Dryad Ward, she had recently fractured her femur. She had a history of heart disease. She was regularly reviewed by Dr. Barton and Dr. Reid and was noted to be suffering poor appetite, agitation, variable confusion and no significant improvement in her mobility.

9.6 Between 15 and 18 November, her condition deteriorated following a chest infection. She became distressed and breathless. Dr. Barton was abroad from 12 to 16 November, but on her return on 17 November, she prescribed Oramorph. On 18 November, she prescribed Diamorphine.

9.7 Dr. Wilcock considers that the patient's decline over a number of weeks was in keeping with the natural decline into a terminal phase of her illness. He considers the dose of Diamorphine was unlikely to have been excessive.

9.8 Dr. Black refers to the patient's history of heart failure and lung disease. The patient was very elderly and frail when she fractured her femur. Dr. Black observed that in circumstances there was a very significant risk of mortality and morbidity.

9.9 Dr. Black reports that Dr. Barton failed to record a clinical examination, apart from some brief details concerning the patient's history.

9.10 Dr. Black notes that within a short period of her transfer to Dryad Ward, it is likely that she suffered a small stroke. Essentially, she made no improvement in rehabilitation in the two months that she was in hospital.

9.11 Dr. Black refers to the patient's rapid deterioration on 18 November. He says the prescribing of oral Opiates was an appropriate response to a patient who had an extremely poor prognosis.

9.12 He also considers that a decision to start the patient on Diamorphine was a reasonable decision. He regards the dosages of Diamorphine to have been in the range of acceptable clinical practice.

9.13 He does express a concern about Dr. Barton's practice of prescribing strong Opioid Analgesia in anticipation of a patient's decline. Notwithstanding this, he concludes that no harm came to Mrs. Gregory as a result of this practice.

9.14 Apart from a lack of clinical examination (or possible failure to document such an examination), both on the date of her patient's admission and during the period that her condition deteriorated, Dr. Black appears to be satisfied that the dosages of Diamorphine administered in this case were reasonable. He confirms that the patient died of natural causes.

9.15 The police took 22 witness statements during their investigation relating to this patient.

Initial View

9.16 A case of inappropriate prescribing cannot be made out on the basis of the views expressed by the expert save to the limited extent that one of the experts criticises the practice of "anticipatory" prescribing.

9.17 There are additional concerns raised with regard to lack of note keeping and the possibility that clinical examinations were not carried out. This is one of the weakest cases.

10. **Packman**

10.1 The patient was aged 67 when he was admitted in August 1999. He suffered from gross morbid obesity (in April 1999, he weighed in excess of 23 stone). He was first admitted to the Queen Alexandra Hospital on 6 August 1999, having suffered a fall at his home. On admission to QAH, he was noted to have an abnormal liver function and impaired renal function. He also had leg ulcers and cellulitis (infection of the skin) and pressure sores over his buttocks and thighs.

10.2 It is not clear whether he suffered a gastrointestinal bleed whilst he was at QAH (the experts seem to think that if a bleed occurred, it was not significant or life threatening at that stage).

10.3 On his admission to Dryad Ward on 25 August 1999, he was examined by Dr. Ravindrane, a Registrar working under Dr. Reid, the Consultant.

10.4 On 25 August, he was seen by a Locum GP, Dr. Beasley (it is not clear why Dr. Beasley was involved and Dr. Beasley's name does not appear in the list of witnesses interviewed by the police).

10.5 On 26 August, the patient was seen by Dr. Ravindrane following a report that the patient had been passing blood rectally.

10.6 It appears that the patient's condition deteriorated during the course of the day on 26 August. The experts conclude that a blood test taken on that day revealed a large drop in the patient's haemoglobin, which made a significant gastrointestinal bleed likely.

10.7 In her police statement, Dr. Barton indicated on 26 August, she was concerned that the patient might have suffered a myocardial infarction. In addition, she believed that the patient had suffered a gastrointestinal bleed.

10.8 The experts, in particular, Dr. Wilcock, criticise Dr. Barton for not transferring the patient to an acute ward for treatment for the underlying cause of the bleeding - thought by Dr. Wilcock to be a peptic ulcer.

10.9 In her police statement, Dr. Barton says that the patient was very ill and a transfer to an acute unit would have been inappropriate given the likely further harmful effect on his health. **[Query whether the experts have given this assertion due consideration.]**

10.10 Dr. Barton does not say in her statement why she did not consult anybody - Dr. Ravindrane or Dr. Reid - before taking a decision not to transfer and/or before

prescribing Diamorphine and Midazolam. Note that the police do not appear to have interviewed Dr. Reid in connection with this case, even though Dr. Wilcock, in his report, believes that Dr. Reid, albeit to a lesser degree than Dr. Barton, failed to provide treatment with a reasonable amount of skill and care. It is possible that Dr. Reid only saw the patient on one occasion, i.e., on 9 September, two days before the patient died. Therefore, it may be that Dr. Reid was unaware of the gastrointestinal bleed which occurred on 26 August 1999 - if that is the case, then Dr. Wilcock's criticism of Dr. Reid seems to be limited to the subsequent use of Opioids.

10.11 The police obtained an expert opinion from a Consultant Gastroenterologist, Dr. Marshall. He concludes that a transfer to surgery should have been considered on 26 August when the possibility of a G/I bleed was first considered. He indicates that surgery, in this case, may have resulted in the patient's death because the patient was morbidly obese.

10.12 The police obtained 27 witness statements in this case.

Initial View

10.13 There appears to be at least an arguable case that Dr. Barton should have sought assistance from a Consultant before she made the decision not to transfer the patient to an acute unit following the G/I bleed. Dr. Wilcock, in particular, is critical of this and the decision to prescribe Opiates. His view is that prescribing Opiates contributed "more than minimally" to the patient's death. Dr. Black takes the view that these deficiencies probably made very little difference to the eventual outcome.

10.14 The role of the other practitioners in this case will need to be considered in more detail - i.e., Dr. Beasley, Dr. Ravindrane and Dr. Reid.

10.15 Overall, there is sufficient evidence to refer this case to the Case Examiner.

IOC Instructions Form

IOC Cases: Instructions

Name of doctor:	Dr Jane Ann BARTON
Type of case (new/review):	New
Date/time of IOC hearing:	7 October 2004, 09:30 am (General Chiropractic Council)
If review hearing, date of initial IOC Order:	N/A
Date of any previous review hearings:	N/A
Date considered by PPC:	29 – 30 August 2002
Listing status: (provisional/working listing date?)	Matters are currently subject to Police investigation (Hampshire Constabulary) and therefore the case has not been listed
Has notice of inquiry been sent?	No
Any significant developments since last IOC hearing:	N/A
Do we need to ask the Committee to direct Registrar to apply to High Court for an extension to Order?	N/A
Any other specific instructions:	Information has previously been considered by the IOC against Dr Barton, the latest hearing being in September 2002. This referral to the IOC was made by the President. The Police have now progressed their enquiries to the point that they have been able to disclose information in respect of 19 patients whose treatment their experts believe, having carried out a preliminary screening exercise, may have been sub-standard. The Police have disclosed the medical records, Police reports and expert screening forms for those 19 patients, and it appears that in 14 cases there may be information that should be put before the IOC.

	The Police have referred information in respect of 10 – 15 other patients whose treatment their experts believe, having carried out a preliminary screening exercise, was such that criminal charges against Dr Barton should be considered. The Police have been asked to prepare a statement disclosing as much information as is possible at this stage of the investigation in respect of these more serious cases, and we should receive this by 28 September 2004. Dr Barton has been informed of the referral and has been told that we will disclose to her all of the information that we will put before the Committee by 30 September 2004.
Name and tel. no of caseworker	Paul Hylton **Code A**

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~~

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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**~~

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**~~

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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**~~

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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**~~

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**~~

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~~**

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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**~~

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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~~

Linda Quinn Code A

From: Toni Smerdon Code A
Sent: 10 Dec 2003 17:42
To: Linda Quinn Code A
Subject: FW: Dr. Barton

Barton.gmc.doc

-----Original Message-----
From: Robert Englehart Code A
Sent: 10 Dec 2003 17:43
To: Code A
Cc:
Subject: Dr. Barton

Herewith, as promised, Advice on Dr. Barton.

Regards.

Robert Englehart QC
10/12/03

<<Barton.gmc.doc>>

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

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

OE end

TS/PCC/Barton

11 May 2005

General
Medical
Council

Regent's Place
350 Euston Road
London NW1 3JN

Telephone: 0845 357 8001
Facsimile: 020 7819 5001
Email: gmc@gmc-uk.org
www.gmc-uk.org

The Clerk to Mark Shaw, QC
Blackstone Chambers
Blackstone House
Temple
London
EC4Y 9BW

Dear Sir

Dr Jane Barton

Further to our instructions to Mr Shaw to draft a formal but 'friendly' letter to Hampshire Constabulary, requesting disclosure of information in relation to its case against Dr Barton, and receipt of such a draft in an email from Mr Shaw dated 21 January 2005.

The GMC has now received a response from Hampshire Constabulary to its letter of 25 January 2005, and we therefore require further advice from Counsel as to the options available to the GMC in light of the response. Counsel is therefore instructed to advise the GMC of the options available to it in light of the response from Hampshire Constabulary, and in doing so the GMC asks Counsel to express his view as to what action he would advise the GMC should take.

Yours faithfully,

Code A

Toni Smerdon
Solicitor
Direct Dial
Direct Fax
email

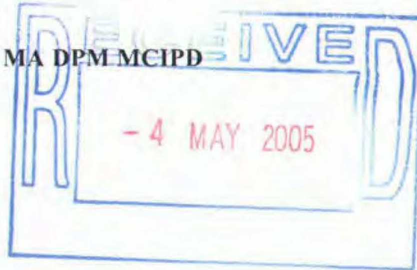
Code A

Encs.

Copy of the GMC's letter to Hampshire Constabulary dated 25 January 2005
Copy of Hampshire Constabulary's response to the GMC dated 28 April 2005

HAMPSHIRE CONSTABULARY

Paul R. Kernaghan QPM LL.B MA DPM MCIPD
Chief Constable



Fareham Police Station
Quay Street
Fareham
Hampshire
P016 ONA

Tel. 0845 0454545
Fax. 023 92891663

Our Ref. Operation Rochester

Your Ref.

28th April 2005

Mr Paul Philip
Director of Fitness to Practise
General Medical Council
2nd Floor
Regents Place
350 Euston Road
LONDON
NW1 3JN

Dear Mr Philip

Operation Rochester - Investigation into Deaths at Gosport War Memorial Hospital

Thank you for your letter of 25th January 2005, acknowledged by E-mail on 28th February to yourself with an update of the position of the Hampshire Constabulary, and latterly your letter to ACC Watts dated 21st April 2005 arriving on my desk this morning 27th April 2005.

In response may I acknowledge your request for what is termed as 'limited disclosure' of information in respect of the police investigation into the death of Elsie Devine, in particular:-

Witness statements
Medical records
Written representations and transcripts of tapes
Recorded interviews with Dr Barton
Experts reports

May I advise you that as the Senior Investigating Officer in this case I am not minded to make disclosure of any record in relation to the Elsie Devine investigation other than the medical records of the deceased, these having previously been served upon Dr Barton.

The other records requested are to form the basis of challenge interviews with Dr Barton later this year, it cannot be either in the public interest or the interests of justice, particularly in the interests of an effective and continuing interview strategy and criminal investigation to allow these documents into the domain of the GMC ultimately to be served upon Dr Barton in pursuance of a professional conduct committee hearing.

Secondly, I have concerns that such information might not just reach Dr Barton but also the public thereby, affecting the fairness of potential proceedings caused by adverse prior publicity.

My view is that the process of criminal investigation/prosecution and a GMC disciplinary investigation/proceeding should not be blurred by simultaneous proceedings using evidence that may be germane to a criminal prosecution.

I would like to take this opportunity to set out our position having taken advice from Counsel.

Firstly, I would like to summarise my interpretation of events to date and concerns arising from our meeting of 13th January 2005.

The purpose of our meeting was to discuss progress in terms of the police investigation and to consider a request by the GMC for further information in respect of category 3 cases in the light of a decision made on the 12th September 2002 to suspend GMC investigation whilst deciding to formulate a charge against Dr Barton to be heard by a professional conduct committee.

I made particular reference to our understanding that:-

1. *The GMC has a duty to satisfy itself that there are no matters of professional conduct or performance warranting formal action.*

2. *The GMC's right to demand disclosure under s.35A Medical Act 1983 when necessary to carry out a statutory/regulatory role.*

3. *The principles of Woolgar v Chief Constable Sussex 2000.. weighing the balance of competing public interests.*

4. *Previous significant disclosures made by the police in February 2002 (case papers in respect of deceased Page, Cunningham, Wilson, Wilkie and Richards) and the current categorisation of those cases. Furthermore, disclosure of 47 category 2 cases to the GMC and NMC between September and December 2004.*

5. *Result of Interim Order Committee hearings of 12th Sept 2002, 19th September 2002 and 7th October 2004.*

We then discussed the Generic issues in respect of Dr Barton indicating the initial response by evidential experts:-

That Dr BARTON commenced the post of Clinical Assistant to the Geriatric Division at Gosport War Memorial Hospital in 1988(in addition to her GP role).

She worked 20 hours a week but 24 hour a day cover. An experienced GP working autonomously.

Consultants Drs Lord, Tandy and others provided limited cover in 1998/99 due to sickness.

Dr Bartons workload and note taking suffered as a consequence.

Dr Barton felt obliged to adopt a policy of proactive prescribing outside Trust policy, to give nurses a degree of discretion to administer within a range of medication.

Dr Barton comments that prescriptions were reviewed on a regular basis by Consultants.

Dr Bartons workload continued to increase due to increasing bed occupancy and patient dependency, as a result of increasing time pressures corners were cut.

Dr Barton had clearly failed the duties of the post particularly in note taking and providing 24 hour medical cover.

I informed those present that papers had been submitted to the Crown Prosecution Serve on 24th December in respect of the death of Elsie Devine the brief circumstances being that:-

Dr Barton had incorrectly treated her for a non- existing Myeloma (cancer diagnosis).

Mrs Devine had been treated for chronic renal failure. It was debatable however, that this condition was an irreversible terminal event or decline in renal function that could have been stabilised or reversed.

Morphine and a fentanylpatch were prescribed outside the range of other appropriate analgesia (for severe intractable cancer pain and to relieve anxiety and agitation).

An excessive dose of strong opiods were administered to Mrs Devine to enable nursing care.

There was a lack of clear assessment of a worsening condition.

The patient died 2 days after administration of Diamorphine and Midazolam.

The diagnosis of Multiple Myeloma would be clarified with a Haematologist.

The renal failure issue with a Renal Physician.

Finally I informed Mr Philip that investigations were ongoing, the Dr Barton was to be interviewed regarding 9 further cases, and that other healthcare professionals may be interviewed under Caution. The priority cases should be complete by the middle of the year, but realistically, the investigation would span the duration of 2005.

Mr Philip explored the possibility of incremental disclosure of category 3 expert evidence following particular interviews under Caution, the problem with this approach was that interviews were likely to extend throughout the year, and it would be difficult to assess whether revealing the information to the GMC would prejudice the criminal investigation.

The issue of the risk posed by DR Barton was discussed. The voluntary arrangement seemed to be holding but Mr Philip was concerned that Dr Barton could practice even in a short term locum position without being supervised and that a risk under those circumstances existed, as did the voluntary arrangement itself.

Mr Philip was reluctant to go to an administration hearing over the issue of disclosure however, it was agreed by parties present that he would write a formal letter setting out the position of the GMC and concerns, and that the police would respond through our own Counsels advice. It may be that having documented the issues that this would suffice if the risk was perceived as low.

Mr Philip was encouraged to make contact with the NMC to establish whether they were held similar concerns regarding the position of nursing staff.

I note that the GMC are to consider serving a Notice to Disclose Under Section 35A of the Medical Act 1983.

In declining the disclosure requested I have considered the ACPO protocols for the notification and disclosure of information, 'Managing Risks to Public Safety from Health Care and Teaching Professionals.

As the Senior Investigating Officer, I am advised to carefully balance the need to ensure 'Confidentiality' and the 'Security' of the criminal investigation, and the human rights of the individual including Article 6 The Right to a Fair Trial, with the need to protect the public.

I am mindful that there has been significant previous disclosure to the GMC between August 2002 and October 2004, including full evidence of what ultimately were assessed as category 3 cases, Cunningham and Wilson, the interim Order Committee did not make any Order against Dr Barton, seemingly content with her voluntary acceptance of conditions in terms of the prescription of controlled drugs.

Yours sincerely,

Code A

David Williams Code A
Detective Superintendent

Paul Hylton (020 7189 5115)

From: Code A
Sent: 28 Apr 2005 11:33
To:
Cc: Code A
Subject: Gosport War Memorial Hospital.

Paul HYLTON..

Paul.. Apologies for not getting back to you as promised week commencing 18th April..

I picked up an attempt murder investigation that weekend.. Just too busy..

Hard copy of the attached letter to follow..

●gards.DW.

To Paul PHILIP
Director of Fitness to Practise
General Medical Council
2nd Floor
Regents Place
350 Euston Road
LONDON
NW1 3JN

Dear Mr PHILIP

Operation ROCHESTER - Investigation into Deaths at Gosport War Memorial Hospital

●ank you for your letter of 25th January 2005, acknowledged by E mail on 28th February to yourself with an update of the position of the Hampshire Constabulary, and latterly your letter to ACC WATTS dated 21st April 2005 arriving on my desk this morning 27th April 2005.

In response may I acknowledge your request for what is termed as 'limited disclosure' of information in respect of the police investigation into the death of Elsie DEVINE, in particular:-

Witness statements
Medical records
Written representations and transcripts of tapes
Recorded interviews with Dr BARTON
Experts reports.

May I advise you that as the Senior Investigating Officer in this case I am not minded to make disclosure of any record in relation to the Elsie DEVINE investigation other than the medical records of the deceased, these having previously been served upon Dr BARTON.

The other records requested are to form the basis of challenge interviews with DR BARTON later this year, it cannot be either in the public interesting the interests of justice, particularly in the interests of an

COPY

Our ref: PP-TS/PCC/Barton
Your ref: Op Rochester

25 January 2005

Detective Chief Superintendent Steve Watts
Head of CID
Police Headquarters
West Hill
Romsey Road
Winchester
Hampshire
SO22 5DB

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Dear DCS Watts,

Operation Rochester – Investigation into Deaths at Gosport War Memorial Hospital

I write in the wake of our helpful meeting on 13 January 2005 to seek disclosure of certain limited information relating to the above.

You will have appreciated from the recent meeting that the GMC remains very concerned at the pace of an investigation which, while complex and onerous, began as long ago as September 1998. An important part of the GMC's statutory function is the protection of the public interest. It is very eager to fulfill that function as promptly and efficiently as possible. But, at present, the pursuit of the disciplinary investigation/proceedings is being hampered by the speed of the criminal investigation/proceedings.

As I understand it from our meeting, you acknowledge the legitimacy of the GMC's concern but are understandably anxious to ensure that the release of information to the GMC should not prejudice either the investigation or the fairness of any ensuing trial.

Against that background, I come to the GMC's request for limited disclosure. What is sought at this point is all the information in the possession of the police in relation to the case of Elsie Devine, in particular:

- witness statements
- medical records
- written representations and transcripts of tapes.
- recorded interviews with Dr Barton
- experts' reports

The basis of the request is as follows:

3rd Floor Regents Place 350 Euston Road London NW1 3JN Telephone

- As I understand it, the police have so far had reservations about disclosing the fruits of its investigation for two essential reasons. I believe I can now allay fears in relation to both.

- First, the police have been concerned that information revealed to the GMC might form the basis for an application for an interim order against Dr Barton before the GMC's Interim Orders Committee (now known as the Interim Orders Panel). The information supporting any such application would have had to be copied to Dr Barton. If this had happened before any police interview of Dr Barton, the advantage of surprise would have been lost: see, for example, the last few paragraphs of the letter dated 6 October 2003 from the police.

  I believe that this concern is no longer real because, as emerged at the meeting on 13 January, Dr Barton *has* now been interviewed in relation to the case of Elsie Devine (but, as yet, none of the other nine patients whose cases the police have identified as being especially troubling). In fact, I understand that Dr Barton has now been interviewed twice in relation to the case of Elsie Devine: one a generic interview, one an in-depth interview. (In any event, as the GMC has mentioned previously, it seems a little fanciful to suppose that Dr Barton could be taken much by surprise. The facts and issues affecting Dr Barton have been examined by several inquiries over recent years. She must already be well aware of them and the consequential questions that could be put to her.)

- Second, the police have been concerned that information revealed to the GMC might reach not just Dr Barton but also the *public*, if used as the basis for an application before the Interim Orders Panel. The fear was that this might give rise to an argument that Dr Barton could not have a fair trial because of the risk of contamination of jurors' minds caused by adverse prior publicity. The GMC has sought to reassure the police that there was never any real risk of this happening because proceedings before the Interim Orders Panel take place in private (unless the doctor requests a public hearing, which would be extraordinary).

I believe that the GMC has already mentioned to you its statutory power to require the disclosure of information, conferred by section 35A of the Medical Act 1983, as amended. This provides that, for the purpose of assisting the GMC or any of its committees in carrying out its disciplinary functions, a person authorised by the GMC is entitled to require a doctor or 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. I attach, for information only and so that you can see its general format, a blank request for such disclosure.

I very much hope that it will not become necessary to invoke the power under section 35A. Much the better course is to proceed by agreement. The meeting on 13 January was a useful step in that direction. With that aim in mind, I look forward to receipt of the information sought, or confirmation that GMC staff might attend to take copies. If you have any queries or wish to discuss any aspect of this request, or indeed any aspect of the matter as a whole, I should be very happy to meet.

Yours sincerely,

Code A

Paul Philip
Director Fitness to Practise

Code A

Encs.

Œ start

IN THE PROFESSIONAL CONDUCT COMMITTEE OF
THE GENERAL MEDICAL COUNCIL

and

IN THE MATTER OF DR

REQUEST FOR DOCUMENTATION PURSUANT TO SECTION 35A(1) OF THE MEDICAL ACT 1983 (AS AMENDED)

To

I, PAUL PHILIP, Director of Fitness to Practise, General Medical Council ("GMC"), 178 Great Portland Street, London W1W 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, [name of Solicitor], the following documents:

   a. [description of document]

   b, [description of document]

   c. [description of document]

3. This documentation is relevant to the discharge of the GMC of its functions in relation to professional conduct and disclosure of this documentation is required accordingly.

4. I confirm that [name of Solicitors] will reimburse your reasonable costs incurred in providing the information requested.

We ask that the documents requested be provided to Field Fisher Waterhouse within 14 days.

SIGNED:.. **DATED:.................**

Paul Philip
Director of Fitness to Practise
GENERAL MEDICAL COUNCIL

Medical Act 1983

(as amended by the Professional Performance Act 1995, the European Primary Medical Qualifications Regulations 1996, the NHS (Primary Care Act 1997, the Medical Act (Amendment) Order 2000, the Medical Act 1983 (Provisional Registration) Regulations 2000, the Medical Act 1983 (Amendment) Order 2002) and the National Health Service Reform and Health Care Professionals Act 2002)

...

General Council's power to require disclosure of information

35A.—(1) For the purpose of assisting the General Council or any of their committees in carrying out functions in respect of professional conduct, professional performance or fitness to practise, a person authorised by the Council may require—

(*a*) a practitioner (except the practitioner in respect of whose professional conduct, professional performance or fitness to practise 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.

(2) As soon as is reasonably practicable after the relevant date, the General Council shall require, from a practitioner in respect of whom a decision mentioned in subsection (3) has been made, details of any person—

(*a*) by whom the practitioner is employed to provide services in, or in relation to, any area of medicine; or

(*b*) with whom he has an arrangement to do so.

(3) For the purposes of this section and section 35B the relevant date is—

(*a*) the date of a decision to refer a case in respect of a practitioner to the Preliminary Proceedings Committee in accordance with rules made under paragraph 5(2) of Schedule 4 to this Act;

(*b*) where rules have been made under paragraph 1(1) or 5A(1) of Schedule 4 to this Act which provide for any of the following decisions—

(i) to invite a practitioner to agree to an assessment of his professional performance;

(ii) to invite a practitioner to agree to an assessment to determine whether his fitness to practise is seriously impaired by reason of his physical or mental condition;

(iii) to notify a practitioner that medical reports received by the General Council appear to provide evidence that his fitness to practise may be seriously impaired by reason of his physical or mental condition,

the date of the decision in question.

(4) Nothing in this section shall require or permit any disclosure of information, which is prohibited by or under any other enactment.

(5) But where information is held in a form in which the prohibition operates because the information is capable of identifying an individual, the person referred to in subsection (1) may, in exercising his functions under that subsection, require that the information be put into a form which is not capable of identifying that individual.

OE end

(6) Subsection (1) shall not apply in relation to the supplying of information or the production of any document which a person could not be compelled to supply or produce in civil proceedings before the court (within the meaning of section 38).
(7) For the purposes of subsection (4), "enactment" includes an enactment comprised in, or in an instrument made under, an Act of the Scottish Parliament.
(8) For the purposes of this section and section 35B, a "practitioner" means a fully registered person, a provisionally registered person or a person registered with limited registration.

cc: Paul Hylton
BARTON

Chief Executive and Registrar Finlay Scott TD

6 December 2004

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Paul R Kernaghan QPM LLB MA DPM MCIPD
Chief Constable
Hampshire Constabulary
Police Headquarters
West Hill
Winchester
Hampshire
SO22 5DB

Dear Chief Constable

Operation Rochester

You will recall that you wrote on 2 July 2004 following our telephone conversation.

Since your letter, our colleagues have continued to cooperate in relation to our respective, but complementary, responsibilities. I am grateful for the contribution that you and your colleagues have made to trying to find a way forward.

The position is that our Preliminary Proceedings Committee has referred Dr Jane Barton to the Professional Conduct Committee in relation to heads of charge derived from five cases. The PPC made that decision on 29 August 2002. On 2 December 2002, Detective Inspector Nigel Niven wrote on behalf of Detective Chief Superintendent Steve Watts to Field Fisher Waterhouse, our solicitors, who were investigating the allegations against Dr Barton on our behalf at that time. DI Niven asked us not to proceed with the PCC hearing until further notice.

Some two years on we need to take stock and to consider what options might be available to us.

I wonder whether it would be helpful to arrange a high-level meeting at which we could explore the current position with you, with a view to agreeing how next to proceed. My colleagues and I would be willing to come to Southampton. Alternatively, we would be glad to welcome you here if that would be more convenient.

I look forward to hearing from you.

Yours sincerely

Code A

2nd Floor Regents Place 350 Euston Road London NW1 3JN Switchboard 0845 357 8001 Central fax 020 7189 5001
Central e-mail gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No 1089278

Mariana Armatti Code A

From: Toni Smerdon Code A
Sent: 06 Oct 2004 18:55
To: Mariana Armatti Code A
Subject: FW: Dr Barton

Importance: High

-----Original Message-----
From: Toni Smerdon Code A
Sent: 06 Oct 2004 18:51
To:
Cc: Code A
Subject: Dr Barton
Importance: High

Roger

Further to our conference this afternoon I attach 2 versions of the conditions - the first is int he way the IOC would express itself, the second is adding to your note.

The reason for the first is that the IOC will top and tail the conditions by referring to the relevant parts of s41A, the period of time for which the order will be in place (ie 18 months) and also specify the fact that the case will be reviewed as required by the rules within 6 months. Really all the IOC will be concerned about is the actual conditions sought.

Hope this does not appear too presumptious.

Will be in the office until about 7-00pm on Code A

Toni

barton1.doc

barton2.doc

IN THE MATTER OF:

DR JANE ANN BARTON

DRAFT CONDITIONS

---

1. You shall not issue or write any prescriptions for benzodiazepines or opiates.

2. You shall notify all employers and all prospective employers, whether for paid or voluntary employment, for which registration with the GMC is required at the time of application of the matters under consideration by the GMC.

3. You shall inform the IOC Secretariat of the GMC before undertaking any position for which registration is required.

IN THE MATTER OF:

DR JANE ANN BARTON

DRAFT CONDITIONS

The Interim Orders Committee of the General Medical Council hereby orders:

1. That the registration of Dr Jane Ann Barton be conditional upon her compliance with the following requirements:

   (i) That she issues and writes no prescriptions for benzodiazepines or opiates for a period of 18 months from today, unless otherwise ordered;.

   (ii) That she shall notify all employers and all prospective employers, whether for paid or voluntary employment, for which registration with the GMC is required at the time of application of the matters under consideration by the GMC.

   (iii) That she shall inform the IOC Secretariat of the GMC before undertaking any position for which registration is required.

2. That this order be reviewed within 6 months of today.

Toni Smerdon Code A

From: Mark Shaw Code A
Sent: 25 May 2005 16:33
To: Toni Smerdon Code A
Subject: DR BARTON - advice

Dear Toni,

I attach my draft advice in the above.

Could we discuss and finalise tomorrow morning please?

Best wishes,

Mark

This message has been scanned for viruses by MailController.

DR JANE BARTON

CHRONOLOGY
(with the more important dates in bold type)

1 May 1988	Dr Barton began work as clinical assistant at GWMH.
Jul 1991	RCN convenor met nurses to discuss improper use of opiates at GWMH.
Feb-Oct 1998	Alleged mistreatment (of five patients principally) by improper use of opiates at GWMH.
Sep 1998	**Concerns first raised by Richards family. Police investigation began.**
Mar 1999	**CPS decided there was insufficient evidence to pursue criminal prosecution in respect of Mrs Richards.**
Jan 2000	NHS Independent Review Panel found that opiate doses were high but appropriate in circumstances.
?????? 2000	Health Service Ombudsman rejected complaint.
5 Jul 2000	**Dr Barton resigned from GWMH.**
27 Jul 2000	**Police notified GMC of allegation by Richards family against Dr Barton and restarted investigation. But no complaint ever made directly to GMC by any family[1].**
Mar 2001	11 other families raised similar concerns with police. Four (Page, Wilkie, Cunningham and Wilson) were investigated.
Jun 2001	**First IOC hearing. IOC considered Richards allegation and made no order.**
Aug 2001	Police passed concerns to CHI, which began investigating care at GWMH *since* 1998 (including through interviews of relatives and staff).
Feb 2002	**CPS decided not to pursue criminal prosecution in respect of four other patients (Page, Wilkie, Cunningham and Wilson). CPS papers disclosed to GMC.**

[1] All are "information", not "complaint", cases.

Feb 2002	**Barton gave voluntary undertaking to Health Authority (not to prescribe opiates or benzodiazepines).**
21 Mar 2002	**Second IOC hearing. IOC considered allegations in respect of all five patients and made no order.**
31 Mar 2002	**Dr Barton's voluntary undertaking given to Health Authority (not to prescribe opiates or benzodiazepines) lapsed.**
28 May 2002	Mrs Richards' daughter protested about lack of progress.
Jul 2002	CHI reported concerns (especially about anticipatory prescribing).
Aug - Oct 2002	**Pressure (in political quarters) created by Mrs Richards' daughter's protest led, despite some apparent reluctance, to police sending further papers to CPS and re-opening investigation to encompass all (62) patients who died while under Dr Barton's care at GWMH. GMC's investigation put on hold.**
29 Aug 2002	**PPC referred all five cases to PCC but made no referral to IOC.**
Sep 2002 - Sep 2003	Police referred all 62 patients to panel of five experts, who began investigation.
12 Sep 2002	Suspension of GMC's investigation.
19 Sep 2002	**Third IOC hearing. In response to referral by GMC's President, IOC again considered allegations[2] in respect of all five patients but again made no order (in view of the absence of any new material[3]).**
19 Sep 2002	Health Authority sent GMC file of correspondence concerning use of diamorphine in 1991.
9 Oct 2002	FFW advised that screeners would be misdirecting themselves if they were to refer Dr Barton to IOC again in light of Health Authority's disclosure.
20 Nov 2002	Meeting between GMC and police.
2 Dec 2002	Police asked GMC to removed Dr Barton's case from PCC hearing list. GMC did so[4].

[2] It had reports from Dr Ford and Dr Mundy.

[3] The Legal Assessor advised that in the absence of "new evidence ... it would be unfair to the doctor ... to consider the matter any further": apparently a reference to the doctrine of *res judicata*.

[4] Dr Barton's case has not yet been reinstated into the list.

30 Sep 2003	**Police met GMC and stated that panel of five experts had concluded that treatment of about 25% (15-16) of patients and cause of death gave rise to concern and should be investigated further (by a single new expert, auditing and refining the work of his five predecessors). GMC sought disclosure but this was refused because of risk of disclosure to Dr Barton if her case were to return to IOC.**
2 Oct 2003	GMC letter again pressed police for disclosure.
Oct 2003	**Baker report (independent clinical audit of care of 81 patients, sampled at random, who died at GWMH from 1988 to 2000 with particular emphasis on Dr Barton's conduct) sent to CMO but not to GMC[5].**
Oct 2003	**Screener refused to refer case for a fourth time to IOC (in view of absence of new evidence).**
Jan 2004	GMC believed (wrongly according to police) that audit and refinement of conclusions of panel of five experts by another, single expert was due to be completed.
7 Jan 2004	GMC pressed police for update on progress.
28 Jan 2004	Police unable to provide any further information on progress.
6 Feb 2004	GMC confirmed to police that GMC inquiries were "on hold" pending conclusion of the police investigations.
Mid-Feb 2004	Conclusions of panel of five experts were to be communicated to relatives[6].
Feb 2004	GMC met CMO, at latter's request, to discuss Dr Barton's case.
27 Feb 2004	**Meeting between GMC, FFW and police. Police said that the investigation was still incomplete, that they did not know when it would end or when Dr Barton would be interviewed and that they would not release any information to GMC unless GMC guaranteed not to pass it on to Dr Barton.**
5 May 2004	GMC again pressed police for report on progress.
17 May 2004	Baker report sent to GMC, subject to undertaking not to copy or disseminate.

[5] A copy was, however, passed to GMC by CMO. A summary of is attached. It should be treated as confidential because circulation of the Baker report is still strictly limited.
[6] It is unclear whether this took place.

11 Jun 2004	CMO met police to discuss Dr Barton's case.
13 Jan 2005	Meeting between GMC and police.
25 Jan 2005	GMC wrote to police seeking disclosure of material in relation to Mrs Devine, backed by reference to section 35A of the 1983 Act.
Feb 2005	Police planned to interview Dr Barton[7].
28 Feb 2005	Police email to GMC gave update.
28 Apr 2005	Police replied to GMC letter dated 25 January 2005 refusing the disclosure sought.

[7] Not yet occurred.

DR JANE BARTON

SUMMARY OF BAKER REPORT

Overview

Commissioned by CMO and written by Head(?) of Department of Health Sciences, University of Leicester.

Completed in October 2003.

Audit of care of 81 patients (random sample) who died within DMfEP (not just under Dr Barton's care) at GWMH from 1988 to 2000.

Only documentary evidence audited and no opportunity given for relatives or staff (including Dr Barton) to comment on issues or findings.

Conclusions

- A practice of almost routine and liberal use of opiates before death was followed in order to "make [patients] comfortable": culture of limited hope/expectation towards recovery.
- Patients who experienced pain and whose death was expected in the short term were given opiates.
- Alternative treatment with other pain-relief and detailed assessment of the cause of pain/distress was generally ruled out.
- Practice (of premature use of opiates) began in 1988 at latest.
- Impossible to identify its origin but Dr Barton may merely have implemented it.
- It almost certainly shortened the lives of some patients.
- In some patients, determined rehabilitation could well have led to a different outcome.
- In some (but fewer) cases it is probable that patients would otherwise have had a good chance of being discharged from hospital alive.
- Opiates administered to almost all sampled patients regardless of illness.

- Opiates often prescribed before needed (often on admission), even if not administered for days or weeks.
- Proportion of patients who received opiates before death was remarkably high.
- Difficult not to conclude that some patients were given opiates but should have received other treatment.
- Many records did not show a careful clinical assessment before use of opiates or a proper stepped approach to management of pain in palliative care.
- Records often poor: silent on recent fractures, on deteriorations and their causes and on causes of pain.
- Most patients had acute, chronic illness and were believed unlikely ever to be capable of discharge to nursing home.
- Unlikely that death rate was higher than in a comparator unit.
- Starting doses were too high.
- In 16 cases, because of inadequate records, there were concerns about the indications for starting opiates, the investigation of pain or the choice of pain-relief.
- Dr Barton was part of a team (under a consultant) but she:
    - issued most of the MCCDs;
    - made most of the entries in records; and
    - was responsible for most of the prescribing.

Recommendations

- Audit reinforces concerns (raised by relatives) so investigations should continue.
- Rota followed by Dr Barton and partners should be obtained and analysed to explore patterns of death.
- National and local policies/guidelines on opiate medication should be devised and applied.
- Use of opiate medication should not be limited to needy patients; sometimes insufficient opiates was used.
- Better statistics/codes should be compiled to enable better monitoring in future.

DR JANE BARTON

ADVICE

Introduction

1. Further to consultations on 26 May 2004 and 14 June 2004[1], I am asked to identify, and to advise on the strengths and weaknesses of, the options available to the GMC in the light of the letter dated 28 April 2005 from DS David Williams of the Hampshire Constabulary ("the police letter") responding to the GMC's letter dated 25 January 2005 ("the GMC letter").

2. The GMC letter:
   - expressed concern that the slow pace of the police investigation was hampering pursuit of the disciplinary investigation;
   - sought limited disclosure of information in the possession of the police in relation to the case of Elsie Devine, in particular five items (witness statements, medical records, written representations and transcripts of tapes, recorded interviews and expert reports);
   - explained the two bases of that request (first, that Dr Barton had been interviewed twice in relation to the case of Elsie Devine so the advantage of surprise had been already been secured by the police and, second, that any IOC/IOP hearing would almost certainly take place in private so there would be very little risk of prejudicial publicity); and
   - expressed the hope that the requested disclosure could be given without the need to invoke section 35A of the Medical Act 1983 ("section 35A").

[1] My notes for those consultations have already been provided and should be read with this Advice.

3. The police letter[2]:

- declined to disclose any record in relation to the case of Elsie Devine other than her medical records because these had already been served on Dr Barton[3];
- stated that the other records are to form the basis of "challenge interviews" with Dr Barton later in 2005 and that it cannot not be in the public interest or the interests of an effective criminal investigation to allow those records ultimately to be served on Dr Barton in a professional conduct hearing;
- stated a concern that the other records might also reach the public, thereby affecting the fairness of a potential criminal prosecution through adverse prior publicity;
- set out a summary of the police interpretation of events and concerns arising from the meeting on 13 January 2005[4] and informed by counsel's advice;
- stated that Dr Barton was to be interviewed about another nine patients and that the priority cases should be complete by the middle of the year but that the investigation would span the whole of 2005;
- dismissed the possibility of incremental disclosure;
- stated that the voluntary arrangement seemed to be "holding" but noted the GMC's anxiety that this was not secure and that Dr Barton could practise in a short-term locum without supervision;
- confirmed that consideration had been given to one of the ACPO Protocols for the Notification and Disclosure of Information entitled "Managing Risks to the Public Safety from Health Case & Teaching Professionals" (2000) ("the ACPO Protocol")[5];

[2] Overall, the police letter is long on facts but short on legal reasoning: see, further, paragraph 6(4) below.
[3] Whichever option is selected by the GMC from those suggested below, the police should be asked to provide copies of those medical records immediately.
[4] Curiously, this (the major) portion of the police letter appears in italics. The reasons is unclear. Is it, perhaps, taken as a quotation from another document?
[5] Available on the ACPO website.

- stated that confidentiality, security of the criminal investigation, article 6 ECHR and the need to protect the public had all been balanced; and
- noted that there had been "significant previous disclosure to the GMC between August 2002 and October 2004" and that the IOC made no order against Dr Barton "seemingly content with her voluntary acceptance of conditions in terms of the prescription of controlled drugs".

Summary of the options

4. In my view, only two realistic options are now open to the GMC.
   (1) The first is to make a formal request to the police under section 35A and to contest the predictable refusal in court.
   (2) The second is to defer making a formal request under section 35A but to keep the progress of the police investigation under very close review.

   I have considered whether any hybrid option is available but have identified none. The GMC letter tried a conciliatory approach but has secured disclosure of only one of five heads. Before a choice between the two options is made, the matters set out in paragraph 11 below should be clarified as much as reasonably possible.

5. The strengths and weaknesses of each option are described in paragraphs 9-10 below, prefaced by an overall assessment of the GMC's position in paragraphs 6-8.

Overall assessment

6. Having been rebuffed by the police in respect of four out of five heads of disclosure, the GMC must now decide whether to invoke its power under section 35A to require disclosure.

7. The GMC can deploy, and the police can respond with, 12 main arguments and counter-arguments.

(1) Section 35A gives the GMC statutory power to *require*, not merely request, a doctor or any other person who in its opinion is able to supply information or produce any document which appears relevant to the discharge of any disciplinary function, to supply such information or produce such a document for the purpose of assisting it or any of its committees in carrying out such function.

(2) Section 35A does not, however, give the GMC an *absolute* right of access. It is phrased in broad, general terms. It does not contemplate the countervailing public interests which can compete in particular contexts. In the present context, the two countervailing public interests were identified by the Court of Appeal in Woolgar v Chief Constable of Sussex [2000] 1 WLR 25.

   (a) The public interest in ensuring the free flow of information to the police for the purposes of criminal investigations and proceedings, which requires that information given to the police in confidence would not be used for some collateral purpose.

   (b) The public interest in protecting public health and safety, which could justify police disclosure to a health regulatory body confidential information relevant to that body's inquiry provided confidentiality would be otherwise maintained.

(3) In balancing those interests, the Court of Appeal in the Woolgar case upheld the disclosure by police to the UKCC of the transcript of an interview under caution of a nurse accused of the over-administration of diamorphine and allied misconduct. There are, however, three important features of the Woolgar case which make it more helpful to the police than to the GMC.

   (a) The police were eager to disclose the transcript of the interview to the UKCC, which was keen to receive it. It was Ms Woolgar who opposed disclosure and who sought an injunction to restrain it[6]. In the present case, the police are reluctant to disclose and it is the GMC

[6] The injunction was refused.

which would need the court's assistance to compel disclosure.

(b) The police investigation was complete. Ms Woolgar had been interviewed and a final decision had been made that that there was insufficient evidence to charge her with any criminal offence. The reasoning of the Court of Appeal focused, therefore, on the competing requirements of confidentiality and Article 8 ECHR[7] rather than those of any on-going criminal (or other) investigation[8]. In the present case, the police investigation is incomplete. Indeed, that is the main reason for the refusal to disclose.

(c) The Court of Appeal recognised that the reasonableness of the police decision (to disclose or not) "may be open to challenge" in court by the regulatory body as well as by the practitioners[9]. It added, however, that the primary decision as to disclosure should be made by the police[10]. In other words, the court will be slow to interfere with the judgment made by the police about the balance to be struck between the competing interests.

(4) The police have failed to identify, precisely or convincingly, the real vice presented by compliance with the GMC's request.

(a) The police letter states, contrary to the understanding set out in the GMC's letter, that the documents covered by the four disputed heads of disclosure are to form the basis of "challenge interviews" with Dr Barton later in 2005. But it is a little difficult to accept that police questioning could take Dr Barton much by surprise. The facts and issues affecting her have been examined by several inquiries over recent years. She must already be

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[7] Article 8 ECHR states expressly that the right to privacy can be curtained "for the protection of health ... or for the protection of the rights and freedoms of others".

[8] The Woolgar case was followed by Munby J in A Health Authority v X (Discovery: Medical Conduct) [2001] UKHRR 1213 (Family Division) and by Newman J in R (Pamplin) v The Law Society [2001] EWHC Admin 300 but they too focused on confidentiality and Article 8 ECHR.

[9] Page 36g-37a.

[10] Page 37b.

well aware of them and the consequential points that could be put to her. Moreover, I believe it would be usual for the police to give *some* (termed "initial") pre-interview disclosure to an interviewee. The police do not explain why, in the present case, this would exclude the documents covered by the four disputed heads of disclosure.

(b) The police letter also states, cryptically, that the documents covered by the four disputed heads of disclosure might reach the public, thereby affecting the fairness of a potential criminal prosecution through adverse prior publicity. How this might happen (given that any IOP hearing would almost certainly take place in private) is not explained.

(5) The criminal investigation began as long ago as September 1998 and has proceeded extraordinarily slowly. It is difficult to detect the reasons for this. Although the criminal investigation is certainly complex (mainly by virtue of the antiquity of the events and the issues of confidentiality and medical practice that have arisen) and burdensome (mainly by virtue of the number of patients and volume of documents involved), I doubt that the police could convincingly explain each period of delay. The attached chronology reveals, in detail, the lack of any sense of urgency on the part of the police. As regards the future timetable for the criminal investigation, the police letter states this in rather vague terms[11]. The (snail's) pace with which the criminal investigation has proceeded is the GMC's most potent argument. There must come a day when its (and the court's) patience is exhausted. That said, if the criminal investigation were to be completed by the end of 2005, as the police letter predicts[12], the GMC has only another seven months to wait. If the GMC were to launch proceedings against the police, a conclusion could not be expected much sooner than that.

[11] The police aim to complete "the priority cases … by the middle of the year" but the investigation will "span the whole of 2005": paragraph 3 above.
[12] Footnote 11 above.

(6) As I understand it, the GMC is seeking only sufficient material to allow its disciplinary investigation to proceed. If the police were to charge Dr Barton and launch a criminal prosecution, the GMC would not hold a disciplinary hearing before or during the criminal trial. Rather, the GMC wants to be in a position immediately to launch the disciplinary proceedings if no charges are pressed against Dr Barton[13]. This should be made clear in any reply to the police letter.

(7) The ACPO Protocol contains some useful passages on police co-operation with professional regulatory bodies, including with the GMC under section 35A. No passage imposes any absolute duty on the police. All are subject to the exigencies of any criminal investigation and/or prosecution and the need to balance the competing factors. But the police are encouraged to co-operate as much as possible and to avoid any unnecessary delays. The passages can be cited against the police to check that the relevant considerations have been taken into account.

(8) Home Office Circular 45/1986 entitled "Police Reports of Convictions and Related Information", cited in the Woolgar case, ("the Circular") also contemplates that confidentiality can be breached by the police by disclosure of material to professional regulatory bodies in order to protect "vulnerable members of society" where there is "serious concern that a person … is unsuited to hold a position of trust"[14]. However, it is less specific and less detailed than the ACPO Protocol and, strictly, applies only to the revelation of doctor's *convictions* rather than to material collected during a criminal investigation[15].

(9) Since the summer of 2002 the police have revealed *some* material to the GMC and the police letter offers one of the five heads of disclosure now requested. But the exact extent of that disclosure, is unclear to me.

(10) The police claim that Dr Barton is currently subject to a voluntary undertaking governing her prescription of controlled drugs. But the accuracy

[13] The longer this is left, the stronger will be an application by Dr Barton that the disciplinary proceedings should be abandoned as an abuse of process on delay grounds.
[14] See, especially, paragraphs 2 and 7 of the Circular.
[15] See, especially, paragraph 3 of schedule 2 of Annex A to the Circular.

of this claim, and the precise ambit of any such undertaking, is unclear to me[16].

(11) On three occasions, in 2001 and 2002, the IOC refused to make an interim order restricting Dr Barton's registration. Moreover, in October 2003 the screener declined to refer Dr Barton's case to the IOC for a fourth hearing (because there was no new information justifying another referral). Thus, the GMC's own committee does not consider that Dr Barton poses an unacceptable risk to the public[17].

(12) There is nothing to stop the GMC seeking its own versions of the documents covered by the four disputed heads of disclosure. It is entitled to approach Dr Barton[18] directly, seek its own interview with her, invite her written comments and obtain its own expert reports; although, of course, it would be much quicker and cheaper for the GMC to have access to the pre-existing police versions[19].

8. In my view, weighing these rival arguments, the GMC is now in a stronger position to make a formal request under section 35A, and to contest any police refusal, than it was when I first advised in May 2004. A legal challenge to such a refusal would be arguable, not risible. Principally, this is because another year has passed with very little progress. However, the challenge would be unlikely to succeed. Principally, this is because the court would be slow to interfere with the judgment of the police that the criminal investigation would be undermined, because the GMC should not have to wait very much longer for the conclusion of the criminal investigation and because even the GMC's own committee considers there to be little or no risk to the public in the meantime.

[16] According to the attached chronology, the undertaking lapsed on 31 March 2002 and has not been reinstated.
[17] Since October 2003 there has been no material change of circumstances suggesting that the level of risk has altered.
[18] And other potential witnesses.
[19] And Dr Barton may rely on her privilege against self-incrimination and decline to co-operate with the GMC for fear of prejudicing her defence to any criminal prosecution.

The first option

9. The first option is to make a formal request to the police under section 35A, allow a reasonable time for reply (say 21 days) and then contest the predictable police refusal[20].

(1) The advantage of this option is that it would transfer the responsibility for balancing the competing public interests from the GMC (and the police) to the court. The GMC could not be accused of passivity, should it later transpire that Dr Barton is harming patients or putting them at risk. The parallels that could be drawn with Dr Harold Shipman are obvious.

(2) The disadvantages of this option are three-fold.

(a) It would raise the profile of the case, drawing attention to the delays that have already occurred (since September 1998). That said, the police have more reason than the GMC to fear the embarrassment of adverse publicity in this respect.

(b) For the reasons explained above[21], the present case is by no means the ideal one in which to test the scope of section 35A. It would be better to start with a case in which, for instance, the IOC has not already refused to make a interim order and in which the end of the criminal investigation is not (apparently) in sight. That said, there is merit in the GMC at least being *seen* to try to force the hand of the police. The mere attempt might force the pace of the criminal investigation[22].

(c) If the GMC were to lose in court, it would probably have to pay its own costs as well as those of the police.

[20] Section 35A does not contemplate a refusal to comply with a disclosure request. Nor, therefore, does it identify a legal procedure for challenging such a refusal. A claim for judicial review by the GMC would be the most obvious procedure. A letter before action would be needed.

[21] Paragraph 7.

[22] It may also have a precedent value beyond the present case. Other police forces, and the CPS centrally, might have a slightly greater sense of urgency in future investigations if they know that the GMC is prepared to actually to *invoke* section 35A rather than just *talk* about invoking it.

The second option

10. The second option is to defer making a formal request under section 35A but to keep the progress of the police investigation under very close review and to be prepared to activate under section 35A at short notice if the progress is not satisfactory.

    (1) The progress I have in mind is very specific: namely, as contemplated by the police letter, that the criminal investigation into the priority cases should be complete by the middle of 2005 and that the investigation into all nine patients should be complete by the end of 2005. The criminal investigation should not be allowed to drift. The police should be asked for monthly reports on progress and left in no doubt that any substantial slippage in the timetable would trigger the section 35A mechanism. If possible, it would be prudent to twin this with political pressure. Representations might be made at a very senior level[23], warning of the potential for a repeat of the criticism surrounding Dr Harold Shipman (but with the police as much more of a target this time) if the present case is not resolved soon. This two-pronged approach might persuade the police to make the present case a higher priority.

    (2) The advantage of this option is that it avoids a public confrontation between two public bodies, through proceedings in which both bodies would probably be criticised to some extent in the media (although the police more than the GMC)[24].

    (3) The disadvantage of this option is that it might be perceived by the police as just another in a series of threats made by the GMC to use section 35A. Experience teaches that the threats do not accelerate the pace of the criminal investigation. It could be portrayed as just more GMC passivity.

Conclusion

11. Before selecting the preferred option, it would be useful to clarify eight factual matters.

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[23] Perhaps by the GMC's President to the Chief Constable of Hampshire or even at Ministerial level.

[24] It would be possible to apply for part of the hearing to be in private but it is likely that a large portion of it (the part dealing with legal submissions) would be public.

(1) The currency and ambit of the voluntary undertaking and Dr Barton's access to areas of practice which are the subject of concern[25].

(2) The precise extent of previous disclosure by the police[26].

(3) The pace of progress in the nine further cases. In particular, will the "priority cases" really be complete by the middle of 2005?

(4) The terms of the email dated 28 February 2005 from the police to the GMC. This is referred to in the first paragraph of the police letter but I am told it has never been received. It seems to be quite important because it is described as setting out "an update of the position of the [police]".

(5) Whether any approach has been made by the GMC to the UKCC to discover whether it has similar concerns as regards nursing staff at GWMH[27].

(6) Whether any approach, formal or informal, to the Department of Health and the relevant NHS Trust under section 35A has yet been made by the GMC or is contemplated[28].

(7) Do the police normally share information with the GMC while the criminal investigation is on-going? Is there a normal practice which the GMC could argue is being departed from in the present case?

(8) Does the GMC usually pursue its investigation while to criminal investigation is continuing? In the present case, what scope is there for the GMC pursue to pursue its investigation in parallel with the criminal investigation?

In addition, I should be grateful to have a complete chronological set of all communications (letters, emails, telephone memoranda, notes of meetings etc.) between the police and the GMC. I have been sent the parts relevant to each set of instructions. But I lack a comprehensive set.

12. Whatever course the GMC adopts, it should reassure the police that any information disclosed will be used solely for the purposes of carrying out the GMC's fitness to practise functions.

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25 Paragraph 7(10) above.

26 Paragraph 7(9) above.

27 The last but three paragraph on page 4 of the police letter states that, at the meeting with the GMC on 13 January 2005, the police encouraged such an approach.

28 It would be useful to secure the support of the Department and/or the Trust and/or the Chief Medical Officer.

MARK SHAW Q.C.

Blackstone Chambers

25 May 2005

DR JANE BARTON

ADVICE

GENERAL MEDICAL COUNCIL
178 Great Portland Street
LONDON
W1W 5JE

Solicitor's ref: Toni Smerdon
Counsel's ref: BARTON – advice (25.5.5)
Tel: Code A
Fax:

25 May 2005

Toni Smerdon Code A

From: Mark Shaw Code A

Sent: 21 Jan 2005 16:53

To: Toni Smerdon Code A

Cc: Code A

Subject: BARTON - draft letter to police

Dear Toni,
As discussed this morning:
1 I attach a draft letter to the police, hoping that its tone and content are roughly what you and Paul want.
2 I am away on a case in Bahrain from Sunday to Wednesday. My flight arrives very early on Wednesday so I may snatch 40 winks at home but should be in the office in the afternoon. If you send me an email with any comments, we can discuss then.
3 I finished Basiouny. Richards J said he would try his utmost (but no promises) to deliver judgment in the w/c 31/1. My prediction remains that he will overturn the weird finding of fact and agree that the sanction was too lenient. But I doubt that he will quite be able to bring himself to say that erarase is the only possible correct sanction. So he will probably order suspension for 12 months and a resumed hearing. Just an educated guess!
Best wishes for the weekend,
Mark

This message has been scanned for viruses by MailController.

DR JANE BARTON

DRAFT LETTER
TO POLICE

Our ref: PS/PCC/Barton
Your ref: Op Rochester

[ ] January 2005

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

I write in the wake of our helpful meeting on 13 January 2005 to seek disclosure of certain limited information relating to the above.

You will have appreciated from the recent meeting that the GMC remains very concerned at the pace of an investigation which, while complex and onerous, began as long ago as September 1998. An important part of the GMC's statutory function is the protection of the public interest and, more particularly, of the interests of patients through taking disciplinary proceedings against doctors. It is very eager to fulfill that function as promptly and efficiently as possible. But, at present, the pursuit of the disciplinary investigation/proceedings is being hampered by the speed of the criminal investigation/proceedings. For their part, the police acknowledge the legitimacy of the GMC's concern but are understandably anxious to ensure that the release of information to the GMC should not prejudice either the investigation or the fairness of any ensuing trial.

Against that background, I come to the GMC's request for limited disclosure. What is sought is all the information in the possession of the police in relation to the case of Elsie Devine. **[Is it possible to be any more specific? Do we know what types of**

information/documents the police have collected?]. The basis of the request is as follows:

- As I understand it, the police have so far had reservations about disclosing the fruits of its investigation for two essential reasons. I believe I can now allay fears in relation to both.
- First, the police have been concerned that information revealed to the GMC might form the basis for an application for an interim order against Dr Barton before the GMC's Interim Orders Committee (now known as the Interim Orders Panel). The information supporting any such application would have had to be copied to Dr Barton. If this had happened before any police interview of Dr Barton, the advantage of surprise would have been lost: see, for example, the last few paragraphs of the letter dated 6 October 2003 from the police. I believe that this concern is no longer real because, as emerged at the meeting on 13 January, Dr Barton *has* now been interviewed in relation to the case of Elsie Devine (but, as yet, none of the other nine patients whose cases the police have identified as being especially troubling). In fact, I understand that Dr Barton has now been interviewed twice in relation to the case of Elsie Devine: one a generic interview, one an in-depth interview. (In any event, as the GMC has mentioned previously, it seems a little fanciful to suppose that Dr Barton could be taken much by surprise. The facts and issues affecting Dr Barton have been examined by several inquiries over recent years. She must already be well aware of them and the consequential questions that could be put to her.) In addition, it is very unlikely that any further application to the Interim Orders Panel would be made by the GMC in the foreseeable future. Four such applications have so far been made: one in 2001, two in 2002 and one in October 2004. All were unsuccessful. Some dramatic new material would need to emerge if a fifth application were to be justified in the foreseeable future. Accordingly, it is highly unlikely that any information disclosed to the GMC by the police would be passed to Dr Barton as a consequence of any Interim Orders Panel proceedings before the investigation has progressed a lot further, if at all.
- Second, the police have been concerned that information revealed to the GMC might reach not just Dr Barton but also the *public*, if used as the basis for an application before the Interim Orders Panel. The fear was that this might give rise to an argument that Dr Barton could not have a fair trial because of the risk of contamination of jurors' minds caused by adverse prior publicity. The GMC has sought to reassure the police that there was never any real risk of this happening because proceedings before the Interim Orders Panel take place in private (unless the doctor requests a public hearing, which would be extraordinary). Be that as it may, there is now an additional reason for reassurance: namely, the great improbability of a fifth application to the Interim Orders Panel in the foreseeable future (see the previous bullet point).

I believe that the GMC has already mentioned to you its statutory power to require the disclosure of information, conferred by section 35A of the Medical Act 1983, as amended. This provides that, for the purpose of assisting the GMC or any of its committees in carrying out its disciplinary functions, a person authorised by the GMC is entitled to require a doctor or 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. I attach, for information only and so that you can see its general format, a blank request for such disclosure.

I very much hope that it will not become necessary to invoke the power under section 35A. Much the better course is to proceed by agreement. The meeting on 13 January was a useful step in that direction. With that aim in mind, I look forward to receipt of the information sought, or confirmation that GMC staff might attend to take copies. If you have any queries or wish to discuss any aspect of this request, or indeed any aspect of the matter as a whole, I should be very happy to meet.

Yours sincerely,

[Author to be decided by GMC]

MARK SHAW Q.C.

Blackstone Chambers

21 January 2005

NOTES

1. I have deliberately omitted any suggestion that the GMC might apply the same approach to the other nine cases as soon as Dr Barton is interviewed in relation to each of them. I can see a possible advantage in such silence, and no disadvantage. The possible advantage is that silence avoids giving the impression that this request is the "thin end of the wedge". Such an impression might make the police think more carefully before replying than they might otherwise do. There is no disadvantage because if the request is agreed, disclosure in the Devine case can in any event be used as a helpful precedent as later cases arise.

2. Could I please have a copy of the statement provided to the GMC by DCS Watts for the IOC hearing on 7 October 2004?

DR JANE BARTON

DRAFT LETTER TO POLICE

GENERAL MEDICAL COUNCIL
178 Great Portland Street
LONDON
W1W 5JE

Solicitor's ref: Toni Smerdon
Counsel's ref: BARTON – letter to police (21.1.5)
Tel: 020-7189-5126
Fax: 020-7189-5101

21 January 2005

Mariana Armatti Code A

Toni Smerdon
Email: Code A

I am sending this email re Dr Barton on Roger Henderson QC's behalf because he has to attend a hospital appointment and then have a wisdom tooth out this afternoon and has not been able to contact you. These are various points which he has raised in no particular order of importance:

1. Will the constitution of the IOC include earlier members from earlier hearings?

2. From pages 467 to 507 there are details re various patients other than the original five. What background document explains how these documents came to be provided to the GMC, what they are, by whom they were created etc., if any?

3. In those documents there is no expert review of C Lee but there is such a review for all other patients. Has it been omitted and if so by whom and is it available?

4. In only some of those patients' cases is there any reference to Dr Barton and in a number of cases the prescription appears to have been by other doctors. Is it envisaged that these will be relied upon by the GMC and if so upon what basis?

5. Where is the letter of 24th September 2004 to Dr Barton? Please fax a copy to me asap.

6. Does the letter comply with Rule 5? I can only judge this question when I have seen the letter.

7. Where is the letter of Dr Barton to the GMC of 27th September which is referred to in the letter of 30th September from Paul Hylton to her? Please fax a copy of it.

8. Do the records which are to be available show Dr Barton's involvement in the relevant prescriptions to the additional patients? If so, can these be flagged and copies provided for me if there is any suggestion that the patient was not properly treated.

9. Is there a transcript of the first hearing of the IOC and any additional part of the transcript of the second hearing?

10. I note that the GMC's preferred outcome is that Dr Barton should be suspended but in the absence of any recent problems or reported problems with her practice and the fact that the present evidence advances the case only a little from the availability of evidence at the third

IOC hearing I question whether it would not be satisfactory to re-establish conditions which prevented Dr Barton from prescribing benzodiazepines or opiates for a period of say 18 months. It should not be thought that I consider that that should remain the state of affairs if the evidence becomes different or Dr Barton is charged or arrested. The case will inevitably have to be kept under review.

11. The recent letters need to be put in chronological order including the letter which is presently at page 508 to bring matters up to date.

12. The cases to which I referred in the draft Advice re Interim Orders of 12th July 2004 at paragraphs 9, 10 and 11 will need to be available for the Committee but should not be provided in advance. However, if the Legal Assessor's identity is known, it would seem to me sensible to provide him and Dr Barton's advisors with a copy of the case referred to in paragraph 9, namely **The Queen on the application of Dr X and GMC (2001) EWHC Admin 447.**

Roger Henderson QC
5 October 2004

CHRONOLOGY

DR JANE ANN BARTON

February 1998 – October 1998	Original alleged period of inappropriate prescription to 5 patients (aet 75-91) at Gosport War Memorial Hospital, all of whom died at the hospital where Dr Barton was a part-time clinical assistant (Page, Wilkie, Richards, Cunningham and Wilson) (pages 4-8)
28th April 2000	Dr Barton resigned from part-time employment and thereafter continued general practice (pages 413 and 424)
27th July 2000	Hampshire Constabulary first informed GMC of concern re Dr Barton re Richards (page 9)
21st June 2001	**First IOC Hearing** (generally re Richards) **No order**
10th July 2001	Professor Livesley's report re Richards: Death occurred earlier as a result of drugs and would have done from natural causes (pages 19 – 52)
14th August 2001	Hampshire Constabulary letter: Insufficient evidence to support a viable prosecution against Dr Barton re Richards but continuing enquiries re other deaths and further review re Richards (page 13)
18th October 2001	Report of Dr Mundy re Cunningham, Wilkie, Wilson and Page (pages 53-58)
12th December 2001	Report of Professor Ford re 5 patients (pages 59-97)
6th February 2002	CPS decided not to institute criminal pleadings and disclose their papers to GMC (pages 15 and 16)
21st March 2002	**Second IOC Hearing** (partial transcript pages 413-431) **No order**

End March 2002	Dr Barton's undertaking to the Health Authority not to prescribe opiates or benzodiazepines ceased (pages 453-4)
11th July 2002	Rule 6(3) Notice (pages 4-8)
27th August 2002	Response from MDU for Dr Barton (pages 404 - 412) (plus partial transcript of second IOC Hearing)
29th August 2002	PPC referred Dr Barton to PCC (hearing still awaited) (pages 1-399)
13th September 2002	Letter from GMC "President" to Dr Barton giving notice of third IOC Hearing
19th September 2002	**Third IOC Hearing** (pages 1-455) (transcript pages 437-455) **No order and a judgment that there as no new material since the second Hearing and it would be unfair to consider the matter further**
September 2002 ... to date and continuing:	Police investigation continues (pages 458 and 460). First papers of selected cases likely to go to CPS in December 04 or early 2005
February 2003	5 experts commence analysis of 88 Gosport War Memorial Hospital patients' records (page 460) work expected to finish October 2004. Classification of cases into 3 categories.
May 2004	Other experts (geriatric and palliative care) instructed to judge category 3 cases (page 460)
24th September 2004	? Letter of notification of 7th October IOC Hearing
27th September 2004	Dr Barton's letter confirming intention to attend IOC Hearing on 7th October
27th September 2004	? Letter from MDU for Dr Barton seeking adjournment and questioning compliance with rule 5
30th September 2004	Receipt by GMC of electronic copy of witness statement from Detective Chief Superintendent

	Steven Watts and supplementary statements re further patients (pages 456 – 507)
30th September 2004	GMC letter to MDU imparting refusal of adjournment by Chairman of the Committee and questioning the challenge to 24th September rule 5 compliance
30th September 2004	MDU letter to GMC re letter of 30th September from GMC maintaining rule 5 non-compliance, concern re absence of documentation and concerning merits e.g. re absence of present cause for concern from Dr Barton's practice
30th September 2004	GMC letter to Dr Barton (page 508)
7th October 2004	**Fourth IOC Hearing** **GMC seek order of suspension and in default conditions to prevent prescription by Dr Barton of benzodiazepines or opiates.**

1 October 2004

Ref: TS/IOC

The Clerk to Roger Henderson QC
Henderson Chambers
2 Harcourt Buildings
Temple
London EC4Y 9DB

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

BY COURIER

Dear Sir/Madam

I write further to the arrangement with Ms Smerdon of our office and now enclose the papers in relation to the case of Dr Barton to be heard before the Interim Orders Committee on 7 October 2004.

Once Counsel has read the papers, then he should not hesitate to contact Ms Toni Smerdon of Instructing Solicitors.

Yours faithfully

Code A

Anthony Omo
Solicitor

Code A

Enc.

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
email gmc@gmc-uk.org www.gmc-uk.org
Registered Charity No. 1089278

In the matter of the Interim Orders Committee

General Medical Council

Dr Jane Ann Barton

Brief to Counsel to attend before the
Interim Orders Committee on 7 October 2004

To: Mr Roger Henderson QC
Henderson Chambers
2 Harcourt Building
Temple
London
EC4Y 9DB

From: GMC Legal
178 Great Portland Street
London
W1W 5JE

Direct Dial:
Direct Fax:
Email:
Code A

Ref: AO/IOC/7 October 2004

Enclosures

1. IOC bundle for Dr Barton
2. Section 41A Medical Act 1983 (as amended)
3. The General Medical Council (Interim Orders Committee)(Procedure) Rules 2000
4. The General Medical Council (Constitution of Fitness to Practise Committees)(Transitional Arrangements) Rules 2003
5. Letter from MDU dated 27 September 2002 (received 27 September 2004)
6. Letter to MDU dated 30 September 2004
7. Letter from MDU dated 30 September 2004
8. Letter to Dr Barton dated 30 September 2004

Instructions

1. Instructing solicitors act on behalf of the General Medical Council in relation to the hearing of Dr Barton's case, taking place before the Interim Orders Committee on 7 October 2004 at 9:30 at the General Chiropractor Council, 44 Wicklow Street, London, WC1X 9HL.

2. Counsel is instructed to attend and present the case on behalf of the GMC.

3. Counsel will see that the case is listed as a new case of conduct. However, Counsel will be aware that the case has appeared before the IOC on 3 occasions previously, the first being 21 June 2001, the second being 21 March 2002 and the last occasion on 19 September 2002. On each occasion the Committee determined that it was not necessary to make an order in relation to Dr Barton's registration.

4. The brief background to the matter is that the case involves inappropriate prescribing to five patients at Gosport War Memorial Hospital between February 1998 and October 1998. The five patients, whose ages range between 75 and 91 all died at the Hospital where Dr Barton at the material time was a clinical assistant in elderly medicine. Dr Barton is also a General Practitioner.

5. Counsel will see that the police began an investigation into the circumstances of the death of one of those patients, Gladys Richards and that the investigation later extended to 4 other patients.

6. In terms of the previous hearings, when the Interim Orders Committee first considered the matter in June 2001, it was only considering the case of Gladys Richards as that was the extent of the information available to the GMC on that occasion.

7. In February 2002 the Crown Prosecution Service, who were also involved with the matter, decided not to proceed with the criminal proceedings and their papers were then disclosed to the GMC and this introduced new material to the case, which was then placed before the Interim Orders Committee on 21 March 2002.

8. In terms of the hearing that took place in September 2002, Counsel will see from the papers that the GMC had available to it, several reports into the ~~debts an~~ deaths and that these reports were considered by the Interim Orders Committee on that occasion but no order made.

9. Essentially, the Interim Orders Committee has considered the papers in the bundle up to page 455 and the new material, as far as the GMC is concerned, commences at page 456. This starts with a witness statement from Hampshire Constabulary. The first statement is from Detective Chief Superintendent Steven Watts – Head of Hampshire Constabulary Criminal Investigation Department and the senior investigating officer in respect of a police investigation named Operation Rochester. As Counsel will be aware, this is an investigation into the circumstances surrounding the death of 88 patients occurring principally in the late 1990's at the Gosport War Memorial Hospital in Hampshire.

10. Counsel will see that during the investigation a number of clinical experts have been consulted and they include Professor Brian Livesly, who provided an expert opinion on the death of Mrs Richards and Counsel will find his expert opinion between pages 19 and 52 of the papers. Police also obtained an expert opinion from Professor Ford in respect of the death of 5 patients – Richards, Cunningham, Wilkie, Wilson and Page and Counsel will find his opinion between pages 59 and 97 of the papers.

11. The police also took an expert opinion from Professor Mundy, who reported on the death of patients Cunningham, Wilkie, Wilson and Page and Counsel will find his report between pages 53 and 58. Counsel should note that all of these reports have previously been before the Interim Orders Committee and do not form part of the new material.

12. Counsel will see that the statement of DCS Watts sets out how the police investigation has proceeded and the extent of the investigation. To date, 330 witness statements have been taken and 349 officers reports created. The police have categorised the cases into 3 categories – Category 1, where there were no concerns in respect of the cases upon the basis that optimal care had been delivered to the patients prior to their death. Category 2, where there were specific concerns that these patients had received sub-optimal care and according to the police, these cases are currently undergoing a separate quality assurances process by a medical legal expert to confirm their rating. 19 of the cases have been confirmed and have been formerly released from the police and have been handed to the GMC for consideration. Category 3, 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.

13. Counsel will see that the police are concerned about releasing all of their information to the GMC as this has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professional involved in their inquiry. The police investigation is ongoing and obviously the police priority is to consider whether any crime has been committed and if so how to deal with it.

14. In terms of the 4 cases previously considered by the Interim Orders Committee, Counsel will see at page 465 of the papers that the case of Cunningham has been assessed as a category 3 case and is being investigated, the case of Wilson is also a category 3 case, the case of Richards has been assessed as category 2 case and in respect of Wilkie, no further police action is to be taken.

15. Turning to the expert opinions that have been provided to the GMC, Counsel will find the first of these at page 467. This deals with the case of Hadley, the expert review at page 469 reports that in the last 5 days before his death, Mr Hadley was inexpertly treated with opioid analgesics, although this did not in any way substantially alter the prognosis.

16. At page 472, in respect of the patient Hobday, the expert report confirmed that although higher doses of opiaites were used than may have been necessary, the cause of death was due to stroke.

17. In terms of the case of Batty at 492, the expert review determined that the treatment was sub-optimal due to the high doses, especially midazolam. The cause of death was felt to be unclear by the expert teams.

18. With respect to the case of Hall at page 498, the experts note that although he undoubtedly had severe underline disease, the acceleration from the 1 dose of Oramorph to 40 mgs of diamorphine was sub-optimal treatment.

19. In respect of the other notes, the conclusion is that although there may have been higher doses of opiates prescribed, this did not in any event alter the death or prognosis.

Adjournment

20. Counsel will be aware from the papers that the solicitors for Dr Barton have requested an adjournment of the case, this is effectively put on 2 basis. The first is that the Counsel who has represented Dr Barton on each occasion, Mr Alan Jenkins is not available and the second is that Dr Barton has not had sufficient time to consider the material.

21. This application for an adjournment was placed before the Chairman of the Interim Orders Committee who has refused it and Counsel has a letter dated 30 September 2004 dealing with the application for an adjournment.

22. Counsel will note from the solicitors letter dated 30 September 2004 that they have renewed their application for an adjournment and this has been rejected by the Chairman of the Interim Orders Committee.

Issue

23. Counsel will be aware that this matter has been before this Committee on 3 previous occasions at which points, no order was made and on the last occasion in September 2002 the Committee determined that they did not have the information before them and so did not consider the matter.

24. Essentially the police provided some further material which sheds some light on their investigation but they are concerned about disclosing all of the material they have given the stage at which their investigation is currently at. The GMC therefore does not have the full case from the police although it does consider that it has sufficient concerns raised from the papers about Dr Barton's practice to warrant the imposition of an order from the Interim Orders Committee. The police have provided some further new material which will be placed before the Committee and although those instructing appreciate that this is not definitive, it does provide the Committee with an idea of the scale of the operation currently ongoing.

25. Counsel will note that Dr Barton has left the job at the Gosport War Memorial and she did so back in 2000. The doctor continues to work full time as a GP, subject to other matters and it is claimed by her Counsel that she does not routinely prescribe benzodiazepines or opiates. The condition to which she agreed with the Health Authority was that she would not prescribe Opiate or bezodiapines lapsed at the end of March 2002 and that undertaking has not been renewed.

26. Counsel is instructed in the first instance to seek an order of suspension from the Committee in respect of this matter as there are grave concerns about Dr Barton's performance at the said Hospital and the fact that she is able now to continue such practice.

27. Counsel is also instructed that if the Committee are not minded to impose an interim order of suspension then the GMC would invite the Committee to consider conditions which are enforceable that Dr Barton does not prescribe benzodiapine or opiates at all.

28. Counsel has with the papers, a copy of the Interim Order Committee's Procedure Rules and a copy of the General Medical Council (Constitution of Fitness to Practise Committees)(Transitional Arrangements) Rules 2003, Counsel also has an extract from the Medical Act 1983 (as amended) Section 41A, dealing with the Interim Orders Committee.

29. Once Counsel has had the opportunity of considering the papers, then he should not hesitate to contact Ms Toni Smerdon of instructing solicitors to discuss matters further on 020 7189 5126 or by e-mail at tsmerdon@gmc-uk.org.

Signed:.... Code A .... Dated:......1/10/04........

Toni Smerdon Code A

From: Mark Shaw Code A
Sent: 14 Jun 2004 19:01
To: Code A
Cc:
Subject: BARTON

BARTON - letter to police (14....

BARTON - notes for con (14.6.4...

Dear Paul & Toni,

As threatened/promised at this afternoon's meeting, I attach a draft letter to the police which ought. It may need to be refined in the light of anything which Paul discovers about the CMO's meeting with the police last Friday. But it should, if at all possible, be sent out before any reply to the 5/5/4 letter is received.

I also attach my own notes for the meeting for your file.

Best wishes,

Mark

<<BARTON - letter to police (14.6.4).doc>> <<BARTON - notes for con (14.6.4).doc>>

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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)
Tel: Code A
Fax:

14 June 2004

DR JANE BARTON

NOTES FOR CONSULTATION
Monday, 14 June 2004

<u>**Three questions/answers**</u>

1. What are the merits of a JR against the failure of the police to:
   (a) disclose information; and/or
   (b) progress the investigation?
2. What steps should GMC take in order to progress its own inquiry?
3. What general guidance can be given on the interface between police and GMC cases?

<u>**Three answers**</u>

[I assume no reply to GMC letter of 5/5/04.]

1. It is impossible to give definitive advice because the merits of a JR depend on the unreasonableness of the extent of the police delay.

The main factor affecting this is the validity of the police's *reasons* for delay.

I do not know what these are except in very broad terms:

- Police thought investigation was closed in 2/02 ([but shouldn't this accelerate?].
- Complexity.
- Now another 57 patients to investigate.
- Liaison with relatives.
- Audit of panel of five [but why needed?].
- New, single expert to refine investigation [but why need another layer?].

My *impression* is that the reasons for delay are **poor** (contrast VV) and court would be troubled, although nevertheless unlikely to intervene because prosecutorial discretion is quite sacred territory:

- **Strong and obvious similarities to Shipman (although he was covert and worked alone):** 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 "accelerate/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 PS was absolutely right to send severe letter on 5/5/04.

  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).
- 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.

  - In VV there have been problems of access to information, flawed earlier inquiries and confidentiality.

  No such apparent problems here.

CONCLUSION

There is enough properly to threaten JR – if only to protect GMC.

If GMC does not mind threatening JR which it may not carry through (serious step), I recommend a further, very sterner letter from GMC to police asking some direct QQ: for example

- **what precisely are reasons for delay (explaining how it's been excessive already);**
- **what if (rough) future timetable;**
- **what event(s) will resolve the disclosure impasse (Barton's i/v)**

I can draft this week, if wished.

This should be twinned with "reading the Riot Act" behind the scenes and making clear that if there is adverse publicity the GMC will not hesitate to divert blame towards the police (since police have asked/insisted) that GMC does nothing.

My criminal colleagues tell me that this would really scare the police: very sensitive about delay/Shipman.

2. It should take whatever the normal steps would be (absent any police investigation) and

Make this inquiry a priority for resources.

Find out where/in what Barton is practising now.

Concentrate on the major areas of current concern so as to compile material asap for reversion to IOC asap (because u/taking has lapsed).

Consider using s.35A against DoH/Trust.

Liaise with CMO to get more pressure exerted.

[IOC has refused to make an i/order thrice (the third time because there was, allegedly, 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 cannot revert unless/until police/GMC investigation reveals new information.]

Press the police for disclosure of anything possible (to provide short-cuts): most especially the names of the 15-16 patients that cause most concern.

[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).]

[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 general 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).]

3. Difficult to add to the general advice I gave in VV's case.

Legitimate for GMC generally to wait for criminal proceedings.

But there are limits – exceeded in rare cases.

It's impossible to give a definition of improper and inordinate delay by police: each case depends intimately on its own facts.

Police will get a wide margin of discretion from court.

Margin ends if delay is unreasonable.

In practice, need a need a protocol to alert caseworker to danger signals and to need to seek legal advice.

Then need a set of QQ for GMC to put to police to flush out how much longer delay is likely to last and whether delay is unreasonable before can decide whether to "unfreeze" GMC inquiries and press/sue police.

<u>QQ</u>

- What is GMC to wait for?
- Why is it to wait (what is the vice)?
- What is the likely timetable?
- What problems have been encountered by police?

(See draft letter to police in this case for other typical questions).

Miscellaneous

The basic principles are the same as discussed on 26/5/04 in relation to VV.

It is legitimate for police to give only limited disclosure before i/v: so can take by surprise (o/w risk of tailoring/contamination).
And to disclose in phases before each i/v (if dealing with different topics).
But why cannot police i/v now (or at least give date)?
Seems that after i/v, vice dissolves: police 6/10/04 letter.

Police under misapprehension about scope for prescribing NOW: police 6/10/04 letter!!
Need to disabuse.

There are 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.

Police position:

- Investigating 62 deaths up to 1998.
- Much further work needs to be done to validate and develop the provisional findings of the panel of five experts: 6/10/03 letter.
  But based on misconception that Barton not permitted to prescribe opiates.
  Baker report not known to police.
- Will probably need to i/v Barton at length and i/v strategy will have to take account of what Barton told in advance: 6/10/03 letter.
  This needs careful consideration.
- Willing to discuss with screener maximum disclosure that can be given.
- The validation and development of the provisional findings of the panel of five experts is to be done by another, single expert: GMC 7/1/04 letter.
  GMC thought due by 1/04 but police deny and still no sign or deadline.

- The provisional findings of the panel of five experts to be communicated to relatives by 2/04: police 28/1/04 letter.

Documents

Apparently there were meetings on 20 Nov 2002 and 27 Feb 2004.

Any minutes available? (Police 28/1/04 letter suggests so.)

Notes

Police team:

1. Steve Watts (DCS)
2. David Williams (DCI) [formerly DCI Nigel Niven)

No complaint. Information case.

Questions

Any discussions pursuant to end of police's 6/10/03 letter?

Any sort of reply received to GMC's letter dated 5/5/4?

DR JANE BARTON

CHRONOLOGY
(compiled for consultation
on Monday, 14 June 2004)

1 May 1988	Barton began work as clinical assistant at GWMH.
Jul 1991	RCN convenor met nurses to discuss improper use of opiates at GWMH.
Feb-Oct 1998	Alleged mistreatment (of five main patients) by improper use of opiates at GWMH.
Sep 1998	**Concerns first raised by Richards family. Police investigation began.**
Mar 1999	**CPS decided there was insufficient evidence to pursue c/p in respect of Mrs Richards.**
Jan 2000	NHS Independent Review Panel found that opiate doses were high but appropriate in circumstances.
?????? 2000	Health Service Ombudsman rejected a complaint.
5 Jul 2000	**Barton resigned from GWMH.**
27 Jul 2000	**Police notified GMC of allegation by Richards family against Barton and restarted investigation: no complaint direct to GMC from any family (all information, not complaint, cases).**
Mar 2001	11 other families raised similar concerns with police. Four were investigated.
Jun 2001	**IOC considered Richards allegation and made no order.**
Aug 2001	Police passed concerns to CHI, which began investigating care at GWMH *since* 1998 (including interviews of relatives and staff).
Feb 2002	**CPS decided not to pursue c/p in respect of four other patients (Page, Wilkie, Cunningham and Wilson). CPS papers disclosed to GMC.**
Feb 2002	**Barton gave voluntary undertaking/condition to Health Authority (not to prescribe opiates or benzodiazepines).**

21 Mar 2002 **IOC considered allegations in respect of all five patients and made no order.**

31 Mar 2002 **Barton's voluntary undertaking/condition given to Health Authority (not to prescribe opiates or benzodiazepines) lapsed.**

28 May 2002 Mrs Richards's daughter protested about lack of progress.

Jul 2002 CHI reported concerns (especially about anticipatory prescribing).

Aug - Oct 2002 **The (political) pressure created by Mrs Richards's daughter's protest led to the police sending further papers to CPS and re-opening their investigation to encompass all (62) patients who died while under Barton's care at GWMH despite some apparent reluctance. GMC's investigation put on hold.**

29 Aug 2002 **PPC referred all five cases to PCC but made no referral to IOC.**

Sep 2002 - Sep 2003 Police referred all 62 patients to a panel of five experts, who investigated.

19 Sep 2002 **In response to a referral by GMC's President, IOC again considered allegations[1] in respect of all five patients but again made no order (in view of the absence of any new material[2]).**

19 Sep 2002 Health Authority sent GMC file of correspondence concerning use of diamorphine in 1991.

9 Oct 2002 FFW advised that screeners would be misdirecting themselves if they were to refer Barton to IOC again in light of the Health Authority's disclosure.

20 Nov 2002 Meeting between GMC and police.

2 Dec 2002 Police asked GMC to removed Barton case from PCC list. GMC did so (not yet reinstated).

30 Sep 2003 **Police met GMC and said that the five experts had concluded that the treatment of about 25% (15-16) of patients and the cause of their deaths gave rise to concern and should be investigated further (by a new, single expert auditing the work of his five predecessors). Disclosure to GMC was sought but refused because of risk of disclosure to Barton if her case were to return to IOC.**

2 Oct 2003 GMC letter pressed police for disclosure.

---

[1] It had reports from Dr Ford and Dr Mundy.
[2] The Legal Assessor advised that in the absence of "new evidence ... it would be unfair to the doctor ... to consider the matter any further": apparently a reference to the doctrine of *res judicata*.

Oct 2003	**Baker report (independent clinical audit of care of 81 patients, sampled at random, who died at GWMH from 1988 to 2000 with particular emphasis on Barton's conduct) sent to CMO but not GMC.**
Oct 2003	**Screener refused to refer case for a fourth time to IOC (in view of absence of new evidence).**
Jan 2004	GMC believed (wrongly according to police) that the validation and development of the provisional findings of the panel of five experts by another, single expert was due to be completed.
7 Jan 2004	GMC sought update from police on progress.
28 Jan 2004	Police unable to provide any further information on progress.
6 Feb 2004	GMC confirmed to police that GMC inquiries were "on hold" pending conclusion of the police investigations.
Mid-Feb 2004	The provisional findings of the panel of five experts were to be communicated to relatives: unclear whether done.
Feb 2004	GMC met CMO, at latter's request.
27 Feb 2004	**Meeting between GMC, FFW and police. Police said that the investigation was still incomplete, that they did not know when it would be complete or when Barton would be interviewed and that they would not release any information to GMC unless GMC guaranteed not to pass it on to Barton.**
5 May 2004	Assertive letter from GMC to police.
17 May 2004	Baker report sent to GMC, subject to undertaking not to copy or disseminate.

M.S.
14 June 2004

DR JANE BARTON

SUMMARY OF BAKER REPORT
(compiled for consultation
on Monday, 14 June 2004)

Overview

Commissioned by CMO and written by head(?) of Department of Health Sciences, University of Leicester.

Completed in October 2003.

Audit of care of 81 patients (random sample) who died within DMfEP (not just under Barton's care) at GWMH from 1988 to 2000.

Conclusions

- A practice of almost routine and liberal use of opiates before death was followed in order to "make [patients] comfortable": culture of limited hope/expectation towards recovery.
- Patients who experienced pain and whose death in the short term were given opiates.
- Alternative treatment with other pain-relief or detailed assessment of the cause of pain/distress was generally ruled out.
- Impossible to identify origin of practice (of premature use of opiates): Barton may merely have implemented it.
- But began in 1988 at latest.
- It almost certainly shortened the lives of some patients. In some patients determined rehabilitation could well have led to a different outcome.
- In some (fewer) cases it is probable that patients would o/w have had a good chance of being discharged from hospital alive.
- Opiates administered to almost all sampled patients regardless of illness.

- Opiates often prescribed before needed (often on admission) even if not administered for days or weeks.
- Proportion who received opiates before death was remarkably high.
- Difficult not to conclude that some patients were given opiates but should have received other treatment.
- Many records did not show a careful assessment before use of opiates or a stepped approach to management of pain in palliative care.
- Records often poor: silent on recent fractures, deteriorations and cau ses, causes of pain.
- Most patients had acute, chronic illness and believed unlikely to ever be capable of discharge to a nursing home.
- Unlikely that death rate was higher than in a comparator unit.
- Starting doses were too high.
- In 16 cases, because of inadequate records, there were concerns about the indications for starting opiates, the investigation of pain or the choice of pain-relief.
- Barton was part of a team (under a consultant) but:
  - issued most of the MCCDs;
  - made most of the entries in records; and
  - was responsible for most of the prescribing.
- Procedurally:
  - only documentary evidence used; and
  - no opportunity for relatives or staff (including Barton) to comment on issues or findings.

<u>**Recommendations**</u>

- Audit reinforces concerns (raised by relatives) so investigations should continue.
- Rota followed by Barton and partners should be obtained and analysed to explore patterns of death.

- National and local policies/guidelines on opiate medication should be devised and applied.
- Use of opiate medication should not be limited for needy patients – sometimes insufficient used.
- Better statistics/codes should be compiled to enable better monitoring in future.

Toni Smerdon Code A

From: Mark Shaw Code A
Sent: 08 Jun 2005 10:06
To: Toni Smerdon (020 7189 5126)
Subject: BARTON

Dear Toni,

Since you told me in yesterday's con that my draft Advice in this case was fine and had been circulated, I attach a final version and enclosures.

I have kept the same date because I made no changes to the 25 May version.

Hard, signed copy is on the way in the post.

Best wishes,

Mark

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(iii) It is based on the identification of a possibility less than any real or realistic prospect of the allegation being sustained;

(iv) Properly arguable means reasonably arguable. An allegation is not properly arguable if it is absurd, frivolous, vexatious or repeats an earlier allegation (whether made by the same or different complainants);

(v) Conflicts of evidence should not normally be resolved;

(vi) Implausible accounts unsupported by other evidence can legitimately be rejected.

3. If the Medical Screener is satisfied that the answers to both 1. and 3. are yes the case must be referred to the PPC.

4. If the Medical Screener is in doubt he should err on the side of caution and refer the case to the PPC.

5. If the Medical Screener's answer to 1 or 3 is no the case must be referred to a Lay Screener.

6. The Lay Screener should follow the above approach in formulating their advice.

Field Fisher Waterhouse
26 November 2002

Good Morning Sarah and Rachel,

Professor Ford's oral evidence is not as punchy as his reports despite repeatedly being drawn back to them paragraph by paragraph. However, in some ways his evidence is all the more effective for it. He is being considered and conservative and ultimately I think that that may make him more persuasive. It certainly makes the defence experts' jobs, who have roundly criticised Ford's 'excesses', much harder, as well as that of Tim Langdale QC. We may lose some of our charges as a result (especially in the area of a failure to examine) but in the wider view this may not be very important.

A great deal of time is being taken because the panel have insisted on a 30 minute break between Ford dealing with every single patient, so that they can read the super-improved chronologies and Dr Barton's statements. I have tried to encourage them to do their reading in 20 minutes or to read up on two patients at a time but my pleas have fallen on deaf ears. They have promised to use this Thursday to read up on the remaining patients, H-L, so that Friday will go much quicker. That should leave 2 ½ days for defence xx and panel questions. It will be tight but do-able we hope.

On a separate timing issue, I was approached by Chris Challis yesterday about a possible two week interlude in the case because of GMC overbooking. I can not remember the exact dates but the suggestion is that we should not sit for two weeks sometime at the end of this month and into August (I think) to allow the GMC to fit in other cases. In my view we must absolutely resist this suggestion as strongly as possible.
At present we estimate that the defence case may take 2-3 weeks. They are calling Barton, Lord, a number of nurses (we believe) and they have now served us with two experts.
My belief is that they will be finishing the defence case in the week of 27th to 31st July. That gives us the 3rd to 5th August for speeches and then just 2 ½ weeks for the panel decision on SPM and sanction.
If we lose 2 weeks in the middle of our case my firm belief is that we will not finish it within the allotted time frame. That would mean, in all likelihood, that the remainder of the case would take place next year. This would be completely unacceptable to us, Barton, and the relatives. This has been a high profile/publicity case. If the GMC wanted to demonstrate an inability to regulate their proceedings properly this would be a very good and very public way of doing so. Dr Barton has been living with these proceedings for a very long time and frankly I think it would be very unfair upon her (whatever the ultimate outcome of this case) for her to have to wait any longer. It would also mean that there is likely to be a very significant gap between the evidence and the decision making (if I am right about timing).
May I suggest that you pass my views on to Peter and that he uses his (not inconsiderable) powers of persuasion to nip this idea in the bud.

It is unfortunate if the GMC have other cases which they can not otherwise fit in, but knocking this case off the road ¾ of the way to the finish line in order to deal with other, less sensitive cases, is surely not the answer.

Perhaps you can call me at your convenience to discuss the above. I will be in chambers all day beginning my preparation on cross-examination.

Kind regards,

Tom

From: Ellson, Sarah Code A
Sent: 08 July 2009 07:42
To: Tom Kark
Cc: Ben FitzGerald; Cooper, Rachel; Ahmed, Zahra
Subject: Dr Barton - Post day 21

I have just skim read yesterday's transcripts and note that we are non sitting today and tomorrow and that obviously we had to discuss the pace of Prof Ford's evidence with a view to fitting him in over Friday/Monday/Tuesday (?? Wednesday). If there is anything we need to discuss or anything you need us to do (recognising Ford is part way through his evidence) - do let us know.

In reading Ford did not seem quite a punchy as perhaps in some of our cons but that may just be the transcript and a reflection of some of the more dramatic evidence we have had in recent weeks.

I am around today if you need anything (in London at meetings tomorrow)

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
dd: Code A

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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 Code A
Cc: Toni Smerdon
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
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

E:\Committee\IOC\Items\2004\October\Barton 07-10-04.doc

Confidential

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee

7 October 2004

New case of conduct

BARTON, Jane Ann

BM BCh 1972 Oxford

Code A

Specialty: GP

Current Employer: Fareham and Gosport PCT

Other interested parties: Hants Police, CMO and Department of Health

Legal representation: Mr Ian Barker, Medical Defence Union

d.o.b.: Code A

FPD Reference and Name of caseworker: 2000/2047, Paul Hylton

Nature of case: Inappropriate prescribing/substandard clinical practice

Reason for referral to IOC : The Police have referred a number of cases to the GMC and the CPS are considering further cases.

Previous history: None

Case history: The Preliminary Proceedings Committee referred information in respect of Dr Barton for an inquiry by the Professional Conduct Committee on 29 August 2002. The PCC hearing has not yet taken place.

Hall, Tamsin

From: Hall, Tamsin
Sent: 12 August 2008 10:35
To: Ellson, Sarah
Cc: Watson, Adele
Subject: RE: Urgent advice re disclosure by GMC

His name is Mr Bradley - Code A (Assistant Coroner)

The letter was sent out on Friday by fax and post - in it I told him Adele would be attending and also apologised for the delay re witness list and said we were currently clarifying our instructions.

See you tonight.

Tamsin

Tamsin Hall | Solicitor
for Field Fisher Waterhouse LLP
dd Code A

Mobile Code A

From: Ellson, Sarah
Sent: Monday, August 11, 2008 6:16 PM
To: Lohn, Matthew
Cc: Hall, Tamsin; Watson, Adele; Room, Stewart
Subject: RE: Urgent advice re disclosure by GMC

Thanks Matthew -

Tamsin/Adele - could you email me with name and no for coroner (and confirm letter re Adele attending this week went on Friday) thanks

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
dd: Code A

From: Lohn, Matthew
Sent: Monday, August 11, 2008 6:06 PM
To: Ellson, Sarah
Cc: Hall, Tamsin; Watson, Adele; Room, Stewart
Subject: RE: Urgent advice re disclosure by GMC

I have spoken to Peter Swain and explained Stewart's analysis.

He accepts the position (recognising that NHS Trusts sometimes ask for a S35 order to cover their disclosure to the GMC) and that we should in the circumstances ask the Coroner for an order.

He asked if the matter could be dealt with by a friendly phone call to the coroner and I agreed that Sarah would pick up the phone and explain the position - i.e. we need an order from him to enable us to jump thro

the DPA hoop.

Hope this is ok.

Matthew.

From: Room, Stewart
Sent: Monday, August 11, 2008 9:14 AM
To: Ellson, Sarah
Cc: Hall, Tamsin; Watson, Adele; Lohn, Matthew
Subject: RE: Urgent advice re disclosure by GMC

Dear Sarah,

It is certainly arguable on the face of 35B that the list "relates" to a practitioner's ftp, as it was prepared in the context of a ftp investigation, but I would regard that argument as tenuous.

As regards the position under the DPA, the exemption under section 35 is engaged. This provides the client with two routes to DPA-lawful disclosure. The first is where that is required under an enactment, rule of law or order of the court; I presume that the Coroner has not made an order as such and I doubt that the MA can be interpreted to require disclosure; so the first route probably isn't engaged. The second route concerns disclosure in legal proceedings, but there is a necessity test and I'm doubtful that the client can overcome that hurdle on the information before me.

Thus, I think there are substantial DPA barriers to disclosure, which the MA may not overcome.

As regards the likelihood of a complaint from one of the people on or connected to the list, yes its possible, but that's a "human nature" thing rather than a DPA issue as such.

If the Coroner really wants this information can they make an order? That would be the simplest route forward.

Stewart Room | Partner
for Field Fisher Waterhouse LLP
dd: Code A

I hope this helps.
Best wishes

Stewart

From: Ellson, Sarah
Sent: Monday, August 11, 2008 9:00 AM
To: Room, Stewart
Cc: Hall, Tamsin; Watson, Adele; Lohn, Matthew
Subject: Urgent advice re disclosure by GMC

Dear Stewart

We wondered if we could run something past you. In the course of investigating a doctor's fitness to practise we (on behalf of the GMC) have built up a list of the names and addresses of families and witnesses.

We have been asked by the Coroner to disclose this list to him for the preparation of some related inquests. The GMC of course wish to be helpful and asked us about any legal reasons not to disclose. The GMC do have a power to disclose information (s35B of the Medical Act which I have copied at the end of this email.

We discussed and I wrote to GMC:

Having considered it further and discussed the idea with Mary and Matthew we think that as S35B really relates to disclosure about a practitioner's ftp and because passing information to the Coroner is not strictly part of your statutory duty (which may affect the schedules which would apply under the Data Protection Act) we should probably get consent from the families - or offer to forward letters from the Coroner.

The GMC then replied:

Peter considers that we are covered by section 35B (2) as this matter relates to Dr Barton's fitness to practise. Consequently we should disclose to the Coroner the requested information but inform the family members and witnesses that we have done so as a matter of courtesy

I responded:

...not convinced that a list of witnesses' names and addresses could really be said to relate to Dr Barton's ftp which is why we have advocated this approach of trying to be helpful but not directly disclosing

but at present the GMC are insisting on disclosure of the list. Matthew asked me to take some advice from you about whether you think we could potentially face a complaint by a family if we do indeed pass on this information without their consent. He would like to quantify the risk before we let the GMC take this step.

It is all quite urgent as the Coroner has been asking for several weeks but we had to wait while a key GMC staff member was on holiday. Could you let me have your thoughts???

Sarah Ellson | Partner
for Field Fisher Waterhouse LLP
dd: Code A

35B.— Notification and disclosure by the General Council

(1) As soon as is reasonably practicable after the relevant date, the General Council shall notify the following of an investigation by the General Council of a practitioner's fitness to practise—

(a) the Secretary of State, the Scottish Ministers, the Department of Health, Social Services and Public Safety in Northern Ireland and the National Assembly for Wales; and

(b) any person in the United Kingdom of whom the General Council are aware—

(i) by whom the practitioner concerned is employed to provide services in, or in relation to, any area of medicine, or

(ii) with whom he has an arrangement to do so.

[

(2) The General Council may, if they consider it to be in the public interest to do so, publish, or disclose to any person, information—

(a) which relates to a particular practitioner's fitness to practise, whether the matter to which the information relates arose before or after his registration, or arose in the United Kingdom or elsewhere; or

(b) of a particular description related to fitness to practise in relation to every practitioner, or to every practitioner of a particular description.

(3) For the purposes of subsection (2)(b) above, the General Council need not consider whether it is in the public interest to publish or disclose the information in question in relation to each individual practitioner to

GMC – v – DR JANE BARTON

REVIEW OF WITNESS STATEMENTS

Table of statements of note –

Witness:	**Ref:**	**Content:**
		ENID SPURGIN
Carl Dormer	ES, tab 5a	Nephew of Spurgin. Fit and healthy all her life. Mid-March, she fell over and admitted to Haslar Hospital on 19/3/99. Op to right hip. Up and moving after op, lucid. Transferred to GWMH on 26/3/99. Visited 4-5 times. In early visits she seemed fine, although rarely saw doctor. I spoke to staff member on 10 or 11/4/99 and said "please make her as comfortable as you can." Visited on 12/4/99 – unconscious. Saw doctor – Dr Reid – he said there was nothing wrong with her, on too high a dose of morphine. He told nurse to reduce dose and said she would be OK. Received call at 22.00 on 12/4 to say she was conscious. Call at 01.30 on 13/4 to say she had died. **Helpful re deterioration and Dr Reid's intervention as dose of diamorphine too high.**
Susan Nelson	ES, tab 5g	Nurse. Explains her entries in nursing notes BJC/45. 10/4/99: Leaning to left – could be due to pain from op. Pain on movement. Oramorph given. 11/4/99: In pain on movement, oramorph 5mg administered. Prescription for oramorph had been written by doctor on 26/3. No specific entry in clinical records from a doctor in relation to the administration of oramorph on 11/4. **Q: Are we going to call all the nurses to explain their entries? Or can Prof Black deal with these matters from the notes? Only call nurses who add particularly to the case? Problem: May be implied criticism of them – will be defensive.** **All these matters are really apparent from the notes. Still – would flesh out the story – demonstrates how decisions taken by nurses after prescription written many days before by doctor.**
Fiona Walker	ES, tab 5h	Nurse. Explains her entries in nursing notes BJC/45. Simply confirms death. No assistance.
Siobhan Collins	ES, tab 5i	Nurse. Barton did ward round every day during the week. Would speak to each patient. Would be

		accompanied by a nurse who would report on each patient. Explains her entries in nursing notes BJC/45. 7/4/99: Nothing significant occurred. 11/4/99: Ill, tolerating sips of fluids, not anxious to be moved, did settle for long periods. 12/4/99: Ill, urine concentrated. Syringe driver satisfactory. In some discomfort when attended to. Breathing shallow. Death on 13/4. Doctor was not called – I can only assume because death was expected. **Simply explains notes. Supportive of some discomfort. Any point in calling?**
Freda Shaw	ES, tab 5j	Nurse. Received on the job training in syringe drivers. Only person who can authorise use of drugs by syringe driver is a doctor. Barton would do quick ward round every morning, speak to patients but only examine patient if there had been a relevant change in condition. Explains entries in nursing notes BJC/45. 6/4/99: Seen by Barton. MST increase to 20mg. Nephew will employ someone to live in once Spurgin discharged home. 7/4/99: Fracture site red and inflamed. Barton prescribed further medication (in fact for infection). No clinical note made of why these were being administered. *Administered MST. Administered diamorphine 80mg at 09.00 on 12/4/99. Can't remember whether it was Barton's calculations which gave the dose or whether it was worked out by me and nurse Hallmann. Calculation would have been based on the previous dose of morphine tablets.* Nursing notes show that Barton saw patient on 12/4, whoch was same day that she prescribed diamorphine. *12/4/99 – Also administered diamorphine 60mg and 20mg, witnessed by Hallmann.* (Both timed at 09.00 on 12/4/99 – strange). **This nurse actually administered the diamorphine. However – does not explain Barton's prescribing practice (when, to whom, range), who made decision to administer, who decided the dose. Consider going back to her for further information. Currently, statement does nothing more than re-iterate the nursing notes.**
Gillian Hamblin	ES, tab 5k	Sister. Key ally of Barton. 1999: Clinical Manager (Senior Sister). Responsible for 24hr care on Dryad Ward. Responsible for all staff on ward, including training. Worked 07.30 to 16/.15, or 12.00 to 20.30. Dryad Ward was for continuing care, Daedalus was a stroke/rehab

		ward with physiotherapy available. Dryad had 20 beds. Daedalus had 24 beds. Barton was Clinical Assistant for both wards. Her line managers were the consultants. Consultants did ward rounds once a fortnight, later once a week. Barton would attend on these occasions. Barton would visit at 07.30 Monday to Friday and see every patient on ward rounds before going to her GP practice. I would accompany her if I was on duty. On her visits, she would prescribe the drugs required by each patient. Barton would go round every patient, speak to them in order to assess how they felt that day, would read any reports from night staff re any change in condition, would always discuss any change in medication with nursing staff, on occasion contacted consultant before amending medication. Barton was always available on the phone and would return to GWMH almost every day. Would return and address new patients. Would see patients in afternoon or evening to reassess them if necessary. My duties were the administration of drugs, the doctors to prescribe them. If I felt a patient was being adversely affected by a drug, would speak with a doctor. May result in decrease, increase or change in drug. If doctor decided to change it, would come in asap to write up the prescription. In exceptional rare cases, would authorise change over the phone and doctor would then have 24 hours to write and sign the prescription [where does this rule come from?] Enid Spurgin: BJC/45 nursing notes. I was manager in overall charge of the patient. Lynne Barratt was named nurse, responsible for day to day aspects of care. I never administered drugs to Spurgin. Goes through drug chart. Patient was prescribed diamorphine on 12/4/99. 80mg over 24 hrs is a slightly increased dose but not dramatic. *When the doctor prescribed drugs they would not always be given until nursing staff thought they required them. They were prescribed on a PRN basis – meaning whenever necessary. It was my duty as senior sister to ensure that drugs were being given appropriately.* **Helpful on how ward was run. But very pro-Barton – no criticism whatsoever, indicating proper assessment and prescription by her. Explains prescriptions being written up PRN, but no explanation of WHO made the decision to administer drugs, WHEN and at WHAT DOSE.** **Q: Decision on tactics required – (a) calling all relevant witnesses as to care for the patient, (b) calling only those who can add something to the notes, (c) calling only those who are supportive of our case, (d) not calling witnesses but relying on notes? What is more damaging to our case – calling or not calling the likes of Hamblin?**
Anita Tubbritt	ES, tab 5l	1999: Senior Staff Nurse, Dryad Ward. Hamblin was line manager.

		[See generic statement – key complainant in 1991, but states no such concerns by 1999]. By 1999, had received training in setting up syringe drivers. Doctor would decide what drugs to prescribe. How they were prescribed would indicate if the nurse could make any decision as to increasing the dosage. [Meaning?] Barton would usually be in the hospital by 07.30 and would sometimes ask regarding specific patients. [Meaning? What sort of patient assessments would she make? Does this suggest not always full?] Spurgin: Do not recall. Goes through entries in nursing notes BJC/45 – I administered oramorph on 26/3/99 and 27/3/99. Administered oramorph on 11/4/99. *The reason I administered oramorph was that it was written up by Barton on 26/3/99. On being admitted, was written up that the patient had complained of a lot of pain. I felt that further administration of the drug was therefore appropriate*. [What about a pain assessment immediately prior to administration of the drug? Plus – does not confirm clearly who actually made the decision to administer the opiate and the dose]. **Further detail required – what level of assessment would be conducted before prescription of drugs, how drugs prescribed, range of dose, who decides what and when to administer, specifically how this operated re Spurgin. Currently a very partial picture – as could be criticised herself?**
Gill Rankin	ES, tab 5m	Nurse. Wrote transfer letter for Spurgin, 26/3/99. Now mobile. Needs encouragement eating and drinking but can manage independently. Only medication is paracetamol. Goes through letter, but really adds nothing to it. **Adds nothing to notes.**
Ian Gurney	ES, tab 5n	Doctor at Haslar Hospital. Goes through medical note entries – JR/14. **Adds nothing to notes.**
Fraser Harban	ES, tab 5p	Anaesthetist, Haslar Hospital. Goes through medical notes. **Adds nothing to notes.**
Lynne Barrett	ES, tab 5q	Nurse, Dryad Ward. Trained in syringe drivers by Hamblin. Aware of analgesic ladder. Syringe drivers used when patients cannot take drugs orally. Goes through notes: 26/3/99 – difficulty in moving, slept long periods, oramorph given as per chart. [Even though on transfer that day only on paracetamol]. Care plan for 26/3 says Enid is experiencing a lot of pain in movement, desired outcome to eliminate pain and keep comfortable, which should facilitate easier mobilisation. 27/3/99 – having regular oramorph but still in pain.

		28/3/99 – vomiting with oramorph, advised by Barton to stop. Codydramol. 31/3/99 – commenced on MST, walked but in a lot of pain. Oramorph given for pain with not too much effect. Continued pain on movement. 11/4/99 – in pain on movement, tenderness around wound. 12/4/99: Reviewed by Dr Reid – diamorphine reduced to 40mg, can be gradually increased if pain recurs. Drug parameters set by Barton were 20-200mg. In my view, none of the amounts of diamorphine administered were excessive. *When parameters are set, they are done so by a doctor. On a scale of 20-200mg, nursing staff would always start on 20mg unless told otherwise by a doctor. I have no idea why Barton started the dose at 60mg. Looking at conversion chart from oramorph, it should have been 15mg.* **Statement is self-contradictory – says diamorphine administered not excessive, then can't justify Barton's dose. Generally just goes through notes, adding nothing. Consider getting further detail on Barton's assessments of the patient (when, how carried out), how drugs were prescribed by her, who made decisions on what to administer and how. How does she know it was Barton who decided on dose of 60mg?**
Irene Dorrington	ES, tab 5r	Nurse. Goes through notes. States: *"All of the drugs administered were written up and signed by Dr Barton and on night duty I used that as my authority to administer them."* **But: When were they written up? How were they written up? Who made decisions on when and how much to administer? No other detail given.**
Shirley Dunleavy	ES, tab 5s	Physiotherapist. Simply goes through notes – 1/4/99: Spurgin needs to walk x 2 daily using gutter frame." Gutter frame suggests patient had difficulty in walking pain-free. **Adds little to notes, except to suggest pain in walking.**
Ingrid Lloyd	ES, tab 5t	Nurse, Dryad Ward. Goes through notes. *The drugs I administered were prescribed and written up by Dr Barton and it was on that authority only that I did my job as a nurse in caring for a patient. The oramorph and co-dydramol were administered to ensure that she had good, pain-free nights sleep.* ***Explains nothing of how system worked. Adds nothing to notes.***
Beverley Turnbull	ES, tab 5u	Staff Nurse. On Redcliffe Annex, Barton took responsibility of all patients. If we had a problem with a patient during the night, would contact her practice for advice. Around this time, syringe drivers started. Result usually

		was that the patient became heavily sedated, unrousable and died. I became very concerned because I felt it was being used on patients who had not presented any symptom of pain. *All the patients of Barton were prescribed in this way. She set the parameters of the amount of drugs and it was at the trained nursing staff's discretion as to when increases were given, depending on the level of pain. I was concerned that patients went straight onto strong drugs without weaker drugs being tried.* Other staff had misgivings. Meetings in 1991 [see generic statements]. I was still unhappy after the meetings. I attended meeting called by Dr Logan. He and medical staff sat like a panel opposite the nursing staff. Condescending. A policy was going to be drawn up, but never was. My colleagues and I were labelled as trouble-makers. Joined Dryad Ward. Barton remained. Dr Reid was consultant. More people were admitted for rehabilitation there. Then goes through notes for Spurgin. [But what about practices in Dryad Ward – 1996-9??] **Adds nothing to notes re Spurgin. Critical around 1991 – but no detail on practices during our period! In generic statement, says she had no concerns re use of syringe drivers on Dryad Ward. Any use?**
Helen McCormack	ES, tab 5v	Consultant. Details condition of Spurgin from 1997-9. Pretty well. **Not really relevant.**
Christopher Yates	ES, tab 5d + e	IV of Barton, 15/9/05. CSY/JAB/10 – tape. CSY/JAB/10A – transcript. JB/PS/9 – prepared statement.
	ELSIE LAVENDER	
Margaret Wigfall	EL, tab 5a + b	Nurse. Initially on Redcliffe Annex. Syringe drivers appeared. Caused concern – felt used too often, rather than to control pain, used on patients approaching death and suffering from anxiety and distress. Would be prescribed by Barton. *Then the decision when to use it would be made by a nurse who would choose the appropriate time.* I never made these decisions, as made by a senior nurse. Discussed concerns with Tubbritt. Meetings. I received training in syringe drivers in 1990. Moved to Dryad Ward. Also throughout this time myself and some of the nursing staff have shared concerns over the use of syringe drivers. Always felt Barton and nursing staff acted in best interests of patient. **This is her generic statement – gives insufficient detail re concerns continuing on Dryad Ward. Generally supportive of Barton. Go back to her for further detail?**

		Elsie Lavender – no recollection. Goes through notes. Adds nothing. **Adds nothing to notes re Lavender.**
Fiona Walker	EL, tab 5c + d	1991 concerns resolved internally. In regard to the doctors I am satisfied with their treatment of patients. Night Sister. There was no on-site doctor 24 hours at GWMH. If there was a need to call a doctor for advice and discuss a patient's condition, this responsibility would often fall to me. The doctor called would then decide whether it was a matter that could be dealt with by the nursing staff or whether doctor should attend. I would usually make an entry in nursing notes if this happened. Elsie Lavender notes BJC/30 – no note of mine. Do not recall any conversation with Alan Lavender. **No assistance. Does not address method of prescribing, who made decisions on pain relief etc.**
Geraldine Broughton	EL, tab 5e + f	Night Sister. Redcliffe Ward – controlled drugs always prescribed by doctor, administered by two trained staff. I retired in 1996. Whilst working there, not aware of any problems with drugs/syringe drivers. Worked permanent nights on Daedalus Ward. Was in-house training on syringe drivers. Elsie Lavender – no recollection – notes BJC/30: 26/2/96 – nursed on alternate sides. Means if a patient is immobile, sleeping position would be changed to prevent bed sores. No change on 27-29/2/96. **No help.**
Sheelagh Joines	EL, tab 5g + h	First statement – generic – as per GCF2, tab 49 – very pro-Barton. Second statement: In 1996, Sister on Daedalus Ward. Trained in syringe driver. 8 stroke beds and 14 long-stay beds. Elsie Lavender: 23/2/96 – recorded administration of insulin (but not the dose). Goes through notes. 24/2/96: Pain not controlled properly, seen by Barton, written up for MST – *I knew that the pain was not being controlled by observing that the patient was in pain when moved. Another reason would be that the patient informed us of pain.* 26/2/96: Son's wife seen by Barton – means that use of syringe driver was explained to Mr Lavender's wife in order for the patient to be comfortable and free from pain. **Minor explanation of nursing records. Very pro-Barton. Explanation given suggests pain on part of patient, justifying analgesia.**
Christine Dolan	EL, tab 5i + j	Nurse. No concerns about diamorphine at GWMH. Elsie Lavender: 25/2/96 – blank entry in nursing care plan, so nothing untoward had happened. **Only possible point – use to show Lavender's condition stable? But adds nothing to notes.**

Catherine Marjoram	EL, tab 5k + l	Nurse, Daedalus Ward. Syringe drivers always used appropriately. Elsie Lavender: I completed paperwork re admission to GWMH. Verified death. **Adds nothing.**
Code A	EL, tab 5m + n	Nursing auxiliary, Daedalus Ward. No concerns about syringe drivers. Lavender: Nurses care plan, 6/3/96 – pain well controlled, syringe driver renewed. **Adds nothing to notes.**
Alan Lavender	EL, tab 5o	Son of Elsie Lavender. Lavender: Diabetic, insulin-dependent, healthy and independent woman right up to admission to hospital in February 1996. Barton was GP. Admitted to Haslar Hospital due to fall. Diagnosed with brain stem stroke. Sat up in bed. Obviously in pain from stroke and the fall. In Haslar for 2-3 weeks. Physiotherapy. Excellent progress. Occupational therapist spoke to me about preparing for her to go home. Walked with assistance of frame. Transferred to GWMH for rehabilitation. Daedalus Ward. Wife and I visited daily. *Within 2-3 days of admission, had meeting with Barton: Asked about going home and what to do about mum's cat. "You can get rid of the cat." "You do know that your mother has come here to die!" Cold and callous. Shocked. It was as if her death had been predetermined. Soon after meeting, noticed mum had been put on syringe driver. Health deteriorated swiftly. One occasion – unconscious and smelling awful – notes say leaking faeces. 2-3 days after visit, got call saying she had died. She had appeared to be making full recovery from stroke. Other than a little pain in her shoulder, she was not complaining of pain. Not until her final day did I realise she was being administered diamorphine through syringe driver.* **Potentially powerful.** **NB. Conflict with physiotherapist notes re return to home.** **NB. Conflict with Margaret Couchman and notes re being informed of syringe driver. Notes also suggest wife was spoken to about syringe driver.**
Yvonne Astridge	EL, tab 5q + r	Named nurse for Lavender. Goes through notes – lots of them. Adds little or nothing to them, save to add that Lavender was in pain at time of constipation and that Waterlow score high. Barton prescribes drugs on notes marked 5-6/3/96. I gave Lavender 100mg diamorphine for pain relief on 6/3/96. No concerns about patient care. 6/3/96: Seen by Barton, medication other than through syringe driver discontinued as patient unrousable – could not swallow, so was only route available. **Adds nothing. Does not deal with method of analgesia prescription/administration.**
Code A	EL, tab 5s	Nursing auxiliary. Nursing notes: 29/2/96 – had analgesia for painful shoulders and upper arms, pain

		relieved. Following day, patient complaining of pain again. 3/3/96 – slight pain in shoulders when moved. **Adds nothing to notes – but does emphasise the relative lack of pain.**
Christine Joice	EL, tab 5u	Staff Nurse, Daedalus Ward. Notes. From admission to 26/2/96, on 10mg MST twice daily. Notes – fairly effective. Only fairly, so increased to 20mg on 27/2/96. All drugs prescribed by Barton. 4/3/96: Seen by physio, exercises, needs analgesia increased. This may have been because exercises were painful. MST was increased because of this increased pain, to 30mg – dose increased by Barton. **Again adds nothing to notes.**
Irene Dorrington	EL, tab 5v	Staff nurse. Notes. 23/2/96: DF118 – dihydrocodeine – given at patient's request, then had comfortable night. **Adds nothing to notes.**
Frances Dominy	EL, tab 5w	Home carer for Lavender – found her collapsed at home in Feb 1996. **Not really relevant.**
Althea Lord	EL, tab 5x	Consultant. 1996: Did weekly ward rounds as consultant responsible for Daedalus Ward. Saw each patient in turn, made note on clinical notes. Available to be called to GWMH or to provide advice at other times. Lavender: No contact – on leave at time. I would expect to be contacted when on leave about a patient I had had no dealings with. **No relevance.**
Margaret Couchman	EL, tab 5y	Nurse, Daedalus Ward. Lavender notes: 29/2/96 – high blood sugar levels, contacted Barton. Can't remember how contacted, can't remember if Barton came in, but clearly her authority was given for medication. 1/3/96 – complaining of pain in shoulders on movement. This would have been recorded because patient had probably told me she was in pain when moved. Not given anything for pain at this time. 5/3/96 – pain uncontrolled, patient distressed, syringe driver commenced 09.30, diamorphine 100mg, son contacted by phone, situation explained. I would have been told by night staff that she had had very bad night, was in uncontrolled pain. She had been seen by Barton who had authorised commencement of syringe driver. I contacted Lavender's son on the phone to explain the situation [cf his evidence]. Notes show Barton's instruction to commence syringe driver on 5/3/96. **Adds little to notes. Conflict with Alan Lavender's evidence about lack of information re syringe driver. Supportive of need for syringe driver and Barton's involvement in decision.**

Elizabeth Thomas	EL, tab 5z	Physiotherapist at Haslar Hospital. Simply goes through notes. 8/2/96 – sits and stands but full support required for a few steps, pain in shoulders a major problem. Upper limb function improving. Mobility poor. "Discharge to own home seem unlikely in near future." **Notes show not in too bad health, but conflict with son's evidence about possibility of discharge. Adds nothing to notes.**
Patricia Wilkins	EL, tab 5aa	Staff nurse, Daedalus Ward. Syringe driver training on the job in 1998. **Simply details notes.**
Christopher Yates	EL, tab 5dd	IV Barton on 24/3/05. Tape – CSY/JAB/5. Prepared statement – JB/PS/4.
	ROBERT WILSON	
Iain Wilson	RW, tab 6a + b	Son of Wilson. Fit and active. Heavy smoker, Code A September 1998 – collapsed at home. Taken to QA Hospital. Looked very ill. Fracture to left shoulder. Doctor said he'd given up will to live. Then he improved – happy, sat up in bed, fully aware of surroundings. Transferred to GWMH, Dryad Ward, 14/10/98. Next saw him 15/10/98 – almost paralysed, distressed and confused. Nurse tells me not expected to recover. 16/10/98 – almost in coma, unable to speak or move, on syringe driver. Don't understand why he went downhill so quickly after left QA. **Possible assistance as to condition on discharge from QA and rapid deterioration.**
Karen Edwards	RW, tab 6c	Daughter. Gives background. Initially at QA he was in a coma, but put on drip and in few days back to usual self. Visited at QA every day. Seemed to be getting better. Assumed would come home at some stage. Saw dad at GWMH on 15/10/98 – unconscious. 17/10/98 – nurse informs me it was likely dad would die that night. There at death. **Minimal assistance.**
Neil Wilson	RW, tab 6d	Son. Visited dad at QA. Injury to right shoulder and hip, fed up but lucid, on very mild pain relief, think paracetamol, in some pain and discomfort but not in any way extreme. Depressed initially. Then physio arranged, and dad realised would go for rehabilitative care. Saw at QA on 11/10/98 before transfer – his normal self, doing crossword, not as mobile as had been. Transfer to GWMH on 12/10/98. *That evening, got call from sister Tracey saying someone had told Gill that dad wouldn't make it to the weekend – shocked, but didn't trust Gill – attention-seeker.* 13/10/98 – went to GWMH. Dad laid out on bed, totally out of it, breathing laboured. [Stark change].

		Nurse said he was on pain relief to make him more comfortable. Thought strange as pain relief had been minimal. I made clear to staff that was not happy. Spoke to female nurse who seemed in overall charge, either South African or Kiwi. She said his kidneys and liver not working properly, I said sounds as if he is drowning. Asked why not on lung drain and why on medication sending into coma. Told to take it up with doctor – didn't ever meet her despite several attempts over the following days. 14/10/98 – dad not responding to me. By evening of 15/10/98, no one expected dad to live beyond the weekend. It was as if the nurses had made this decision. **Possible assistance on rapid deterioration and appearance in GWMH.**
Lynne Barrett	RW, tab 6e	Nurse. On the job training in syringe drivers from Hamblin. Dryad Ward is 20 beds. Aware of analgesic ladder. Syringe drivers used when patients cannot take oral medication. Wilson: Can't remember. Notes BJC/55: Condition continues to deteriorate – p266. He had accumulated secretions as back of throat or further down, used suction to clear secretions. **Adds nothing to notes.**
Mollie Edwards	RW, tab 6f	First wife. Visited in QA – back to old self. Movement restricted, but sat up in a chair and was quite lucid. Day before transfer, refused paracetamol and not on any other painkillers. Next saw him on second day in GWMH – in coma. Shock. He would squeeze my hand but couldn't speak. Nurse said he travelled badly. **Swift deterioration on transfer.**
Gillian Kimbley	RW, tab 6g	Wife – NB. Children think she is unreliable, drinking heavily at time. But – in closest contact. Visited in QA. Initially in bad state, didn't know who I was, black and blue. Then improves, knows who I am, able to hold conversation. Day of transfer, 14/10/98, he seems okay prior to trip. Moved by minibus. Arrives – seen by white female middle-aged doctor – says will give something to calm him down from the trip. Left him later that day, still lucid. 15/10/98 – visited him, looks dreadful, incomprehensible. Ward Sister says "your husband is dying." Shock. Said they didn't give him longer than a week. "You really didn't know how ill he was." **Credibility in issue, but clear on rapid deterioration on admission and Barton/nurse's attitude.** **NB. Notes show Sister who spoke to Kimbley was Hamblin – see below.**
Lesley Clarke	RW, tab 6h	Daughter. Visited on 17/10/98. Unconscious. Recalls death. **No assistance.**
Tracie Huntington	RW, tab 6i + j	Daughter. 14/10/98 or 15/10/98, got call saying had taken turn for worse. Attended. Completely unconscious. Info largely from other siblings.

		No assistance.
David Huntington	RW, tab 6k	Son. Visited in QA – seemed clean, tidy, sat in wheel chair, lucid, happy enough, spoke about going home. Told be staff that being moved tot another hospital to convalesce. Moved by minibus, not ambulance. Next saw on day prior to death – decline in health. Eyes shut but conscious. **Little help – limited re condition prior to transfer.**
Robert Logan	RW, tab 6l	Son. **No assistance, no detail.**
Freda Shaw	RW, tab 6m	Staff Nurse, Dryad Ward. Wilson – notes BJC/55: 15/10/98 – I didn't administer the oramorph, but can explain why 20mg given at night as opposed to 10mg during day – at night, dose was doubled to enable good night's sleep and given less regularly – this was an accepted practice. I witnessed administration of oramorph by Hamblin. Also 15/10/98: Wife seen by Sister Hamblin who explained condition is poor. [So was Hamblin who told Kimbley husband was dying]. **In fact adds nothing to notes.**
Siobhan Collins	RW, tab 6n + o	Nurse, Dryad Ward. Made entry on notes re death. Also signed re diamorphine on 18/10/98. **No assistance.**
Kathryn Taylor-Barnes	RW, tab 6p	1998: SHO to Dr Lord. Went on ward rounds with her. Conducted at bed side with medical notes available and reviewed, and entry made. Also was on call one night in four. Explains medical notes for 24/9/98 – after admission via A&E on 21/9/98. Fractured top of left shoulder. **Not really of help for our case – Prof Black can deal.**
Sandra Milner	RW, tab 6q	Nurse. Goes through notes. 15/10/98: Oramorph given in accordance with care plan – patient required assistance to settle at night. Given 20mg to avoid having to wake during the night. Administered oramorph. Condition deteriorated overnight. Difficulty in swallowing. Each drug prescribed that I signed for came from Barton. **Adds nothing to notes, save to confirm Barton prescribed all and explaining extra dose at night.**
Debra Barker	RW, tab 6r	Nurse. Simply goes through notes. Filled in entry re administration of diamorphine on 18/10/98 as per prescription. Barton conducted ward rounds Monday to Friday around 8am. Lord conducted ward round once a fortnight. **Adds nothing to notes. Again – nurses not dealing with our issues – method of prescribing, who decides what to give and when, what assessment took place of patient.**
Althea Lord	RW, tab 6s	No contact with patient.

Gillian Hamblin	RW, tab 6z + aa	Sister/Clinical Manager. Barton responsible for the patients. Barton would visit Monday to Friday at 07.30 to see every patient. She would return to see relatives that day or later. Would prescribe drugs on her visits. Wilson notes BJC/55: I wrote up the "spell summary" – outlines diagnosis and treatment on day of admission or day after – broken left upper arm, renal failure, liver failure, treatment/recommendation is syringe driver 16/10/98. [Stark contrast with reason for transfer]. This diagnosis was obtained by me as result of reading medical records which accompanied the patient. *The prognosis that I made was that he was being admitted for terminal care at Dryad Ward.* Also under diagnosis – wrote "end stage CCF – congestive cardiac failure" – this diagnosis was based on medical record showing he was in QA Hospital in 1997 with heart problems [!] The syringe driver was commenced by the medical staff, which would have been Barton initially. [What does this mean? When done? By Barton herself? When prescribed?] *The doctors rely on the nursing staff to do the initial assessment. Doctor will then write up the drug treatment chart. The treatment of each patient was based on the observations of all the nursing staff.* At 15.50 on 17/10/98, I increased the dose of diamorphine to 40mg. Oramorph and diamorphine were prescribed by Barton. [But doesn't say when, or how this process was carried out. Statement suggests Barton not consulted re rise in dose]. *The diamorphine was increased because of pain.* [What pain?] *Neither I nor my staff have recorded the reason for the increase in diamorphine, but it would have been increased due to pain level not being controlled by the previous dose....The dosage could only be given up to the maximum that the doctor had prescribed.* Asked to comment on the increased dose on 17/10/98: *I would have assessed the patient's condition and deemed it necessary to increase the diamorphine to 40mg. This increase was necessary due to the patient's increased pain and anxiety. I would always inform the doctor (normally Barton) of the change in medication and the reason. Would not necessarily inform Barton at the time, if it was night time, but would inform her the following day. Diamorphine and midazolam were prescribed by Barton in a range according to the patient's needs as assessed by Barton. In this case, these drugs were prescribed upon admission on 14/10/98. <u>He had been admitted to Dryad Ward for palliative care, as he had multi-organ failure, as recorded on the spell summary</u>.* [No! This was her mistaken evaluation]. 18/10/98: Wife seen by Dr Peters. Diamorphine increased to 60mg. This would have been to control pain – he had a fractured arm and multi-organ failure [cf treatment in QA!] [Unclear if Dr Peters decided to

		increase diamorphine, but Hamblin says he was only called out because increase in hyoscine was required]. On 15/10/98, oramorph given due to pain in fractured arm and because was alcoholic and liver not functioning as well as should be. Had renal and liver failure. **IMPORTANT: This statement suggests that the allegations that Barton was over-reliant on Hamblin are correct. Was her analysis that Wilson was dying, and Barton appears to have prescribed accordingly. Plus shows Hamblin was deciding the dosage up to the maximum prescribed. But can we use this? Can we, as in criminal case, call her as reliable on some points but not on others?** **NB. CHECK whether Prof Black deals adequately with the significant of Hamblin's initial assessment of Wilson and its correctness.**
Jeanette Florio	RW, tab 6bb	Staff nurse. Goes through notes. Involved in syringe driver. No explanation in general as to why/dosage. 16/10/98: A little bubbly, hasn't been distressed, hyoscine increased – when I attended to him, his chest/throat sounded bubbly, incidating secretions were increasing, discussed with Perryman the need to increase the hyoscine. **No real assistance.**
Rosie Luznat	RW, tab 6cc	Consultant psychiatrist. Saw Wilson on 8/10/98: Low mood, wishing to die, disturbed sleep due to pain, early dementia and depression. Prescribes sedative antidepressant. Only analgesic is paracetamol. **Adds nothing to notes, but shows lack of major medical problems – eg prepared to prescribe anti-depressants despite impaired liver function.**
Marjorie Wells	RW, tab 6dd + ee	Nurse. Goes through notes. 15/10/98: I administered oramorph in accordance with prescription – doctor writes up what time the drug should be given – in this case 06.00, 10.00, 14.00 and 18.00, plus prescription for double dose at 22.00 to enable settled night's sleep – written up by Barton. Oramorph is opiate drug, would expect to see entry from doctor as to why prescribed. Is none. Nursing notes for 15/10 show pain in left arm, but I didn't make that entry. It was a large jump from paracetamol (as per referral letter) to oramorph, but I didn't assess patient, so can't say why it was. If pain not controlled, doctor would be informed – could be during ward round, or if couldn't wait a verbal prescription could be given over the phone and prescription sheet would be signed the following day. **Doesn't add much to notes – however, confirms practice of oral prescription.**
Shirley Hallmann	RW, tab 6ff +	Nurse. Goes through notes. Adds little. Her entry on 14/10/98 – received as transfer, seen by Barton,

	gg	oramorph given. 16/10/98: Diamorphine given. *It may have been that Wilson was taken off oramorph if he was in great pain or very agitated, including not being able to swallow.* [Guessing]. Says: "When diamorphine was mixed with midazolam, as midazolam is a sedative, the patient would, depending on the dose, stop eating and drinking. The result of this would be ultimately death." 17/10/98: Diamorphine was increased to 40mg by Hamblin. Then says: *"Barton made the decision to administer all the drugs given and the amounts."* [This is inconsistent, needs explaining]. None of the doses were excessive. **Generally unhelpful. Says Hamblin increased diamorphine dose, then says Barton made all decisions on amounts.**
Irene Dorrington	RW, tab 6ii + jj + kk + ll	Nurse. Goes through notes. 14/10/98 note: "Bob was restless at times...oramorph given for pain control." I gave this to ensure he was pain free during the night, as he was restless, which may have been due to the fact that he was in some pain. **Generally adds nothing to notes. Possible suggestion of pain, justifying oramorph.**
Ewenda Peters	RW, tab 6mm	Clinical Assistant. Covered on 18/10/98 – prescribed increase in hyoscine – approved it verbally, then signed entry as soon as could at hospital. **No real assistance. NB – didn't interfere with diamorphine dose, but had little contact – done on phone in response to nurses' request.**
Cristian Birla	RW, tab 6nn	Doctor at QA. 29/9/98 – decided due to physical condition Wilson would not be resuscitated if stopped breathing – alcoholic. Morphine given due to broken bone, but not more than 5mg, as he would become less mobile if gave more, and needed to be mobile to allow healing process to commence. *The more opiates you give the less mobile the patient.* Page 171 of notes shows evidence of alcoholism – kidneys not working properly, liver affected, not for resuscitation in view of poor quality of life and poor prognosis. On spirouolectone for heart disease. **Tends to support suggestion that Wilson was on his way out. However – really adds nothing to notes.**
Diedre Durrant	RW, tab 6qq	GP. Details dealings from 1993-7. **No assistance.**
Claire Dyson	RW, tab 6ss + tt	Nurse at QA Hospital. Goes through notes. Adds nothing to them. **Adds nothing to notes.**
Ruth Clemow	RW, tab 6uu + vv	Same as Dyson. **Adds nothing to notes.**

Anthony Mowbray	RW, tab 6ww	GP. Saw Wilson in 1997. Describes alcoholism and affect on liver etc – but stable. **Can use this kind of evidence if seeking to show Wilson was OK and rapid decline after admission to GWMH – but his condition immediately before (ie in QA Hospital) is surely more relevant, and can be dealt with by notes/witnesses from QAH.**
Arumugam Ravindrane	RW, tab 6xx + yy	SpR at QAH. Goes through notes from QAH. Number of entries during the stay. Liver disease, renal function deteriorating, then renal function improves slightly by 30/9/98, eating well. Listed for long-term care. Review on 13/10/98: Still needs nursing and medical care, in danger of falling until fully mobilised, left arm swollen, retaining fluid, kidney function to be reviewed. All this is in notes. Then adds: *He was unwell. He may have stabilised and maintained some level of health, equally he could have died suddenly or quite quickly due to his condition. His liver function was abnormal.* **Mostly adds nothing to notes, although provides decent picture of time in QAH. His comment does not detract from our case – that prescribing at GWMH took death as foregone conclusion.**
John Grunstein	RW, tab 6w	Consultant at QAH, but adds nothing.
Nicola Haynes	RW, tab 6zz	Nurse at QAH. Adds nothing to notes.
Collette Billows	RW, tab 6aaa + bbb	Nurse at QAH. Adds nothing to notes. Wrote referral letter to GWMH on 13/10/98. Transfer form: Alcohol problems. Bartel score 7 out of 20 – test of how independent – a low score. Still had a lot of pain in his arm, difficulty in moving. Adds nothing to notes.
Timothy Taylor	RW, tab 6ccc	GP. Details alcoholism and liver function to 1997. A history of alcohol damage that responded to abstinence. Adds nothing to notes.
Anthony Knapman	RW, tab 6ddd	GP. Covered for Barton as Clinical Assistant. Entry in notes for 16/10/98: Decline overnight with SOB. Wrote him up for increase in frusemide due to fluid retention. Can't comment on other drugs. But – says parameters of diamorphine set by Barton of 20-200mg a relatively small amount for someone in pain, doses not excessive. **No assistance.**
Jonathan Marshall	RW, tab 6eee	MISSING.
Christopher Yates	RW, tab 6u + v	IV Barton, 19/5/05. Tape – CSY/JAB/7. Transcript – CSY/JAB/7A. Prepared statement – JB/PS/6.
Kathryn Robinson	RW, tab 6rr	DC. Produces transfer to Dryad Ward letter from GP file – TAS/5/KMR/1 (seems missing from GWMH notes – see Hamblin's statement).

Jacqueline Spragg	RW, tab 6x	JAS/CODC/2 – cause of death certificate.
		RUBY LAKE
Althea Lord	GCF6, tab 66	Consultant Geriatrician, GWMH, 1992-2004. Responsible for Daedalus Ward. Ruby Lake: Made entry on notes that difficult to know how much she would improve, but would be given continuing care bed at GWMH. A complicated medical case. Would not be optimistic about prognosis. Goes through prescriptions, as written up by Barton. Includes "daily review prescriptions" – including diamorphine and midazolam. *All prescribed by Barton, undated – this is intentional so that the administrator of the drug can decide when to start it. The drugs administered to Lake were appropriate. To prescribe within a specified range was appropriate, and was standard practice at that time for these drugs in this instance. This practice developed to ensure that the out-of-hours doctor was only called when necessary. I never had any concerns about Barton's prescribing practices. I would have altered prescriptions as appropriate in my role as consultant.* I was always contactable to advise. **Lord sets out the practice of prescribing in a range and letting nurses decide – but says this was all appropriate. Can we use her, when defence might say we should be equally critical of her?**
Graham Robinson	GCF6, tab 61	Son-in-law of Ruby Lake. She had a fall and was taken to Haslar Hospital for operation. Saw her there, getting over operation and making plans for future. Transferred to GWMH. Saw her there, seemed relaxed and happy. Then sudden deterioration and death. I have no concerns about her care at the hospital. **No use.**
Irwin Lasrado	GCF6, tab 62	Orthopaedic Surgeon. Carried out operation on Ruby Lake, 5/8/98. Describes op, but says nothing about her condition after. Little use. Makes clear, though, that the hemi-arthroplasty procedure is a type of replacement operation and is fairly routine.
Karl Trimble	GCF6, tab 63	Consultant over Lasrado, deals more extensively with Ruby Lake's admission to A&E after fall, and treatment at Haslar Hospital. Describes recovery from operation, not as quick as hoped for. But – no great problems.
Jonathan Phipps	GCF6, tab 64	Anaesthetist for Ruby Lake's operation. Looking at her notes, she was recovering well.
Anita Tubbritt	RL, tab 6a	Nurse. Notes BJC/67. Goes through notes – Barton's prescription of all drugs, details nurses who administered. All admin of drugs was in accordance with the prescriptions written by Barton.

		Adds nothing to notes, save to confirm it's Barton prescribing in each case.
Juliette Hewitt	RL, tab 6b	Nurse, Sultan Ward. Details notes of treatment up to discharge on 7/7/98. Appears to me that Lake was improving by discharge date and there was a good follow up. **Any point in using – evidence of condition pre-final admission? Adds little to notes.**
Bridget Ayling	RL, tab 6c	Nurse in July 98. Adds nothing to notes.
Patricia Shaw	RL, tab 6d	Nurse on Dryad Ward. Note of 19/8/98. Adds nothing.
Sharon Ring	RL, tab 6e	Nurse, Dryad Ward, Aug 98. Goes through notes. Drugs and quantities prescribed by Barton, the ward doctor for Dryad at the time. 20/9/98: Condition appears to have deteriorated overnight – would be from verbal handover from night staff. I informed family of condition – as per notes. *I can't say when these drugs were prescribed by Barton as there is no date to indicate when the entry was made on the prescription chart. Prior to administering the hyoscine the dosage would be discussed between myself and the other trained nurse where it would be decided to administer what we felt was appropriate within the prescribed guidelines as set out by Dr Barton.* Administered diamorphine. **Adds nothing to notes, save to set out how nurses would decide dose re hyoscine. Go back to her to deal with issues in our case – how prescriptions written, who decides when to administer diamorphine and midazolam and the dose?**
Frederick Pick	RL, tab 6f	Radiologist, Haslar Hospital. Adds nothing to notes. Hip replacement satisfactory when viewed on 7/9/98.
Freda Shaw	RL, tab 6g	Nurse, Dryad Ward. 19/8/98: Administered oramorph. Prescribed by Barton on 18/8/98. Adds nothing.
Lynne Barrett	RL, tab 6h	Nurse, Dryad Ward. Explains Waterlow Score (risk of pressure sores) and Bartel Index (activities of daily living). Would assess re Waterlow within 2-3 hours of admission and review every 72 hrs. Goes through nursing notes. Goes through drugs administered, but no explanation of why or methodology. **Adds nothing to notes – although was the named nurse. Go back to her?**
Anne Humphries	RL, tab 6i	Community nurse. Visits Lake in July/Aug 98. Small ulcers on leg, superficial lesions. No other treatment. **Adds nothing to notes. Still – shows no major problems in July/Aug 98.**
Joanne Dunleavy	RL, tab 6j	Nurse. Goes through notes. Adds nothing BUT corrects errors in notes: Date of 29/9/98 should be 29/6/98. Care plan in notes is her original care plan on her admission in September 1995, which was reassessed and updated – eg crossing out entries and making new ones. **Adds nothing to notes, save to clarify what relates to 1998 admission. Only necessary for that clarification.**
Beverley Turnbull	RL, tab 6k	Nurse, Dryad Ward. Explains notes. 20/8/98: General condition continues to deteriorate – probably

		meant that during course of the night Lake showed signs that she was distressed when moved or attended to, and that overall condition worsening. Bubbly means bodily secretions building up, suction attempted without success. Distressed when moved – she was obviously still suffering some distress when moved, and *this was noted by me as an indication that the quantities of drugs she was receiving were not alleviating the symptoms.* Made entries re syringe driver. *The decision to increase the doses of diamorphine and midazolam would not have been made by me alone but would have been based on my observations of Lake's condition when attended to be me and night staff. This would probably have been reported to Tubbritt who was the senior member of staff on duty that night. It is likely that the senior member of the day nursing staff was also consulted prior to the final decision to increase the doses. Barton had prescribed range of doses. It allowed nursing staff to increase the dose without making reference back to the doctor if the prescribed drugs were not having any effect on the patient's condition in lower doses. It may be that contact was made with Barton prior to increasing the doses. Had I made this contact, I would have noted it in the significant events summary.* I would not have administered any drug if I was unhappy about doing so. **Sets out how the prescribing of diamorphine and midazolam worked, but defends appropriateness of the drugs/dosages. Consider whether can call.**
Adele Bindloss	RL, tab 6l	Nurse, Haslar Hospital, Aug 98. Explains all notes at length, but adds nothing to them. Wrote transfer note to Dryad Ward. **Helpful for describing condition prior to transfer, but probably unnecessary.**
Shirley Hallmann	RL, tab 6m	Nurse. Goes through notes. 19/8/98: Complains of chest pain. Oramorph given. Dr notified. Pain only relieved for short period – very anxious. Diamorphine and midazolam commenced. Oramorph had been prescribed for pain control and Lake was given the prescribed dose. I was the nurse who contacted the doctor – Dr Barton. *Did Barton give her authority for the syringe driver to be started at this time? I cannot be specific in my answer. If, as seems likely in this instance, Barton had previously written the prescription then a senior nurse could initiate the syringe driver in accordance with the prescription without having to speak to the doctor. Having read the notes it is my opinion that I felt uneasy about initiating it and that is why I sought advice before putting it up.* Barton prescribed range of dosages. Oramorph given was within the prescription – 5ml first, then 10ml presumably to control pain better. Then administration of diamorphine 20mg – the amount given was within the prescribed dose. [But who decided the dose?]

		I would have expected Barton to have written a note regarding the prescribed drugs – it seems she did not. I would also have expected to see a visit recorded and something about the phone call from me (on 19/8/98). I am surprised to see the comment about Barton being happy for staff to confirm death, as Barthel Score was reasonable and improved on 18/8/98. Have not seem a doctor write such a thing before. **Potentially useful re methodology and failings in assessment. Go back to her for detail on how dosages of prescribed drugs administered were decided.**
David Barrett	RL, tab 6n	Consultant dermatologist. Goes through notes – history of seeing Lake 1990-97. Minor probs. Saw on 3/7/98 on Sultan Ward. Explains notes. Ulceration and swelling to legs. Not on strong painkillers – it did not seem necessary, although at a later stage might have been. I considered she was well enough to go home. **Really adds nothing to notes, save to clarify that entry "aim for home early next week" meant he thought she was well enough to go home.**
Melanie Hillier	RL, tab 6o	Nurse, Haslar Hospital. Goes through lots of notes from Haslar. Assessment prior to transfer – some episodes of shortness of breath but no other difficulties, no difficulties washing and dressing herself, does have pain in her legs at night and does not always sleep well. **Adds nothing to notes, but good review of them.**
Marjorie Wells	RL, tab 6p	Nurse, Dryad Ward. Completed assessment on transfer from Haslar. Adds nothing to notes. Then says: *There were instances when I was concerned that the range of doses prescribed by Barton in relation to diamorphine and associated drugs via syringe driver. 20-200mg is a wide range. A large discretion was placed on the nurse to administer the correct dosage at the time.* **Opinion fits our case, but she wasn't involved in administering diamorphine in this instance.**
Tina Douglas	RL, tab 6q	Nurse, Dryad Ward. Notes on admission, 29/6/98 – ticked box stating that her pain was not controlled – "I mean that the patient is receiving medication ie co-proxamol however she is still in pain from her arthritis." Otherwise adds nothing. **Adds nothing to notes – save to clarify meaning of ticking of box that pain was not controlled.**
Martin Connor	RL, tab 6r	Consultant Microbiologist, Haslar Hospital. Lake – blood culture report from specimen received on 10/8/98. Negative culture, but would place no emphasis on it. **Adds nothing to notes.**
Ian Reece	RL, tab 6s	Consultant in A&E, Haslar Hospital. Adds nothing to notes.

Althea Lord	RL, tab 6t	Consultant, Dryad Ward. Saw her at Haslar Hospital, 13/8/98. Goes through notes. Difficult to know if she would improve, but accepted onto ward at GWMH. *I have no recollection of a discussion with Dr Barton concerning Mrs Lake and there is no note of any such discussion in the records of Ruby Lake.* Would be a clinical examination of the patient on admission, which would form the basis of the care plan for the patient. Would expect Barton to address patient's medical need on day to day basis and to consult me if in her opinion it was necessary. I had no contact with Lake after 13/8/98. **Adds nothing to notes, save if it is important to confirm that Barton did not seek Lord's opinion.**
Sheila Chartres	RL, tab 6u	Community nurse. Visits to home in 1998. Adds nothing to notes. Leg ulcers.
Derek North	RL, tab 6v	GP. Suffered from leg ulcers. Previous admissions. Adds nothing to notes, save to say that in July 1998, biochemistry results indicated to him that Lake was suffering from chronic renal kidney failure. Goes through notes showing general picture of health. **Adds nothing to notes – all apparent from them.**
Diane Mussell	RL, tab 6w	Daughter of Ruby Lake. Gout and leg ulcers caused her quite a bit of pain. Arthritis. Mobilitiy limited. Fall in late July 98. Visited each day in Haslar. Raised concerns with them that she was not well enough to be moved. Was assured she was. Moved to GWMH on 17/8/98. On 18/8/98: Clean, well-cared for, able to talk, no concerns. Late on 19/8/98: Quite agitated and distressed. 20/8/98: Noticeable deterioration, gave no visible signs, unable to respond orally or by gestures. Think she was on syringe driver by this stage. Didn't talk to staff at length about condition. **Possibly helpful on speed of deterioration, but not critical.**
Timothy Coltman	RL, tab 6x	Doctor, Haslar Hospital. Simply explains notes, does not add to them, but good explanation. NB. 17/8/98 – seemed well, comfortable, happy, mobilising well. Plan to continue with current treatment. **Adds nothing to notes, but provides good picture of treatment at Haslar. NB. Must read together with others, eg Dr Lord, re condition/prognosis on discharge from Haslar to GWMH.**
Paul McGarry	RL, tab 6y	Doctor, Haslar Hospital. Adds nothing to notes, save: Over the first 5-6 days post-operation, management of her fluid balance was problematic, however by 7-8 days fluid balance had been corrected and the patient deemed fit enough to move to the rehabilitation phase of management. **Adds nothing to notes really, but maybe helpful to emphasise rehabilitation.**
Margaret Woodford	RL, tab 6z	Daughter of Lake. Saw mother 4-5 days prior to transfer to GWMH. She was quite lucid. Saw her at GWMH on 20/8/98 at 2pm, she was asleep. Did not wake up again. No concerns re treatment.

		No real assistance.
James Coales	RL, tab 6aa	Anaesthetist, Haslar Hospital. Adds nothing to notes.
Gemma Murray	RL, tab 6cc	House Officer, Haslar Hospital. Goes through notes at length. Adds nothing to them.
Pauline Robinson	RL, tab 6dd	Daughter of Lake. Initial days after admission to Haslar – not eating, very subdued. The following weekend of 15th-16th August 98, she was in wheelchair, lucid, normal self, getting better. Then saw in GWMH on 20/8/98 – unconscious, think on syringe driver. Quite a dramatic decline. **Shows dramatic deterioration.**
Michael Farquharson-Roberts	RL, tab 6ee	Consultant Surgeon, Haslar Hospital. Goes through all Haslar notes – 35 pages of statement. Adds nothing to the notes. Helpful if want overview only.
Christopher Yates	RL, tab 6ff	DC. IV Barton on 14/7/05. Tape – CSY/JAB/8. Prepared statement – JB/PS/7.
		ARTHUR CUNNINGHAM
Althea Lord	GCF6, tab 44 + AC, tab 5q	Consultant Geriatrician, GWMH, 1992-2004. Responsible for Daedalus Ward. GCF6 statement: Arthur Cunningham: Don't recollect any conversation with Barton over Cunningham's care. My entry in the clinical notes sets out my advice to the staff on the ward. Would be my normal practice to phone or talk to Barton about the admission. Did not see Cunningham again after his admission to Dryad Ward. AC file statement (26 pages): AC had Parkinson's. Visited him from Sept 97. Breathlessness, left ventricular failure. Assessed at length in June 98 – lost weight, depressed, hallucinations, involuntary movements. Continued assessment in July. Rehearses notes and summarises them. [Up to end of August 1998 he is not too unwell – continued Parkinsonism etc but not at death's door]. 23/9/98 [should be 21/3/98]: *Reviewed at Dolphin Day Hospital – large necrotic sacral ulcer. Parkinson's no worse, but still very frail. Admitting to Dryad Ward with a view to more aggressive treatment on the sacral ulcer. Keep nursing home place open – to establish whether he would become well enough to return there. Prognosis poor. "I felt that he was unlikely to recover."* *As the ulcer was extensive, he would have had a significant degree of pain for which I recommended oramorph. I prescribed 2.5mg-10mg orally as required at intervals of 4hrs.*

		Doesn't really add anything to notes, but explains at length AC's condition prior to admission to Dryad Ward. Does make clear that admission was to give chance of recovery – contrast with Barton/Hamblin strategy.
Susan Rynn	GCF6, tab 45	Nurse who dealt with Arthur Cunningham on Mulberry Ward of GWMH – simply goes through her nursing note entries. No apparent assistance.
Fiona Walker	GCF6, tab 46	Night Clinical Manager (Sister) at GWMH, Dryad and Daedalus Wards, 1981-2001. Fully aware of analgesic ladder. Trained in syringe driver. Aware of concern in 1991, but believe resolved internally. I would complete my own ward rounds, asking staff about poorly patients and any concerns. Made entries in notes of Arthur Cunningham – goes through – shows involved in administration of diamorphine, prescription sheets written up by Barton, a low dose. **No assistance. Little detail, no criticism.**
Sharon Ring	GCF6, tab 48 + AC, tab 5c	Nurse on Dryad Ward. GCF6 statement: Involved in treatment of Cunningham, including administration of diamorphine with Hamblin. Prescribed by Barton. Barton decided in this case what the starting dose would be. She would presumably know the BNF and guidelines. If any dose made a patient drowsy a doctor would be spoken to. AC statement: Barton wrote prescriptions for diamorphine and midazolam. I put them into syringe driver – 26/9/98. Barton prescribed range – eg 40-200mg diamorphine. On 26/9/98, I mixed 80mg diamorphine, 100mg midazolam. All medication was within the parameters set by Barton. *Any increases in the medication would be discussed between the doctor if available and the senior nurse. If the doctor was not available, the decision would be determined by the two trained staff on duty [ie nurses]. Re increased dose to 80mg on 26/9/98, I assume it was because of increased pain. Who decided to increase it? Decision would normally be doctor's, but if not available could be by two trained staff members within the prescribed parameters. The increase was not excessive.* **Doesn't explain how Barton decided the starting dose. Doesn't explain how and by whom decision was made to start the drugs. Does explain how nurses could determine dose. No criticism of Barton.**
Pamela Rigg	GCF6, tab 49	Nurse on Dryad Ward. Also involved in treatment of Cunningham. **Simply sets out entries in notes. Provides no detail on how and by whom decisions made.**
Siobhan Collins	GCF6, tab 50	Nurse on Dryad Ward. Also involved in treatment of Cunningham. Remembers him a little, suffered from Parkinson's and dementia. Involved in administering opiates, as was Hallmann. He was in early stages of

		dementia, very difficult to manage. **No real assistance.**
Ingrid Lloyd	GCF6, tab 53 + 54	Nurse on Dryad Ward, 1998. Good knowledge of analgesic ladder. Trained in syringe drivers. Details entries in notes for Cunningham. Barton prescribed variable dose, 20-200. I administered syringe driver with 20mg, the lowest dose. 21/9/98: I was aware from verbal handover at about 20.15 that the incidents in Hallmann's note made on 22/9/98 had already taken place (as her note was retrospective). It was with this knowledge that together with Shirley Hallmann it was agreed that a syringe driver should commence. *With regard to who authorised the syringe driver this was a decision made by three trained nurses including myself, Shirley and Fiona. The drugs were prescribed to be given at our discretion.* **Revealing as to how Barton would prescribe drugs and nurses would decide when and at what dose to administer them. Consider use/going back for more detailed account. However, note that she will be defensive as to the practices.**
Charles Stewart-Farthing	AC, tab 5a	Step-son. Cunningham had Parkinson's. Could be difficult. Racist beliefs – likely caused deep enmity with Dr Lord – Sri Lankan. 21/9/98: Saw AC in Dryad Ward – perfectly normal, cheerful, said he was there because he was a bit sore. Spoke to Hamblin. *She said AC has worst bedsores she could remember and expressed opinion that they were so serious that he could not survive them.* 22/9/98: Spoke to Hamblin on phone, *she said AC had become difficult and rude to staff, had been given something "to quieten him down."* 23/9/98: Visited – AC totally unconscious, on syringe driver. Demanded it to be stopped. Hamblin refused – only doctor could authorise removal. Had to wait for Barton to arrive around 5pm. *Barton said AC was dying due to the poisons from bedsores, too late to interrupt the drugs, which were necessary to ensure he was not discomforted.* Death certificate said cause of death was bronchopneumonia – signed by Dr Brook. Dr Brook was unknown to me and AC. Totally disagreed with this cause of death. Complaints made. Conspiracy afoot with Coroner's Office. *I have no doubt that AC was the subject of a well-oiled disposal machine being administered by a culture of able individuals who were well used to their evil practice. I believe the godfather was Lord, the executioners were Barton and Hamblin.* **May have fair complaint, but expressed in conspiracy-theory terms. Caution. If to use – obtain letters of complaint from 1998 to Inspector of Nursing Homes and Portsmouth Healthcare Trust.**
Shirley Sellwood	AC, tab 5b	Friend. Visited in GWMH twice. First time a few days after admission – seemed fine, had bedsores, quite

		normal, not close to death. Visited few days later – he asked me to leave as he was very drowsy and was being given diamorphine. **Minor assistance re deterioration.**
Freda Shaw	AC, tab 5d	Nurse. Adds nothing to notes. Administered diamorphine and midazolam on 25/9/98 – says nothing more about it. **Adds nothing to notes.**
Gillan Hamblin	AC, tab 5e + f	First statement: Sister/Clinical Manager, Dryad Ward. Barton visited at 7.30am Monday to Friday and see every patient. On visits, would prescribe the necessary medication. Cunningham: Goes through notes. *He had a huge bed sore on his back, through to his spine. Dr Lord rang me and asked me to take him on the spot because of the bed sores. I collected him from Dolphin Day Hospital. Barton helped me push his bed to Dryad Ward. He was extremely uncooperative. Whole of sacral area had a deep recess, due to him being non-compliant with his sitting/lying/dressings.* Administered 20mg diamorphine on 21/9/98, 22/9/98 and 23/9/98 and *this was clearly not holding him [ie the pain – second statement clarifies the meaning].* Administration of 60mg of diamorphine on 24/9/98 was possibly done by night duty. *The dose administered could be anything from 20-200mg, so the doses were well within acceptable limits and could only be increased in consultation with the doctor.* **[cf Sharon Ring – says two nurses could decide to increase it – see second statement for clarification].** The drugs were written up by Barton in consultation with Lord. Spoke to Mr Farthing on 23/9/98: Angry that syringe driver started. Explained required to control pain and would need consultant's permission to discontinue. [Why?] I don't believe syringe driver was an issue – was because he couldn't talk to his father. Second statement: Barton and Lord spoke together about AC and his medication when we picked him up from Dolphin Day Hospital. However, can't find Lord's discharge letter on medical records. *The doctor to be contacted in the event of any change in medication outside the range of prescribed drugs was Barton [so nurses can change it within the range prescribed?]. A variable dose means an increase or lower dose can be administered if necessary. Nursing staff can decide if they consider the pain is too severe and dose needs increasing. If that be the case then Barton would be informed. In the case of a lower dose Barton would have consulted with Lord. [This is pretty garbled].* Step-son told me he didn't have a problem with the syringe driver. **Again, may show how the system worked, but can we use her? These statements are not very clear on**

		how the prescribing/administration of drugs worked.
Sarah Brook	AC, tab 5g	GP. Minor entries in records – covering for Barton. 25/9/98 – for TLC – I felt he was dying. I issued the death certificate. As I was not that familiar with the patient, discussed with Lord (as notes say) for cause of death. **Brook just filling in death certificate on basis of Lord's evaluation. See step-son's criticism.**
Yasir Hamed	AC, tab 5i + j	Pathologist. Conducted PM. Cause of death – bilaterial bronchopneumonia. Lungs had inflammation due to infection. Also had advanced heart disease.
Joanna Taylor	AC, tab 5k	Nurse. 25/7/98 – Attends to hygiene a little, irritated at times, mood variable. Capable of getting up and walking about. One night – filled plant pot with faeces and threw it at staff [!] Goes through notes up to 19/8/98 – cooperative, but suffering from paranoia and delusions. **Adds nothing to notes. Does paint picture pre-deterioration.**
William Munro	AC, tab 5l + m	Clinical Assistant in Old Age Psychiatry. Details notes. Adds nothing, save to confirm that AC suffered from severe dementia – when seen on 17/8/98 and 18/8/98. [cf step-son's statement]
Shirley Hallmann	AC, tab 5p	Nurse, deputy manager of Dryad Ward. Hamblin was line manager. Hamblin did not make me feel welcome. Had concerns on the ward - patients did not always have chance to try alternative medication, before syringe driver started. Expressed concerns to others. Wrote my concerns privately at home. Have given the police my personal papers. Spoke to mother also. Repeats what is in other statements re asking Hamblin about syringe drivers, Hamblin saying "I hope when you die, you die in pain." Barton: "You don't understand what we do here." Barton and Hamblin would do rounds together around 7.30am. Cunningham: Goes through notes, adds little. Says: *Whilst the doctor determined the drugs and parameters of them to be administered, the nurses would decide where and to what level, according to the pain level increase in the patient. The diamorphine was administered for AC's pain, the midazolam for his anxiety. It* <u>*may*</u> *be that if AC could not take oramorph, that was why the syringe driver was started.* **May help in showing how prescribing/administration of drugs worked. Says little about AC himself.**
Debra Barker	AC, tab 5r	Nurse. Involved in administration of diamorphine. *Amount and range of drug prescribed by doctor. At the time, there were no protocols in place for the increase in drugs to be given to a patient who may have increased pain, other than the parameters set by the doctor in the drug chart. On 22/9/98, administered 20mg – this was the lowest dose. If a patient were experiencing greater pain, the dose may well have been increased by trained nursing staff. Sliding scale always used – would work up from the lowest dose of the weakest analgesic [!] The decision as to the drugs to be given and the amounts of drugs to be*

		administered would always be determined by a doctor [ie the range of dose?] I had no concerns about Barton.
Christine Dolan	AC, tab 5u	Nurse. Generally adds nothing to notes, save re 23/9/98 – a little agitated, seems in some discomfort when moved. Re the agitation, he may have been crying out when being turned, it would be obvious that the patient was in discomfort. **Adds little/nothing to notes.**
Beverley Turnbull	AC, tab 5v	Nurse. First part of statement is same as generic statement – big concerns about syringe drivers up to 1991, being used on patients who had not presented any symptom of pain. But change over time as type of patients accepted changed. No concerns re AC. Notes simply re death. States: *At this time it was usual practice for the senior staff nurse or nurse in charge to increase dosage of drugs to a patient, within the parameters set by the doctor if she considered it necessary.* **Potentially useful to confirm method of prescribing/administering drugs. Otherwise adds nothing to notes.**
Mary Scott-Brown	AC, tab 5w	Doctor, GWMH. Deals with notes from June-July 98. Adds nothing to them.
Helen Capes	AC, tab 5x	Nurse, Mulberry Ward. Deals with AC in July-early Aug 98. Adds nothing to notes.
Susan Nelson	AC, tab 5y	Nurse. Few notes re syringe driver. Nothing about how/why etc. Adds nothing to notes.
Wendy Childs	AC, tab 5z	SHO in psychogeriatrics at the time. Goes through notes, July 98. Explains all but doesn't add.
Lesley Croft-Baker	AC, tab 5aa	SHO at GWMH at the time. Details notes in Aug 98. Explains but adds nothing.
Victoria Banks	AC, tab 5bb	Consultant, old age psychiatry. Details notes re AC on Mulberry Ward, July-Aug 98. Explains notes, adds limited amount. States re July 98 admission: *He was suffering from depression, mobility not good, Parkinson's. A challenging patient due to falls, behaviour and demands. As a consequence, decided to treat him at GWMH and then to discharge him to the most appropriate care environment.* Adds: *AC made reasonable progress during his admission, mood improved and behaviour improved, but remained physically very dependent. Progress enabled him to be discharged to a nursing home.* **OK, but this is pre-last GWMH admission, when sore had developed etc. Any point calling this sort of witness? Deal with notes only? Should we only choose particularly helpful witnesses re background and condition (eg family members), or call them all?**
John Grocock	AC, tab 5cc	GP. Wrote referral letter in June 98 to Lord. Summarises notes/general medical history from 80s on – very potted summary, adding nothing to notes.
Code A	AC, tab 5dd	Nursing assistant. Mulberry Ward – July-Aug 98. Notes. Adds nothing.

Pamela Gell	AC, tab 5ee	Produces notes from Thalassa Nursing Home – DW/PG/1. Discharged there from Mulberry Ward on 28/8/98. 78, Parkinson's, blood sugar problems, difficult behaviour. On admission noticed large red sacral area. Sacral sore continued to be treated and dressed. Quite settled. No changes required to his psychiatric treatment. Attended Dolphin Day Hospital on 21/9/98 – admitted to Dryad Ward as result. He appeared unwell that day. Could have been start of chest infection. **Possible relevance re stability except for sore?**
Maureen Young	AC, tab 5gg	Nurse, Aug 98. Few entries – AC mobility not too bad. Adds nothing to notes.
Rachael Ross	AC, tab 5hh	Clinical Assistant under Lord. GP. Goes through GP notes. Includes letter from Ross, 17/9/98 – discharged from Mulberry Ward to Thalassa Nursing Home, eating not too badly, bit brighter, some stiffness, will liaise with nursing home. **But adds nothing to notes.**
Christopher Yates	AC, tab 5h	IV Barton, 21/4/05. Tape – CSY/JAB/6. Prepared statement – JB/PS/5.
		ELSIE DEVINE
Beverley Turnbull	GCF2, tab 8 GCF6, tab 38	Staff nurse on Dryad Ward. Barton joined unit (pre-1991), use of syringe drivers increased. Became extremely concerned, as used on patients who had not presented any symptom of pain. All patients who received this pain relief were under care of Barton and it was done on her instruction, but it was at the nurses' discretion to administer the drugs. Attended meetings in 1991 about it. A policy was going to be drawn up, but never saw it. *I had no concerns about the use of syringe drivers after the unit moved to Dryad Ward. Believe they were correctly used for the people who needed them.* Produces corres re 1991 debacle – JEP/GWMH/1/BAT. I handed these to Toni Scammell with Anita Tubbritt in 2002. Vague recollection of Elsie Devine, but can't recall any detail of her care or treatment. BJC/16/PG/195&195 – Nursing note entries: 19/11/99 – relatives stayed until 23.00, peaceful night, syringe driver satisfactory – signed by me. She would have been very poorly, closely monitored through the night. BJC/16/PG/222&223 – Summary of Significant Events Card: 19/11/99 – peaceful night, syringe driver satisfactory, recharged 07.35, diamorphine 40mg, midazolam 40mg – signed by me. Shows syringe driver

		refilled by me at 07.35 on 20/11/99. Controlled Drugs Record Book shows diamorphine administered or witnessed by Turnbull, Hamblin, Tubbritt. Administration of a controlled drug takes two trained members of nursing staff, to ensure checks carried out correctly. Prescription chart must be legible, dated, signed by doctor. Had I had any concerns about given the drug to the patient, would have discussed with doctor or senior nurse. I have seen nothing indicating that I had concern re drugs given to Elsie Devine. If she had complained to me of pain, or if I had noted symptoms of pain, would have noted this on Significant Events Form and Night Care Plan. **Cannot use – says appropriate use during our period, even though very critical before this. This is strange – should we check her view now?** **NB. A problem might be that she and other nurses *continued* in the practices after 1991, so would not want to incriminate themselves – eg in her administration of diamorphine to Elsie Devine.** **JEP/GWMH/1/BAT: GCF3, tab 14 – same material as in JEP/GWMH/1 – below.**
James Reeves	GCF6, tab 33	Grandson of Elsie Devine. Describes how active she was in the past. No detail of her health 1991-9. Visited nan on 22/10/99 – she had had a bath, quite emotional but otherwise in great spirits. Visited one week later – she was in sitting area, unhappy and crying, but said not to worry. Visited on 4/11/99 – nan fine but tearful. Visited on 19/11/99 – after being told by uncle that nurses said she had 36 hours to live, nan in private room, nurses say she won't know we're there, breathing very slowly, wouldn't open eyes. Dr Barton arrives, does not say good evening, says "follow me," snaps that had come in especially, thought her very rude and insensitive. Barton states nan put on medication to make her more comfortable as she had been in a lot of pain. Says she would put renal failure on death certificate – insensitive, not dead yet. Barton said there had been a deterioration in kidney function, tested on Tuesday and results came back on Thursday. Barton: "You know that your mother is suffering from multiple myeloma?" My mother corrected this immediately. Day before death – found would seemed to be a syringe driver under nan's pillow [!] **Potentially powerful evidence – re Barton's attitude, mistake re myeloma, deterioration.**
Helen Bower	GCF6, tab 34	Doctor at Queen Alexandra Hospital. Dealt with Elsie Devine, but all matters probably described adequately by Black from notes? Simply goes through notes.

Claire Spice	GCF6, tab 35	Same as Helen Bower. No individual recollection of Elsie Devine. Simply goes through notes (pre-GWMH). Could be used if wanted notes gone through in this sort of detail.
Callum Pearce	GCF6, tab 36 + 37	Same as Helen Bower.
Helen Passmore	GCF6, tab 39 ED, tab 9ii	Produces HP/1-3 – Medical Certificate of Cause of Death for Elsie Devine (tab 40), notification of death by coroner (tab 41), death register entry (tab 42) – chronic renal failure, certified by Barton.
Gillian Hamblin	ED, tab 8b + n + o	Generic statement: General comments as in all statements re Barton, concerns re syringe drivers in 1991. If ever had concerns over medication, would check with Barton – would not give if not satisfied. Meetings in 1991. Never had doubts over syringe drivers. **Nothing re ED.** Second statement: Goes through notes, adding her interpretation and further detail. 15/11/99: Thioridazone continued – a sedative. 19/11/99: Marked deterioration over last 24hrs, extremely aggressive this am refusing all help from staff. Syringe driver commenced at 09.25, Fentanyl patch removed. ED's son [Harry] seen by Barton at 13.00 and situation explained to him, he will contact his sister and inform her of ED's poor condition [ties in to his call to family that day saying 36hrs to live]. *This entry relates to fact that ED's kidneys were failing. Long history of renal problems. Had been throwing the staff, Debbie Barker, into a book case. During the night had been trying to pull patients out of bed, hitting out and anybody and anything. Given chlorpromazine [sedative] due to her aggression, to calm her. Barrett injected this. Prescribed on advice of Barton after her phoned for advice. ED had hold of Barker's wrists and wouldn't let go. Syringe driver was started that morning. Fentanyl patch was removed, as can't use both together. Barton explained deterioration to son due to kidney problems. The syringe driver was set up and diamorphine administered on the advice of Barton. This was because the chlorpromazine had no effect*. **[When did Barton prescribe? Why? Seems on Hamblin's evidence that had nothing to do with pain. Also – ED's activity that night doesn't sound like woman at death's door!]** Entry for 3/11/99 relates to conversation with Mr and Mrs Devine (Harry and wife) re ED returning home. They say she can't do stairs [Ann Reeves says this is a lie] and concerned about her returning. Ann Reeves wanted them to look after her. [Irrelevant really, but Ann Reeves complains about it]. I administered fentanyl patch on 18/11/99. I administered diamorphine 40mg on 19/11/99. [No detail on dose etc].

		Again – can we use? Statement inadvertently helps our case – but very pro-Barton and many of our issues not dealt with.
Lynne Barrett	ED, tab 8c ED, tab 9kk	Generic statement – nothing re ED. Diamorphine used to control pain if necessary. All drugs given as per prescription. On prescription, doctor would dictate the amount and method of delivery. Nurses would have an input with the doctor, but could not deviate from the prescribed method of delivery. No concerns re syringe drivers. Don't remember meeting in July 1991. Patients are now dying in pain because doctors too scared to prescribe pain relief. *Barton is being used as a scapegoat so that the relatives who first started this vicious campaign can have a name on an official document.* **Generic statement only. Very pro-Barton. No concerns.** Specific ED statement. Made note on 21/10/99 upon admission – CRF, still confused at times, minimal assistance with ADLs, little unsteady. ED then seen by Barton. Oramorph prescribed to be given as required. My personal recollection: Would rummage in other people's lockers, take their things. One morning, held Debbie Barker by both wrists, trying to push against rail, hit me around face, shouting loudly, also involved Hamblin and Bell. Barton came in to do early morning ward round, saw what was happening, prescribed sedative. I gave her the injection – looking at notes, fits entry for 19/11/99 and admin of chlorpromazine. **Only addition to notes is 19/11/99 incident. Compare nurses' accounts of whether Barton present. This is the day of rapid decline – seems to be very significant – OK till 19/11/99, then unconscious. NB. <u>Check what nursing/medical notes say about this incident</u>.**
Joanne Dunleavy	ED, tab 8d	Generic statement only – no concerns re syringe drivers.
Elizabeth Bell	ED, tab 8e	Generic statement only – no concerns.
Christine Evans	ED, tab 8f + g	Generic statement – no concerns. Elsie Devine statement: Night sister was Fiona Walker. Syringe drivers used appropriately for pain control. Notes: 18/11/99 – no entry, means no significant change in condition. **So adds nothing to notes.**
Irene Dorrington	ED, tab 8h	Nurse. Notes on 16/11/99 and 17/11/99. Adds nothing, save re 16/11/99 – I don't know why ED refused her medication in the morning – not unusual.
Althea Lord	ED, tab 8i	No dealings.
Tessa Lancaster	ED, tab 8l	Radiologist. Scans kidneys, chest etc, April 99. Lungs normal. Kidneys slightly small but no other renal abnormality. Adds nothing to notes.

Ann Reeves	ED, tab 9e + f + g	Incredibly detailed statement of 30 pages. Lots of detail about family squabbles. ED was active all her life. Describes diagnosis of multiple myeloma followed by tests showing this was not correct – May 99. Admission to QA hospital for kidney infection. Clears up. Transfer to GWMH – 21/10/99. 28/10/99: Visited. Sitting in lounge. Alert, looks well. 11/11/99: Visited. Walking unaided. Talking – not wanting to be a fuss. Not agitated. 19/11/99: Got call from brother Harry, saying ED had kidney failure and had been given 36 hours to live. Visited that day. Spoke to Freda Shaw: "She won't know you love." Mum does not wake up, but squeezes hand. No drip set up (ie no fluids being received) – daughter Bridget asks how can go on without fluids. Breathing laboured. Around 5pm, see Barton – although hadn't asked to see. *Barton very regimental. Says "follow me" and walks off down corridor. Says in hostile voice that came in especially. Barton says mother has multiple myeloma. I correct. Barton says will put kidney failure on death certificate. I was appalled at her attitude.* Did not see Barton again. Brother Harry surprised as deterioration – he said the night before he had been sitting with ED in lounge, chatting. [**Statement? Unlikely, as died in 2000 – So: Hearsay?**] 20/11/99: At bedside. Squeezes hand. Stops breathing for long periods, then starts again. Freda Shaw mentions funeral arrangements and that we could see Pastor Mary – who we did see. 21/11/99: At bedside. Later phoned by GWMH that she had died. Describes conversation Harry had with Barton over the death certificate – further coldness. [Statement?] Wrote to Portsmouth and Southsea Health Authority with questions – letter is ARR/1. Details response ARR/2. Can't understand why thioridazine was administered on 11/11/99 – she was not agitated. Hamblin's nursing note of 1/11/99 that ED could not climb stairs was untrue – she could. Bath on 11/11/99 not recorded in notes. Fentanyl patch administered for pain that she was not in. Plus seems clear from notes that ED had fentanyl patch and syringe driver at same time. Further correspondence and complaints – other ARR/exhibits – detailed at length. Gives her view on comparison of what likes of Barton and Hamblin have said with the medical records. Second statement: Deals with treatment in QA Hospital. 11/10/99 – concerned that ED not eating or drinking enough, and not enough care shown. Being neglected. Doctor had drip set up when showed him she couldn't drink for herself. Saw entry in medical notes relating to this episode – untrue. Complained re

		nurse – staff nurse Bean. Wanted her reprimanded for slanderous comments re brother's marriage in the note. **Can give relevant evidence re ED's decline and Barton's attitude. NB: Long history of complaints, lots of correspondence. Mostly not relevant to our issues.**
Freda Shaw	ED, tab 9c + d	Generic statement – no concerns with syringe drivers. ED statement: Renal failure and dementia. Contact with Ann Reeves: Note of 19/11/99 – daughter has visited, seen by Barton. This was the only time I met Ann Reeves. ED was very poorly. When family arrived I called Barton, who said she would come after her surgery. Barton arrived, I took Reeves into quiet room. Barton explained deterioration, prognosis poor but would do all to make comfortable. I later asked if she had understood everything. She said she had and just wanted to sit with her mother. Would never say how long a patient had to live. **No assistance. Conflict with family. Any point in getting into this?**
Bridget Reeves	ED, tab 9h	Ann Reeves' daughter. ED was tower of strength in 1999 when dad diagnosed with leukaemia. Similar evidence to mother re failure to give sufficient fluids in QA Hospital. 22/10/99: Visited ED on Dryad Ward. In good spirits, chatted for 2-3 hours. 4/11/99: Visited. Quite tearful, asked about dad, chatted. 11/11/99: Visited. Had bath. Rollers put in hair. 19/11/99: We got call from uncle Harry saying ED only had 36 hrs to live. Visited. Freda Shaw: "She won't know you're here, she's unconscious." 20/11/99: Visited. Had deteriorated further. *None of us knew she had been in any pain, so none of us could understand why she was on syringe driver. Harry had been with her on evening of 18/11/99 and she had seemed fine, sitting in lounge chatting to him.* **Potential use re deterioration.**
Arumugam Ravindrane	ED, tab 9i	Registrar, QA Hospital. Made tentative diagnosis of myeloma in April 1999. Explains it. Only a clinical suspicion. **No assistance.**
Elizabeth Bell	ED, tab 9k	Nurse, Dryad Ward. Entries in medical notes – inconsequential. Adds: One morning, ED stood in corridor holding onto rail, very aggressive, refused to sit in chair. Debbie Barker dragged by ED down the corridor. Barker, Hamblin and Barrett were needed to get her to calm down and persuade her to sit in chair.

		Another time, sat in chair, I held her hand, she said "I bet you thought I was asleep in aggressive manner" and dug her nails into my hand. Cannot remember dates of these incidents. **So: Nothing significant in notes for her – but adds detail re ED's aggressive behaviour, in contrast to family's presentation of ED as no trouble. NB. She does not seem to have made any entries re these incidents – check others' entries.**
Debra Barker	ED, tab 9l	Nurse. No concerns re syringe drivers. ED used to wander around the day room. One day: Saw ED in corridor, swaying. Went to talk to her, she refused to go and sit. Grabbed my arm, wouldn't let go. Bell, Hamblin and Barrett assist. ED walks up corridor pulling me along. Becoming aggressive. Managed to get her into a chair. Hamblin went to get Barton. ED given an injection to calm her down. Goes through notes. Explains them but adds nothing. **Only adds to notes to describe aggressive incident.**
Jeanette Bean	ED, tab 9p	Nurse at QA Hospital. Subject of criticism there – not really relevant. Goes through notes – adds nothing to them. Shows aggression and disruption by ED there. Says Ann Reeves was distressed and aggressive at times. ED was medically fit for discharge on 21/10/99 – urinary tract infection had been stabilised, confusion stabilised. Says that ED had multiple myeloma [!] **Not really relevant. Notes sufficient for condition on discharge.**
Barbara Maw	ED, tab 9t	Produces computer medical records for GP surgery – BM/1, 2.
Fiona Wright	ED, tab 9u	Nurse at QAH. Goes through notes. Adds little/nothing.
Robert Logan	ED, tab 9v	Consultant geriatrician. Dealt with ED up to June 99. Adds little to notes. Kidney problems etc. Dr Cranfield says insufficient evidence for a diagnosis of myeloma.
Joanna Taylor	ED, tab 9w	Psychiatrist at GWMH. Explains notes in Oct/Nov 99. [NB. She also thinks diagnosis myeloma]. Doesn't really add to notes. By 18/11/99: Had deteriorated somewhat, restless, more aggressive.
Eileen Bollen	ED, tab 9x	Friend. Visited once before death – can't give date but daughter and granddaughter present. She seemed normal to me. **Marginal help. Woolly.**
Ian Reckless	ED, tab 9y	House physician, QA Hospital. Goes through notes from 10/10/99 to 21/10/99 and discharge. Explains all notes fully. Adds some comment: Initially dehydrated, aggressive, abnormal behaviour. By 18/10/99, no longer aggressive, normal behaviour, usual fluid balance. Medically fit for discharge from 13/10/99. Discharge plan. Was suffering chronic renal failure – but was admitted primarily due to confused state, not kidney problem. Discharge letter – bloods: nil of note stable; IgA paraproteinaemia – excess amounts

		of a particular protein produced in bone marrow, sometimes represents a cancer of the bone marrow, but can also be a finding of unknown significance. Diagnosis – multi infarct dementia and chronic renal failure. **Could deal on notes alone, but this is a good summary of progress and condition on discharge. Explanations are good, and does add comment.**
Mary Sandell	ED, tab 9z	Pastor Mary. Nothing useful – saw ED a few times, a contented patient, didn't complain, talked about family, sometimes asleep. Daughter was stressed.
Peter Smith	ED, tab 9aa	GP. Goes through notes in 1999. Includes referral letter for QA Hospital – but adds nothing to it.
Walter Jayawardena	ED, tab 9bb	Consultant Geriatrician, QAH. Twice weekly ward rounds. 19/10/99: Signed entry that ED was suitable for rehabilitation, arrange transfer to GWMH. Would have to have recovered from UTI. Goes through notes and letter written re discharge. **Doesn't really add to notes.**
Hywel Cooper	ED, tab 9dd + ee	SHO at QAH. Supervisor of Reckless. Like Reckless, reviews notes. Admitted due to confused state, also with evidence of renal impairment. NB. Very low mental test score on 14/10/99. Summary: Admitted very confused, possible UTI. Confusion then reduced. CT scan suggested multi-infarct dementia. Mental state stabilised/improved slightly, so transfer to GWMH appropriate for rehabilitation prior to long-term placement. When admitted, marked "not for resuscitation" – due to poor condition eg age, kidney impairment etc. **Questionable whether adds anything to notes. Does provide good summary.**
Judith Stevens	ED, tab 9ff	Consultant re kidney problems at QAH. Goes through notes, from outpatient in June 99. Renal impairment then, but no pallor. Treated conservatively. Plus Sept 99 outpatient clinic. Renal finction gradually getting worse. All this in notes/letters. Picture of gradual decline but not acute problem. **Adds little to notes, beyond explaining them all.**
Tracy Mulholland	ED, tab 9gg	Granddaughter. Saw ED a week before admission – quite normal (quite active). Visited every day in QAH – never changed, always normal, did not look ill, never complained of pain. Visited in GWMH a few times per week. Wanted to take her out of hospital for fish and chips etc – not allowed – couldn't see why. First few visits – OK, no deterioration. 14/11/99 – normal, chatted, but was last time saw her conscious. 19/11/99 – got call from dad saying ED not expected to last much longer. Visited – unconscious. **Another relative view – potentially helpful, but (eg re ED in QAH), demonstrably unreliable.**
Sandra Briggs	ED, tab 9hh	Wife of Harry (so daughter in law). Visited ED several times in GWMH – always in communal room sat n chair. Always seemed fine, always talked, recognised me, never seemed in pain or distress. Always wanted to go home. 18/11/99, around 2.30pm: ED had hair washed, came into communal room, chatted as normal, ED drank tea unassisted. 19/11/99: Call from Tracy with news from Harry that ED was dying –

		shock. **Good picture of rapid decline – comparison between 18/11 and 19/11.**
Graham Gordon	ED, tab 9jj	Doctor at QAH. Adds nothing to notes – confusion/aggression on 12/10/99.
Bryan Palmer	ED, tab 9ll	GP. Explains notes re home visit on 6/10/99 – vomiting since started co-odanal (strong pain killer) for diarrhoea. Stopped co-odanal. **Irrelevant. Adds nothing to notes.**
Robert Lennon	ED, tab 9mm	SHO under Judith Stevens. Explains notes on treatment of ED in July 99 – extent of renal problems. Kidneys not working properly. "Remains well, no new problems." Plan to see againi in 6 weeks. **Shows no major problem, but adds nothing to notes beyond explanation.**
Richard Reid	ED, tab 9nn + oo	First statement: Consultant Geriatrician. Responsibility for Dryad Ward. Supervised Barton. Did weekly ward round. Would be accompanied by Barton once a fortnight, if she was available. *If Barton had a particular problem re management of patient, would expect her to contact me for advice or for me to attend. If my advice sought, would expect note to be made on clinical notes by Barton. Barton very experienced, so would have to be a serious clinical problem for her to do this.* Saw ED on 25/10/00, 1/11/00 and 15/11/99 (so pre-19/11/99 and swift deterioration). Explains notes of each visit – although notes speak for themselves. 25/10/99: Mobile unaided, continent, mildly confused, chronic renal failure. Note to find out more about family was because need to find out if they could care for her of if residential/nursing home needed [showing in decent condition]. *Not unusual that no entry in clinical notes between 25/10 and 1/11, as there had been no major change in ED's condition or treatment.* 1/11/99: Physically independent, continent, quite confused and disorientated, try home visit to see if functions better at home. Confusion had worsened since 25/10/99. *Physical condition stable. Had there been any concerns re her physical condition, would have made note of it. Would have been best practice for an entry to have been made in clinical notes as to being more confused – not done.* 15/11/99: Very aggressive at times, very restless, has needed thioridazine, being treated for UTI, gross oedema, other matters normal. *No note was made of these things in clinical notes since last visit – this entry was result of verbal reports from staff and possibly Barton. Thioridazine in a major tranquilliser – was correct drug and low dose. Would be good practice to enter the administration of this drug onto the clinical notes. Would have been best practice also to make entry re UTI. So – condition and treatment <u>had</u> undergone a marked change – antibiotics for UTI, temazepam and thioridazine. Would have expected entries in clinical notes. Still – treatment appropriate.*

		Was no apparent physical reason for ED's behaviour, so asked her to be referred to Dr Luznat – done. Spoke at length to Ann Reeves after death – established rapport. She intensely disliked Barton. **Second statement:** Prescription sheets. Would almost certainly have been examined by me on the ward rounds. Thyroxine prescribed from 21/10/99 [on admission]. Taken from 22/10 to 17/11 – can only assume that ED's condition after that time meant she was unable or refused to take medication orally. [Notes say refused medication on 18/11, by 19/11 unconscious]. 21/10/99: Temazepam 10mg prescribed as required – sleeping pill. Reasonable given her confusion. Administered once. *There was no resident medical cover at GWMH, therefore was good practice in my view to prescribe as "as required" sleeping pill. Would allow nurse to administer without consulting a doctor.* 21/10/99: Oramorph prescribed by Barton, as required, in usual starting dose. *This is usually used in treatment of pain. Given no resident doctor, would be reasonable to prescribe a <u>simple analgesic</u> on an as required basis, but in the absence of any documented pain, this was <u>inappropriate</u> due to strength of oramorph.* [NB. Reid does not appear to have done anything about it on ward rounds]. 11/11/99: Barton prescribed antibiotic for UTI. [NB. UTI and treatment not in clinical notes]. 11/11/99: Thioridazine prescribed by Barton as required – tranquilliser/sedative. Bottom end of dosage range. Administered 10 times between 11/11 and 17/11. Consistent was aggression and restlessness. *Reasons for prescription should have been recorded in clinical notes. But prescription wholly appropriate.* 18/11/99: Fentanyl patch prescribed. Administered at 09.15. Removed at 12.30 on 19/11/99. *A strong analgesic. No complaint of pain on records. <u>Explains why this might have been done</u>: Elderly/confused patient may be in pain but not able to communicate it or display any symptoms of pain other than confusion/restlessness. In first instance, would treat with sedative – done here with thioridazine. But clinical notes show became more restless and aggressive on 18/11. <u>Could</u> be indication of pain. An option then was to cease sedative and commence analgesic. Barton did this – fentanyl. ED was refusing on 18/11 to take oral medication, so would explain patch.* [So: Justifying Barton's prescription – but (a) there was no indication of pain and (b) what follows next day is admin of lots of sedative and analgesic on basis of terminal care – can't justify]. 19/11/99: Chlorpromazine 50mg prescribed by injection. Administered at 08.30. Upper end of dosage range. [Due to incident that morning with aggression]. *Consistent with her continued confused and*

		aggressive state. *Barton should have made entries in clinical notes re fentanyl patch and chlorpromazine – powerful drugs.* Barton's notes for 19/11: Marked deterioration overnight with confusion and aggression and marked deterioration in kidney function. Needs sub-cutaneous analgesia with midazolam. *In my opinion, this indicated Barton had formed the opinion that ED was terminally ill and overriding priority was to relieve ED from symptoms, ensure comfortable and free from distress.* [But why?] 19/11/99: Barton prescribes diamorphine 40-80mg, midazolam 20-80mg. Prescription of diamorphine was correct replacement dose for the fentanyl patch [cf Prof Black]. *But fentanyl patch not removed until 12.30 on 19/11 – diamorphine/midazolam started at 09.25. Plus fentanyl remains in system for 12-24hrs. So – likely to have received more than the equivalent dose. However, the fentanyl hadn't relieved ED's distress, and unlikely that max dose of diamorphine was exceeded. Normal starting dose for midazolam is 10-20mg. Other methods/doses may have been more appropriate, what happened could have led to over sedation, but in my view syringe driver and these drugs were appropriate.* *Can see nothing in notes to indicate why midazolam not started at the lowest dose in the range prescribed.* *Problem: Chlorpromazine administered at 08.30 on 19/11. Would expect effect ½-1hr later. Effect would last 3-6hrs. But midazolam and diamorphine started at 09.25. Could have led to some over-sedation. This is of some concern.* *Barton's note of 19/11/99 is an indication of a change in course of treatment of ED to palliative care, relieving ED of symptoms of confusion, restlessness and aggression on a background of rapidly declining renal function.* [But why? What evidence of rapidly declining renal function? What efforts to deal with it? What assessment of pain? What justification for the combination of powerful drugs which made death a foregone conclusion?] *The variable dose prescription by Barton of diamorphine and midazolam was to allow the nursing staff the discretion to increase the dosage should the initial dose not control the symptoms.* **Makes significant criticisms of Barton – particularly regarding note-keeping. Concerns re combination of fentanyl/diamorphine/chlorpromazine/midazolam. Seeks to justify Barton's prescribing in part, but in my view demonstrates Barton's single-mindedness. Like Hamblin – although seeking to justify Barton's actions, partly exposes them. Can we call such witness. PLUS – is Reid just providing expert opinion, like Black?**

Tanya Cranfield	ED, tab 9ss	Consultant haematologist – re blood tests to deal with myeloma. Referred in April 99 by Logan. Examined in May 99. No evidence of multiple myeloma. Goes through records re this diagnosis. Explains all. *Kidney function was slowly worsening by physical condition stable*. Was to be treated only for her symptoms, not cause. **Explains general slow worsening of kidney function and absence of myeloma, but is it really necessary? Only explains notes.**
Anita Tubbritt	ED, tab 9tt	Nurse. Witnessed admin of diamorphine. Says nothing about it.
Kathryn Buttriss	ED, tab 9uu	Care Manager, Haslar Hospital Social Services. Patients would be referred, we would assess needs. ED referred on 8/11/99 by Nurse Barker, Dryad Ward. Goes through checklist. Statement from Nurse Barker. Barthel Score 10. 11/11/99: Called Dryad Ward, likely spoke to member of nursing staff – ED in end stafe renal failure, aggression and confusion improved, can't go home due to UTI. 12/11/99: Visited – aggression resolved [gets worse later], still confused, inappropriate behaviour. Discussion re where to care for her. **Possible assistance with general state of health pre-19/11/99, but all in notes.**
Geoffrey Hillam	ED, tab 9ww	GP – details notes to 1996. No assistance.
Christopher Yates	ED, tab 8j + 9vv	IV Barton on 4/11/04. Tapes. Transcripts.
Geoffrey Quade	ED, tab 8m	IV Barton on 4/11/04. Tapes – CSY/JAB/1-3. Prepared statement – JB/PS/1.
		GEOFFREY PACKMAN
Victoria Packman	GP, tab 6a	Daughter. Obese. Virtually housebound. Admitted to QAH on 6/8/99. Made good progress, antibiotics, looked best he had for years, chatty, keen to go home. *Never complained of being in pain, nor showed any signs of being in pain.* Transferred to GWMH for rehabilitation and remobilisation, due to his lack of mobility. *Within 3-4 days of being in GWMH, suddenly appeared to be spaced out. Eyes glazed, very sleepy, couldn't pick anything up. Change was dramatic, and progressively worse. Became a vegetable and just slept. I visited regularly if not daily. By 1/9/99, not stirring. Died on 3/9/99.* **Good picture of rapid deterioration and lack of prior pain.**
Betty Packman	GP, tab 6b	Wife. Obesity. Legs swollen, constantly weeping fluid. Throughout, never complained about his health, never had to take medication for pain relief. Visited at QAH. Rash on groin. Treated with penicillin for legs. Visited every day. Made god recovery – legs dried up. Better than in recent years. Transfer to GWMH for rehabilitation. Initially fine on Dryad

		Ward – eating and drinking well and without assistance, *never complained of being in pain, nor did he appear to be in any pain. Couple of days after admission, chatting to GP in normal way, visited by lady doctor – believe called Barton – who said: "I'd like a word with you." Followed. She says: "Your husband is going to die and you have to look after yourself now." Didn't explain why or when, just said she liked my coat, that was end of conversation.* Stunned, confused. At some point around this time, got call from hospital saying GP had had heart attack. Went in – GP said he hadn't, just indigestion, which he had a lot. He seemed fine. *Within 2-3 days he became progressively worse, looked spaced out, eyes glazed, long periods asleep, couldn't feed self or hold a cup.* Nurse said he was on morphine, something behind the head of bed had the diamorphine in. Last saw him on 1/9/99 – asleep, out of it. **Potentially useful re decline. Heart attack pre-decline will be crucial though.**
Elliott Beresford	GP, tab 6c	Friend. Visited in GWMH early on – doing well, sat up, chatting, didn't seem ill. Another day, Betty got phone call saying suspected heart attack. Visited after this – chatting away, didn't look as well as he was, but didn't look ill. Female doctor came in – "Mrs Packman?" in abrupt tone, "I want to see you in my office." Think visited after this and he was chatting as always [wife's statement suggests they didn't visit after this]. **Possible help on health pre and post-suspected heart attack.**
Dorothy Beresford	GP, tab 6d	Friend. First visit to GWMH – usual jovial, lively self, chatting, normal. The same the following night. Next day – Betty got phone call saying possible heart attack. Visited – in bed, normal, chatting, *didn't complain of pain*, no machines around him. Lady doctor came in – "Mrs Packman? I want to see you" – very abrupt. **Further evidence health pre and post-suspected heart attack.**
Mark Packman	GP, tab 6e	Son. Visited in QAH – thought there because of sores, normal chatty self. Visited in GWMH twice. First time – soon after admission, well, good spirits, drinking for himself. Second time – weekend after he took turn for the worse, barely conscious, kept dozing off, moaned as moved, no sort of conversation, didn't look well, tube going into arm. **As above – but suggests in pain/uncomfortable after suspected heart attack.**
Ruth Topping	GP, tab 6f	Mark Packman's wife. Visit to QAH – very well, good spirits. Visited in GWMH after turn for worse – very groggy, muttered about being uncomfortable, moaned if shifted position, later "unconscious and uncomfortable." **As above – but suggests in pain/uncomfortable after suspected heart attack.**
Margaret Sherwin	GP, tab 6h	Curate. Visited in GWMH – first time – sat up, chatting, didn't think dying. Visited few days later – told by nurses he had taken turn for the worse and didn't have much longer to live – I gave last rites and sat with him until he died. **Minimal assistance.**

Richard Chinn	GP, tab 6i	GP. Last saw in July 99 – suffered from hypertension, obesity, immobility, cellulitis of the legs and atrial fibrillation – prognosis not good. Referred to urologist re possible prostate problem. Referred to dermatologist re granulomatus area on calf. **Helpful general picture of health in 99, but all apparent from notes.**
Stephen Chiverton	GP, tab 6j	Urologist. Referred by GP, June 99. Don't think ever saw him.
Stephen Keohane	GP, tab 6k	Dermatologist. Referred by GP. Seen by SHO, 30/6/99.
Wendy Beadles	GP, tab 6l	SHO at QAH. Goes through notes re admission and proposed treatment at QAH – admitted 6/8/99. Simply explains notes. Admitted for decreased mobility, from obesity/leg oedema. Pulse 80 and irregular, heart sounds normal. Had atrial fibrillation – had an irregular heartbeat but the rate was controlled. Treated for fluid in legs and tissue infection. **Helpful re reason for admission, but all in notes. NB. Heart condition.**
Claire Davies	GP, tab 6m	SHO at QAH. Minor notes of treatment there.
Claire Dowse	GP, tab 6n	SHO at QAH. Made entry on 6/8/99 – not for CPR, in view of pre-morbid state and multiple medical problems. Not saying expected him to die, in fact was receiving full active treatment – but in view of chances if in arrest. **Adds nothing to notes. May assist if defence seek to make point on "not for CPR."**
Arumugam Ravindrane	GP, tab 6o + p	Registrar, QAH, saw GP in GWMH. Explains notes and summarises condition – provides opinion. 23/8/99: Saw GP on day of admission to GWMH, maybe with Barton. Had been stabilised and transferred to GWMH – obesity, immobility, pressure sores, *no pain, cardiovascular system normal*. Possible blood in stool on 13/8 but HB stable. Able to feed self on 23/8 and 30/8 but not on 1/9. Continent of faeces on 23/8 and 30/8, but not on 1/9. *On 23/8/99, was very dependent, unwell and immobile, very little prospect of active rehabilitation*. Fact of transfer from QAH does not indicate an improvement, only stabilisation. Large amount of black faeces passed on 31/8 and 1/9 – indication of gastrointestinal bleed. HB level dropped dramatically on 25-26/8 – indicating a massive internal bleed. [Seen by Barton – thought may have had heart attack of massive internal bleed, too unwell for transfer to acute unit, keep comfortable]. Think by 26/8 was too late to prevent the internal bleeding. Hamblin's note "do not resuscitate" on 26/8 – she did not speak to me about this, only about bleeding from rectum and stopping clexane (anti-coagulant). Re transfer from GWMH to another hospital – no guidelines in place, just act sensibly depending on the situation. **Adds little to notes – does not express view on Barton's actions. Does seek to provide bleak prognosis, which may assist Barton. No real assistance.**

Gillian Hamblin	GP, tab 6q	Sister, Dryad Ward. General statements re Barton's responsibilities, ward rounds, consultants available for rounds and advice etc. *If I felt a patient was being adversely affected by a drug, I would speak to Barton or consultant – may result in a change. If doctor decided to change the type or amount of drug, would come in at once or as soon as possible to write up the prescription. Exceptionally, authorisation would be granted over the phone, doctor then had 24hrs to write the prescription – if this was done, nurses would enter decision on prescription chart and sign. Barton would write up the drugs required. One type of prescription was "as required" – would have a set of parameters of the amount.* [Doesn't explain further – but entries below suggest doctor's authority required for <u>any</u> change in dose even within the parameters]. GP: Goes through notes. Explains actions taken. 25/8/99: Passing fresh blood. Withhold clexane. 26/8/99: Fairly good morning. Unwell at lunchtime, colour pale, feeling unwell, seen by Barton, await HB result. Further deterioration, complains of possible indigestion, pain in throat. Verbal order from Barton for diamorphine 10mg injection. *Mrs Packman informed – will visit this evening.* I may well have thought he had had a heart attack, but wouldn't write this in notes as not a doctor. Barton wrote possible myocardial infarction, too unwell for transfer – *this was normal practice in cases where patient may well die in an ambulance.* [But what if going to die without it?] If patient can't take medication orally, nursing staff contact doctor for authorisation for syringe driver. [Suggests this is what happened in this case, but no note of it – simply note of commencement]. 30/8/99: Condition remains poor, syringe driver commenced, diamorphine 40mg, midazolam 20mg, no further complaints of abdominal pain. *The diamorphine and midazolam were written up by Barton on 26/8/99* [no explanation of why]. *As I made the syringe driver it was me who put him on 40mg, I would have called Barton to agree this – was standard practice, although no record of the call in notes.* [Suggesting would not have simply chosen starting dose herself without authorisation]. *Dose was later increased to 60mg – the authority to do this would always be a doctor – would not necessarily call the doctor first, as parameters were set, but a call would be made at some point.* [So nurse could adjust the dose without authorisation, and let doctor know later?] Later says – *for the increase in dosage, the doctor's authorisation is always required.* [Does this mean for any increase within the parameters?] Oramorph prescribed also on 26/8/99 – administered until 30/8/99.

		Injection of diamorphine prescribed on 26/8/99, maybe because analgesia not controlling pain. Prescribed again on 28/8/99, maybe as an emergency measure if required. [Guessing]. **Again is illuminating, although seeking to exculpate Barton. Defends not calling ambulance for GP. Defends prescribing methods, and not clear about how would work in practice. Less helpful to us than in other examples – notes may speak for themselves.**
Siobhan Collins	GP, tab 6r	Nurse. Neutral generic parts. Sets out Barthel score on 23/8, 30/8 and 1/9 – getting worse. Goes through notes. Administered temazepam on 24/8/99 – written up by Barton in variable dose of 10-20mg, gave because patient needed assistance to settle for the night. **Adds nothing to notes – not very significant entries.**
Shirley Hallmann	GP, tab 6s	Nurse. As before, sets out generic concerns – Hamblin didn't want her there, concerns about syringe drivers around 1991. Barton: "You don't understand what we do here" [unclear what meant]. GP: Verified death. 26/8/99: Notes – Barton here, for oramorph 4 hourly, wife seen by Barton, explained condition and medication. **Adds nothing to notes, save to add that sores were worst she had seen. She administered diamorphine (see Florio below), but does not deal with why/how/dose.**
Jeanette Florio	GP, tab 6t	Nurse. 2/9/99: Nurse – notes show she witnesses Hallmann administer diamorphine 90mg and 80mg midazolam. *Barton had written up variable dose of diamorphine 40-200mg, midazolam 20-80mg. The decision to increase the medication would have been taken by a doctor, either by way of a verbal message or a phone call. Can't imagine would have been done without authority of a doctor, however I can't see where this decision is recorded in the notes.* **Doesn't add to what notes say happened, but gives her evidence of how the system of increasing dose within the prescribed range worked – NB. Contrast with the evidence suggesting nurses had discretion within the range prescribed.**
Beverley Turnbull	GP, tab 6u	Nurse. Usual generic comments in other statements: Use of syringe drivers resulted in deaths, not used on patients with pain. *All Barton's patients were dealt with in this way – she set the parameters, was then at nurses' discretion as to when increases were given, depending on the patient's increased level of pain.* 1991 concerns. Meetings. Changed as time went on and types of patient admitted changed. GP: Goes through notes. 27/8/99 – oramorph given as prescribed, not c/o chest pain. 28/8/99 – oramorph given as prescribed. 31/8/99 – passing tarry black faeces, *may indicate internal bleed* – I would have reported it to Hamblin on handover to day staff, can't see note of it being reported to a doctor. 1/9/99: Incontinent of tarry black faeces on settling. **Adds little to notes – does say would have passed on word of black faeces (re internal bleed), but no**

		sign of consideration by doctor – but apparent from notes/Black anyway.
Anita Tubbritt	GP, tab 6v	Nurse. Simply repeats entries from notes where she witnessed/administered oramorph. *These drugs would be administered because written up by a doctor. If that dose was to be increased or decreased, decision and reasons should be documented in nursing notes.* **Doesn't deal with how decisions on dose made. No assistance.**
Irene Dorrington	GP, tab 6w	Nurse. Goes through notes. 29/8/99: Slept, given oramorph, c/o left abdominal pain. 31/8/99: Passed large amount of black faeces. Administered oramorph – written up by Barton on 26/8/99 in 10-20mg range. *Black faeces may have indicated bleed in stomach. Matter would not have been reported to a doctor immediately, as there was not one on duty overnight. Would have been passed on to the day Sister on handover and she would have informed the doctor. No entry in the notes shows what happened about this.* 30/8/99: Large amount of black soft faeces. Same for 31/8/99. **Only addition to notes is to suggest black faeces info would have been passed to Hamblin and then Barton – so she would have known about it. Do we need this?**
Code A	GP, tab 6x	Nursing auxiliary. Adds nothing.
Jennie Press	GP, tab 6y	A&E medical records – JHVP/AE/1.
Kathy Eborn	GP, tab 6z	GP records – KDE/1.
Christopher Yates	GP, tab 6aa + bb	IV Barton on 17/11/05. Tape – CSY/JAB/12. Prepared statement – JB/PS/11. Transcript – CSY/JAB/12A.
		LESLIE PITTOCK
Fiona Walker	LP, tab 6a + b	Night Sister. Concerns over diamorphine were resolved internally. Satisfied with doctors' treatment of patients. No on-site doctor 24 hrs a day. Goes through notes. Witnessed oramorph being administered. Adds nothing to notes.
Gillian Hamblin	LP, tab 6c + d + e	Generic statement (2/2/03): Consultant visit every fortnight. Barton visit every morning Mon-Fri to see every patient. Would return to see family etc. Would prescribe on her visits. Concerns raised in 1991. Meetings. If ever doubted the prescription, would raise it with Barton. Never had doubts about syringe drivers. Main use is to administer drugs to a patient once oral medication stopped, generally due to inability to swallow. Leslie Pittock statement: In Jan 96, was Clinical Manager, Dryad Ward. Worked 37½hrs per week, early or

		late shifts. Barton responsible for medical care on day to day basis. Goes through notes. 10/1/96: Condition remains poor – *this was a way of writing that the patient was very likely going to die.* Seen by Barton and Tandy – Barton would have returned in the afternoon to do ward round with Tandy, the consultant [would have?] To commence oramorph every 4 hours – was given instead of diamorphine whilst the patient could swallow, *to remove pain*. To stay on long stay bed – *this means LP would stay with us until he died.* 17/1/96: Further deterioration in already poor condition – *he was fading fast.* Appears more settled. Although still aware of when he is being attended to. Chaplain would tell wife of deterioration. *I started syringe driver with diamorphine 80mg. At some stage it was increased to 120mg.* [No explanation of how doses arrived at]. Prior to 2000, was no policy/protocol re use of syringe drivers within the hospital. **Not very illuminating. Explanation of notes of minor significance. No explanation of how prescribing/doses arrived at.**
Lynne Barrett	LP, tab 6f + g + h	Generic statement: Nurse. All drugs given as per prescription [no comment on prescription of dose ranges]. No concerns re use of syringe drivers. Hamblin and Barton very approachable. People now dying in pain because doctors too nervous about using syringe drivers. Barton used as scapegoat. Leslie Pittock statement: *Drugs and dosages given to patients are sometimes based on the 24hr observations of nursing staff. These observations are passed on to the doctor when doing ward round. If necessary, doctor may well be phoned.* [What does this mean? No increase in dosage without doctor's authority, even within range prescribed? Not clear]. Goes through notes. 9/1/96: Complains of generalised pain. 16/1/96: Condition remains very poor, some agitation. Syringe driver recharged. *The increase in the syringe driver on 16/1/96 was authorised by Barton.* 18/1/96: Syringe driver recharged with diamorphine 120mg. Oral suction – where chest secretions removed from back of throat. *Under no circumstances would I alter, add or change prescribed drugs to a patient without the authorisation of a doctor. No record in nursing notes showing visit to ward from a doctor that would have led to the increase – the note must have been omitted.* **[So – clearly saying nurses did not adjust doses without getting authorisation from doctor – conflict with some other witnesses].** Further entries re syringe driver use – diamorphine at 120mg. No entry for Barton visiting on 19/1/96 – does not mean she didn't visit. Would only be an entry if an alteration made (wasn't).

		Could be non-verbal indicators of pain – eg facial expression, body language, position, insomnia, distress. Further statement: *Barton was prescribing doctor. When LP was showing signs of pain and distress despite dosage, staff would discuss it with Barton on phone or when she visited. Barton would give her authority to increase the dosage within the specified range, which had originally been set on the prescription chart. Each dosage given to LP was authorised by Barton.* **No assistance to our case. Adds little to notes re facts of case. Insists that any increase in dosage, even within range prescribed, had to be authorised by Barton, and must have been despite lack of entry in notes.**
Freda Shaw	LP, tab 6i + j	Generic statement: No concerns about syringe drivers. Unfair criticism. Leslie Pittock statement: Adds nothing to notes. No drugs administered.
Rena Young	LP, tab 6k + l	Generic statement: Auxiliary nurse. No concerns. Leslie Pittock statement: Confirmation of death. Adds nothing.
Tina Douglas	LP, tab 6m	Nurse, Dryad Ward. Deals with verbal order for nozinan by Dr Brigg. Points out errors in notes in various places. Goes through notes. 17/1/96: Seen by Barton, medication increased as patient remains tense and agitated – dose of diamorphine was increased from 80 to 120mg, *and was increased as a result of my observations of the patient's medical condition. I would have informed Barton whilst she was conducting her rounds.* **Points out errors in notes. Otherwise adds little to notes, save to make clear that Barton authorised changes in dose, as result of exam and being informed of condition. No assistance to our case.**
Mary Martin	LP, tab 6n	Nurse, Dryad Ward. Administered oramorph, 10/1/96 – administered after consultant's ward round (Tandy) accompanied by Barton, prescribed by Barton. Further notes on poor condition/suction required. Verifies death. **Adds nothing to notes, save that Tandy accompanied by Barton on round on 10/1/96.**
David Morgan	LP, tab 6o	Nurse, Mulberry Ward. Wrote transfer letter for admission to Dryad Ward, 5/1/96. Letter speaks for itself: Admitted for low mood/physical aggression, Parkinson's, medication [no analgesic], poor physical condition – broken pressure areas, poor fluid intake and diet etc. **Notes/admission letter speaks for itself. Statement adds nothing – unless want to call to emphasise.**
Althea Lord	LP, tab 6p	Only contact – assessment prior to transfer to Dryad Ward, 4/1/96. Relies on assessment letter – chronic depression, recovered from recent chest infection, Barthel of 0, hypoproteinaemic, eating little, prognosis poor. Adds to this: Completely dependent on nursing care, prognosis poor due to functional dependency, nutritional state, pressure sores, depression. Physical needs outweighed psychiatric

		problem, so transfer to Dryad Ward suitable. Said that rest care home bed could be given up – would only do this when satisfied that condition and prognosis so poor that would not be able to return to it. Chances of survival slim, unlikely to survive for very long. *Copy of letter to Hamblin.* **Just adds emphasis to letter – not to our advantage. NB. Letter to Hamblin – may have given her the message that LP was a goner.**
Sharon Ring	LP, tab 6q	Nurse. Entry re syringe driver being recharged with diamorphine 120mg on 21/1/96. Condition didn't change during shift. Simply recharged driver as per prescription chart written by Barton – shows that this dosage and mixture could be administered. *If we nurses felt the amount of drugs was no longer required, would not administer them – would firstly phone doctor on duty for advice.* **Adds nothing to notes. Doesn't really go into methods of prescription in any detail.**
Bridget Ayling	LP, tab 6r	Nurse. Witnessed diamorphine only. No useful info.
Martin Asbridge	LP, tab 6s	GP. History: Chronic depressive illness. In Hazledene Rest Home from 1992. January 1995 – was felt that his mental state was deteriorating. Assessed on 18/8/95, due to concern about *slow deterioration in his general condition*. Physical examination showed no abnormalities. *Apparent that in the 5 months before he died that his physical condition had begun to deteriorate*. **No explanation of nature of deterioration in months before death. Fact of it does not help us.**
Lynda Wiles	LP, tab 6t	Daughter. Registered mental nurse. LP – severe depression for great deal of life. Went to rest home around 1993 as very depressed/no motivation. Progressively worse in rest home physically and mentally, stopped eating and drinking properly. Moved to Dryad – I understood for terminal care. He was extremely frail, I think died of self-neglect. Nurse told me his skin was breaking down and he cried out when turned. I considered morphine was appropriate. **No assistance. Describes deterioration before into Dryad, and appropriate use of morphine.**
Jane Tandy	LP, tab 6u	Consultant for Dryad Ward, Jan 96. No resident doctor. Day to day cover by Barton. I did ward round once a fortnight, normally with senior nurse and Barton. Would see all patients, review drug regimes, tests, check medical notes. Would very infrequently be called for advice. *10/1/96: Did ward round with Barton/Hamblin. Oramorph was commenced that day as result of patient stating he was in pain. Given to alleviate pain and also the distress.* Bartel 0. I wrote "for TLC" – to be kept comfortable, not in pain or distress, and meaning prognosis extremely poor. Nursing notes from 9/1/96 showed that he was in generalised pain. Barton maintained oramorph prescription to 15/1/96 – syringe driver commenced. Diamorphine is used

		as a pain killer and to alleviate distress. 16/1/96: Driver with diamorphine, haloperidol, midazolam, hyoscine – only given as patient was distressed. 17/1/96: Notes show that patient remained tense and agitated and distressed on turning. Seen by Barton and note recording change in medication made. Seems dosage of diamorphine increased to 120mg. He was very poorly, it is likely that he was dying. Nozinan commenced for agitation and anxiety. *I would have used a lower initial dosage of diamorphine and midazolam – but I didn't see the patient when the dosage was commenced. Would have been lower because my practice is to use lowest dosage likely to achieve desired outcome, diminishing possible adverse effects.* **Only contact with LP was review on 10/1/96. Defends use of oramorph from that date. No other comment on method of prescribing. Criticises initial doses of diamorphine and midazolam as too high. Consider use – although can we use as pseudo-expert on dose? Other than that, is defender of Barton and may bear responsibility re oramorph.**
Victoria Banks	LP, tab 6v	Consultant in old age psychiatry – Mulberry A Ward. LP: Chronically depressed, very frail re ability to cope with life. Admitted on 13/12/95. Reviews notes during admission – mostly not her notes. Picture: Depression, wanting to die, not eating and drinking properly, deteriorating. Led to Dr Lord's review on 4/1/96. *It had been agreed by the team that his physical state was very poor. This was the process should a patient be expected to die.* **Provides a review of condition pre-transfer to Dryad Ward. Picture is of deterioration and frailty, poor prognosis (still, no analgesia). No great help. Notes do speak for themselves.**
Michael Brigg	LP, tab 6w	GP. Authorised nozinan on 20/1/96 by verbal order. If nurse was concerned re condition, could ring duty doctor. If immediate change in medication necessary, might require verbal order to avoid delay, would later be signed. Was rung by Staff Nurse Douglas in this case. (No review apparent of other medication). **No need – only re issue of nozinan prescription by him.**
Christopher Yates	LP, tab 6x	DC. IV Barton on 3/3/05. IV tape – CSY/JAB/4. Prepared statement – JB/PS/3.
	GLADYS RICHARDS	
Ian Piper	GR, tab 4a +	Interviewed under caution.

	b	Chief Executive, Fareham and Gosport Primary Care Trust. 2002: Saw the papers provided by nurses re concerns in 1991 – handed by Jane Parvin. Had had no idea about it. Changes from 2000 – eg full-time staff grade doctor replaces Barton. Independent review re Mrs Reeves' complaint – care was appropriate, but communication poor. **No assistance.**
Gillian MacKenzie	GR, tab 4c + d + e + f + g	Daughter of GR. Witness statement: Makes complaints about the police re (a) failure properly to investigate allegation of unlawful killing of GR and (b) failure properly to investigate her allegation that her sister Leslie Lack had destroyed part of GR's will. Unlawful killing was reported by her to Gosport Police Station on 27/9/98 following sister's inspection of death certificate, believing there was no indicatation of pneumonia, and sister's conversation with registrar re death. **No other useful info. Was very keen to pursue case re mother and case against sister in criminal courts. Caution.** IV, 17/11/99 – summarised in statement dated 6/3/00 (but I/V fuller): Complains of treatment in nursing home, suggesting medication contributed to so-called dementia. Got call on 30/7/98 that GR in Haslar following a fall, having operation for hip. Good treatment at Haslar, good progress. Was decided she would go to GWMH for rehabilitation. By this time – more alert than in nursing home (had taken her off trazadone), on occasions could speak coherently, eating well, looking better than for months. Then – got call saying had fallen at GWMH. Transferred to Haslar. Treated there. Good recovery, quite alert again (after tranquillised again in GWMH). *Went to GWMH the day GR was transferred back (Monday) – moaning in pain, due to poor lying position with weight on new hip. Nurse Manager Philip Reed agreed GR was in pain and needed pain relief.* Barton agreed on x-ray. Taken for x-ray – still moaning despite injection for pain [poss was dementia, not pain?] Beed confirmed no further disclocation, but some bruising, and would give diamorphine for pain. *I said no, not giving her diamorphine...I will not tolerate euthanasia*. [Already in her mind]. Sister (Leslie) wanted her moved back to Haslar. Barton: No, keep pain-free overnight and review in morning. *Next day (Tuesday): Beed tells us – nothing could be done for her, massive haematoma, only treatment was diamorphine on syringe driver for pain-free death. Syringe driver set up. Barton came by – "presumably things have been explained to you about the syringe driver...next thing for you to expect is a chest infection." That was only conversation we had with Barton. No mention of surgery or any intervention. Decision had simply been taken that she was dying and only thing left was pain-free death.* Stayed there from then until GR died (Tues-Fri). *In that time, Barton did not visit at all.* GR was not left

		alone by me or sister for the whole time, except for washing by staff. No sign of pneumonia. She had diet of diamorphine *and there was no hydration whatsoever*. [So decision had been made that would now die]. Don't know why action wasn't taken for the haematoma. *I was present when my sister told Barton she had spoken to Haslar and they could take GR.* My sister made notes (LFL/2 and GM/1 – my copy) whilst in GWMH, because not happy with care – identifies them in I/V as accurate. *Barton did not discuss the situation fully with us. She did not make sure we were aware that surgical intervention for haematoma would require general anaesthetic.* If so close to death on the Tuesday, why continued to live on to Friday? Esp with no hydration. Should have gone to Haslar again for treatment of causes of condition. Barton should have sought consultant's opinion. Barton should have acted after knowing GR fell to rectify cause of pain. Cause of death not pneumonia – no sign of it. Was it diamorphine poisoning and dehydration? Use of oramorph at GWMH – whilst at Haslar, GR was pain-free, but was almost immediately administered at GWMH, perhaps due to misreading dementia for pain. [But witness says later moaning was pain – tricky]. GR was deaf in both ears. Could see from one eye with glasses, but glasses lost by nursing home. She knew she was in pain – but couldn't hear anything, so couldn't respond to questions about it. Wasn't a case of being unable to understand the position due to dementia, just couldn't communicate. [How known?] Goes through exhibits re complaints to health authority and other corres – **obtain exhibits**. **Agrees on fact of pain on re-admission to GWMH. But highly critical of Barton's failure to take steps to treat cause of pain/distress. Good on deterioration in GWMH. Potentially useful, if litigious.**
Philip Beed	GR, tab 4h + i + j + k + l	IV under caution on 24/7/00. **No statement.** Clinical manager, Daedalus Ward. Dr Lord is consultant. Clinical Assistant provides day to day medical cover. In 1998 – Barton, comes in Mon-Frion daily basis to review all patients and on call. Pharmacist Jean Dalton would visit once a week, goes through the drug records, if sees doses about or below what would normally see, points them out. [Significance for Barton?] If patient comes from Haslar, comes with medical notes, drug record, transfer letter. A decision to move to palliative care – when recognise the person is dying – is made by the medical and nursing team and in consultation with the family. The nursing staff are the ones who work most closely

		with the patients so really have the full picture, and would discuss it with the medical staff in making decisions about care. *We nurses could initiate syringe driver/palliative care without reference to a doctor, but would have discussed care and prognosis with doctor and syringe driver would have been written up with the instruction that could be started if deteriorated.* [**cf other nurses saying only on doctor's say so**]. If needed consultant's advice, would seek it, but didn't happen often. *Barton's morning visits would last usually 20-30 minutes.* Would go through all patients with the nurse in charge of ward, discuss any changes in condition and medication. If there are any patients who need to be seen personally, Barton would go and examine [so didn't examine all each day]. So the doctor relies on the nurse's judgment – only knows from nurses whether patient improving or deteriorating, or if needs to see.** GR: Reviews all notes – gives account of what happened. GR very confused, very agitated, came for assessment and gentle rehabilitation. Prospect of regaining mobility poor. *In my judgment, was in considerable pain – so Nurse Crawford and I gave analgesia, oramorph, to try to make comfortable.* Not able to communicate effectively. Fall from chair. Transfer to Haslar. Re-admitted. *GR uncomfortable and in pain from the time she arrived back. Screaming in obvious pain and distress.* Barton agreed to fresh x-ray. We gave oramorph to make comfortable. Dr Peters said – no dislocation, but make sure proper pain control and review by Barton in morning. [MacKenzie says this was Barton]. GR in lots of pain, looked unwell, refusing to eat or drink – oramorph continued. Pain control kept her comfortable, but no improvement overnight. Reviewed by Barton on Tuesday 18th – *the view was that transfer to Haslar not appropriate "because there was dislocation that was going to be fixed" [?], likely cause of pain was haematoma, pain control not effective, condition very poor, appropriate to start syringe driver. I presented picture to family – just how poorly she was, looking at palliative care. They agreed.* Sometimes difficult to distinguish between pain and dementia – may tell by shouting when moved. From GR's actions and movements, difficulty in transferring her, it indicated to me that she had pain as well as dementia. Also, daughter said sometimes agitated if needs toilet, tried that and no result, so indicated was pain rather than that. I gave oramorph because considered she was in *severe pain*. (Does Haslar sent patients in severe pain?) The transfer can cause it. She was in a lot of pain on the second transfer – was on a sheet rather than a canvas. *GR wasn't in pain when Barton saw her and prescribed oramorph, but it was written up in case she should become in pain. GR later did, so I gave the oramorph. Was appropriate course.* [**Shows Barton's methods**].

		Confirms no oramorph or other pain killers given on first admission up to point when realised had dislocated hip. Was admitted for gentle rehabilitation. Barton prescribed oramorph and the drugs that could be given by syringe driver, including diamorphine, on the 11th – date of admission. *Syringe driver often gets written up if patient looks very poorly, and can be used if in the judgment of the nursing staff the patient's condition deteriorates and it is required to keep them comfortable. Left to our judgment. Could use it without need to call out the doctor.*** [**Again, shows prescribing method and nurses' responsibility**]. Transfer letter accompanying GR on transfer back to GWMH on 17th – can mobilise, fully weight bearing – was a significant improvement in Haslar. But on 17th – in obvious pain and discomfort, although not when Barton saw her, but after Barton left. Was transferred just on a sheet, not canvas, so not the same support. No new prescription by Barton – we still had the old one. *On 17th – GR refused to eat but was swallowing. Daughters very concerned about the pain she was in. Needed to get the pain under control. Could give oramorph, but if that hadn't kept GR comfortable, next logical step was whether syringe driver would allow me to give stronger dose to keep her pain-free.* *On 18th – I was on duty when GR reviewed by Barton. No record of how she was overnight, but obviously night staff would have told me they had given the oramorph and she hadn't been completely comfortable. Was an oversight that this was not on the records. "She's really overall she's worse" – fluid and diet intake is poor, not really controlling the pain, quite agitated. Reviewed her with Barton – overall condition deteriorating, only way to control pain was with syringe driver, Barton thought GR was dying, would not achieve rehabilitation and would die shortly.* [Beed does not provide adequate justification for this conclusion, especially in light of lack of notes]. **Similar witness to Hamblin – can we use?**
		GENERIC CASE FILES
Irene Dorrington	GCF2, tab 4	Staff Nurse, Dryad Ward. Describes set up and practices: Drugs always prescribed by doctor, controlled drugs entered into controlled drugs book, consultant was Dr Lord, drugs administered in accordance with sliding scale, starting with mild analgesics and trying stronger drugs until patient comfortable. Trained in use of syringe

		driver – sings its praises for providing pain relief. *Doctor would sign drug card stating drug, dose, method of administration. Then was decision of the staff nurse when to actually start the patient on the syringe driver of this was a method recommended by the doctor. Before a syringe driver was used, all other methods of pain control had been tried but unsuccessful. Syringe driver remained the last resort.* Dr Barton would attend ward every morning during the week. She attended early so we would see more of her. **Cannot use her. Says all was fine, positive about Barton, paints perfect picture of pain relief. Only possible benefit is fact of responsibility being delegated to nurses. Not worth it.**
Sylvia Giffin	GCF2, tab 5	Staff Nurse, Daedalus Ward. One of nurses who complained about use of syringe drivers and produces documentation re complaints around 1991 – produces papers re this (exhibit SG/GWMH/1). Blames Sister – Gill Hamblin – for encouraging use of syringe driver. After she came, patients were going on them when not in pain and not needed. Also, when they were first introduced, did not have sufficient training. (But received by time of our period). *Decision to place patients on syringe drivers was entirely down to the doctor responsible for the ward. This was Dr Barton, she was the unit doctor for several years. I got on well with her and felt she was competent. However, what usually happened was Barton would sign up that the patient was suitable for syringe driver, then Hamblin or one of duty staff would decide if and when it was necessary to place the patient on it.* Despite my protests, use continued to increase. In 2002, when aware of enquiry into hospital, sent copies of the paperwork saved from 1991 to Anita Tubbritt – letters, reports, minutes of meetings. **Bitter, but provides account of how the incorrect prescribing worked. Risk of being favourable to Barton? Caution: Other nurses (eg Iris Goldsmith, tab 7, or Dorrington, above) take opposite view, saying use of controlled drugs was always totally appropriate.** **SG/GWMH/1: GCF3, tab 13 – similar material to JEP/GWMH/1 below (file handed to Scammell).** **NB. BW/1-4 (GCF3, tab 16-19): Notes of meetings in 2002 when matters blow up again – bear in mind for XX of nurses concerned – explaining how raised concerns and why they were not taken further (eg being made to feel ostracised).** **BW/3: After 1991, staff felt they had taken it as far as they could. When the department moved to**

		GWMH some concerns were still expressed, but *they did not set up syringe drivers if they thought it inappropriate*. No guidelines/policies ever followed the meetings. Staff did not raise concerns during the CHI investigation – not asked by CHI, didn't want to make things worse for hospital, feared loss of jobs, did not feel supported etc. **<u>This emphasises need to seek further detail from any nurses we seek to use as to the practices in 1996-9, not just before then</u>.**
Beverley Turnbull	GCF2, tab 8 GCF6, tab 38	Staff nurse on Dryad Ward. Barton joined unit (pre-1991), use of syringe drivers increased. Became extremely concerned, as used on patients who had not presented any symptom of pain. All patients who received this pain relief were under care of Barton and it was done on her instruction, but it was at the nurses' discretion to administer the drugs. Attended meetings in 1991 about it. A policy was going to be drawn up, but never saw it. *I had no concerns about the use of syringe drivers after the unit moved to Dryad Ward. Believe they were correctly used for the people who needed them.* Produces corres re 1991 debacle – JEP/GWMH/1/BAT. I handed these to Toni Scammell with Anita Tubbritt in 2002. Vague recollection of Elsie Devine, but can't recall any detail of her care or treatment. BJC/16/PG/195&195 – Nursing note entries: 19/11/99 – relatives stayed until 23.00, peaceful night, syringe driver satisfactory – signed by me. She would have been very poorly, closely monitored through the night. BJC/16/PG/222&223 – Summary of Significant Events Card: 19/11/99 – peaceful night, syringe driver satisfactory, recharged 07.35, diamorphine 40mg, midazolam 40mg – signed by me. Shows syringe driver refilled by me at 07.35 on 20/11/99. Controlled Drugs Record Book shows diamorphine administered or witnessed by Turnbull, Hamblin, Tubbritt. Administration of a controlled drug takes two trained members of nursing staff, to ensure checks carried out correctly. Prescription chart must be legible, dated, signed by doctor. Had I had any concerns about given the drug to the patient, would have discussed with doctor or senior nurse. I have seen nothing indicating that I had concern re drugs given to Elsie Devine. If she had complained to me of pain, or if I had noted symptoms of pain, would have noted this on Significant Events Form and Night Care Plan.

		Cannot use – says appropriate use during our period, even though very critical before this. This is strange – should we check her view now? **NB. A problem might be that she and other nurses *continued* in the practices after 1991, so would not want to incriminate themselves – eg in her administration of diamorphine to Elsie Devine.** **JEP/GWMH/1/BAT: GCF3, tab 14 – same material as in JEP/GWMH/1 – below.**
Anita Tubbritt	GCF2, tab 9 GFC6, tab 10	Staff nurse. Critical of use of syringe drivers pre-move to Dryad Ward – around 1991. Main concern was lack of training given to her. Only after involved Geri Whitney (course tutor) did start thinking diamorphine used too much on the ward. Felt ignored at the time by Barton and Hamblin. After move to Dryad Ward, didn't have same concerns. I had more training. Barton more approachable. By 1997/8, practices and procedures had changed, so didn't mention concerns to CHI enquiry. Produced documentation in 2002. Handed to Toni Scammell with Beverley Turnbull. Things handed to her – JEP/GWMH/1. **Problems with using. Doesn't describe our problems in 1991 and says all OK by 1996-9. However, she was at the heart of complaints in 1991 and TJS/1 (a Scammell note) suggests that Tubbritt felt that things hadn't improved after 1991. Consider going back to her for further detail and consideration of our time period.**
Isobel Evans	GCF2, tab 10	Patient Care Manager, 1991-6. Supportive of Barton, and all pain relief appropriate. Dealt with complaints of staff in 1991. Arranged meetings. **Cannot use.**
Keith Murray	GCF2, tab 11	Royal College of Nursing. Received complaints from the nurses in 1991, dealt with the likes of Isobel Evans to voice them. Corres/notes on it – KPM/1-7. Little action. No policy on use of syringe drivers as result of concerns. **Only received info as third party. Can't see assistance. Historical.** **KPM/1-7 in GCF3, tab 2-8 – corres to and fro about meetings etc, without any actual detail as to the criticism.** **KPM/6: Letter from RCN to Isobel Evans stating that "it appeared during our meeting that the issue of the syringe drivers had upset Dr Barton," then makes clear no criticism intended of her.** **KPM/7: Letter from RCN to Isobel Evans, 14/11/91 – it was agreed after the meeting of 26/4/91 that a**

		written policy would be introduced regarding use of controlled drugs and syringe drivers, but this has not been done.
Geraldine Whitney	GCF2, tab 13	Royal College of Nursing and nurse tutor. Tubbritt complained to her. Visited Redcliffe Annex at GWMH in 1991 as result. Made report – JEP/GWMH/1/KMR/COPY/5. Noted large amount of diamorphine being used and I didn't know why. **Get report, but relates to 1991. Can't see use.**
Antonia Scammell	GCF2, tab 16 + 17 GCF6, tab 14	Senior Nurse at GWMH. Only from 2000. At time of commencing work there, not aware of concerns. I considered place old fashioned, too much respect to doctors, documentation poor. Involved in investigation from 2002. Given material by Tubbritt and others. TJS/1 – note of questions/answers with Tubbritt and Turnbull on 16/9/02. GWMH does not have on-site medical presence, so not equipped to deal with medical emergencies – if arose, would have to transfer for Haslar or Queen Alexandra Hospital. All blood test results would be sent to the ward in paper form. If there was a major irregularity, result would have been telephoned in with the paper result following. **Assistance only as to limited aspect of the care available at GWMH.** **TJS/1 – GCF3, tab 11 – both felt nothing had been sorted after 1991/2. Staff were told that they didn't know all the facts and diamorphone was not only used for pain control. They were also informed that Dr Barton had been on a palliative care course and knew what she was talking about.** **TJS/2 – GCF3, tab 12 – notes of meeting of 18/9/02, details some of the history – efforts of Tubbritt, Turnbull and others to raise, but concerns not met, Hamblin difficult to approach. Nursing staff had felt intimidated in the meetings of 1991 – "us and them." They hadn't wanted to upset Hamblin or Barton. Concerned would be sacked or moved.**
Jane Parvin	GCF2, tab 21	Personnel Director. Received the documents from Toni Scammell from Tubbritt, hands to police, produces them as JEP/GWMH/1. **JEP/GWMH/1: GCF3, tab 10 – shows history of complaints and responses – has points undermining both sides –** **Notes of meeting of 17/12/91:** • **Present: Isobel Evans, Dr Logan, Dr Barton, Hamblin, Donne, Tubbritt et al.** • **Meetings held on 11/7/91 and 20/8/91 – aiming to allay staff fears by explaining reasons for**

prescribing.

- **Staff gave no details of specific cases causing concern.**
- **All agreed main aim with terminal patients was to allow peaceful and dignified death.**
- **No one questioned doses of diamorphine.**
- **All staff expressed respect for Barton, did not question her professional judgment.**
- **But still: Some staff feared it was becoming routine to prescribe diamorphine to patients who were dying, regardless of their symptoms.**
  NB. These notes seem to have been written by Isobel Evans, therefore partial.

Letters mention likely grievance procedure if concerns not met. Letters indicate continuing concerns, but not taken any further – Tubbritt et al deal with this in their statements, but undermines their claims somewhat. RCN wanted a written agreement on use of syringe drivers/diamorphine. Isobel Evans in notes of 17/12/91 meeting states that she does not have the authority or knowledge to write a policy on this – not really an adequate response.

Two study days on pain control were arranged for staff after 26/4/91, which temporarily alleviated concerns, but concerns returned. Keith Murray (RCN) states that staff who raised concerns have been ostracised.

Letters suggest that management took view that if nursing staff could not put forward specific cases, complaint would not be dealt with. Memo from Isobel Evans dated 7/11/91 asks for names of any patients for whom diamorphine was prescribed inappropriately. This does not seem to have produced results. RCN corres suggests nurses not prepared to give specifics, as did not want to be drawn into a 'witch hunt.' Result – stalemate.

Includes report of Geraldine Whitney, 4/11/91: Includes specific allegations re patients by Giffin and Tubbritt, without patient names – supportive of allegations. Staff concerned that diamorphine being used indiscriminately, weaker analgesics not considered prior to this.

Summary of meeting 11/7/91 (again by Isobel Evans) – shows complaints being made in line with our

		case: • **Not all patients being given diamorphine have pain.** • **Sliding scale for analgesia not used.** • **Oral treatment not considered.** • **Syringe driver use prevents adjustment of dose.** • **Sedative drugs could be more appropriate.** • **Not all staff views considered before diamorphine started.** **Isobel Evans points out that it was medical practice that was being questioned, so not in her power to change. This is important – ultimately all of this argument led to no criticism of Barton and other doctors – respect always shown to them**.
Margaret Wigfall	GCF2, tab 26	Nurse. In Redcliffe Annex, started using syringe drivers. Caused me some concern, as felt were used too often. Rather than being used to control pain, were used on patients who were approaching death and suffering anxiety and stress. It would be prescribed by Barton, then the decision when to use it would be made by a senior nurse. I discussed my concerns with Tubbritt. I received training on use of syringe drivers in 1990. Then we moved to Dryad Ward. Also throughout this time myself and some of the nursing staff have shared concerns about the use of the syringe drivers. I have always felt that Barton and nursing staff acted in the best interest of patients. Just because I was concerned about syringe drivers does not necessarily mean their use was wrong. **Could be useful. Need to obtain further information on the detail of our period of time. Need to deal with apparent inconsistency between concern re syringe drivers and backing for Barton.**
Gillian Ryder	GCF2, tab 27	Backs Barton. Says all procedures fine. Worked at GWMH from 1990. Diamorphine would be prescribed by doctor, administered by nurses. Other forms of analgesic would always be tried first[!] Barton very professional. **Cannot use. Evidence at odds with records.**
Elizabeth Mears	GCF2, tab 28	Nurse. When visited Daedalus Ward, noticed that the amount of diamorphine prescribed was set between large parameters and therefore the amount administered was left to the discretion of the attending nurse. This placed a lot of responsibility on the nurse. **Didn't work on Barton's wards, but what she says is helpful picture. Seek further detail?**
Pamela Rigg	GCF2, tab 29	Nurse on Redcliffe then Dryad Ward from 1993. General patient care good. Re syringe drivers, the pathway was always met correctly. Always justified, but by charting a variable dose, this puts

		responsibility onto the nurse. **May be useful. Seek further detail?**
Carol Ball	GCF2, tab 30	Nurse in Redcliffe Annex, 1990-1. General patient care excellent, due to Hamblin – a traditional ward sister. I did have several concerns about syringe drivers and diamorphine. Barton would agree diamorphine over the phone and give a starting dose, driver would then be set up by two nurses. But the follow-up visit did not seem to happen. Also felt there were cases where it was inappropriate to prescribe diamorphine, without using the appropriate analgesic scale. In my opinion Hamblin wanted to put patients onto diamorphine before it was required. Barton was overly trusting of Hamblin. Hamblin was able to call Barton and have patients placed on diamorphine without making proper assessment first. Hamblin would show great care, but she became obsessed with these people. It was as if she had an unhealthy interest in the death process. [Gives example of a "Marjorie" – not one of our cases]. It seemd that people were going onto syringe drivers for no reason at all, they were not ill or in pain. Barton was negligent in that she failed to maintain proper patient contact, being overly trusting of Hamblin. **Fits our case exactly (although with focus on Hamblin), but only for period 1990-1. So can we use?**
Sue Donne	GCF2, tab32	Pro-Barton. I had no concerns about syringe drivers or diamorphine. New others had concerns, but thought things could have been explained better to them. From 1991-5, when I left the hospital, nobody raised the issue of syringe drivers again. *Sylvia Giffin's working practices were outdated and quite poor.* **Cannot use. Very supportive of Barton.**
Mary Martin	GCF2, tab 33	Nurse from 1987/8. I did have concerns over syringe drivers on a couple of occasions. A couple of patients were put on them with diamorpine and I thought there were no indications that they needed it. Cannot remember the names. Sylvia Giffin raised these concerns. Later moved to Dryad Ward. As I remember, the issue of syringe drivers was more raised and I do not remember it being resolved or improving. I worked nights, so had little contact with Barton. Found her pleasant and approachable. Never had occasion to talk to her about treatment of patients. **Seek further detail, particularly about practices in 1996-9. Limited prospects – worked nights and little contact with Barton.**
Shirley Hallmann	GCF2, tab 34 + 35 GCF6, tab 15 + 67	Potentially very useful, although real antagonism with Hamblin. Worked as Grade F Senior Staff Nurse on Dryad Ward from 1998. I would run the ward when Hamblin was not around. Hamblin did not want a deputy. Was initially impressed with level of general patient care – clean, eating properly etc. This was due to way Hamblin ran the ward – an old fashioned sister,

		excellent on general patient care. But she could not be approached or questioned. I soon had concerns about syringe drivers. After diamorphine and midazolam prescribed with one, I never saw anyone come off the driver alive. I thought they were used too early, before other methods of pain control had been tried. *As soon as a patient came into Dryad Ward, Barton would speak with the patient and authorise use of syringe driver as and when it was required. She is the only doctor I have known do this. Meant the authority was in place and decision whether and when to use it was with the nurses – this meant Hamblin. She was not in the practice of consulting other nurses to find out if the patient was in pain. Hamblin and Barton were very close. Barton was very trusting of her and would not challenge her views.* Relationship with Hamblin deteriorated. Barton remained civil and professional. I was told I had upset Barton. I said sorry for whatever it was. *Barton said: "It's not that, but you just don't understand what we do here." I took this to mean the syringe drivers.* A post was available elsewhere at lower grade. I felt pressure to take it from Hamblin and Barton. I made a complaint against both of them for harassment – documented. A practice was in place to put patients on syringe drivers because of Hamblin and Barton. I believe they were doing their best for each and every patient. Barton was responsible for the high doses given to patients. This was ill thought out and could have led to the premature death of a patient. Only lip service was paid to the nurse named as responsible for the patient. In reality, if Hamblin or the doctor was on the ward, they would decide what would be done with the patient. On Dryad Ward, rounds conducted every morning, Monday-Friday. Barton would come in around 7.20am, Hamblin would come in around 7.30am, and they would do the round together. Arthur Cunningham: Entries on notes signed by me. Whilst the doctor determined the drugs and parameters of them to be administered, the nurses would decide where and to what level, according to the pain level increase in the patient. GWMH was not set up to cope with medical emergencies – if arose, patient would be conveyed to Queen Alexandra Hospital by ambulance. Blood test results – if urgent, would be telephoned to the ward from the lab, otherwise would be sent by post. **Potentially very useful. Seek further information from her re our case – explain the system in place clearly, explain in more detail the conversation with Barton when she said "you just don't understand**

		what we do here." **Solicitors need to meet her – is she a good witness?** **Obtain documentation re her complaint against Hamblin and Barton.** **Also obtain her "personal papers" she says she gave to police, in which she wrote about her concerns.** **Can she provide any further detail re care for Arthur Cunningham? Any criticism?** **Diaries of mother, Joan McIlroy, who noted daughter's concerns in 2001/2 – JMI/1 and 2 (GCF3, tab 20-21) – adds little – just says Hallman raised the issues, questioned Barton and was not liked for it.** **NB. Sharon Ring (GCF6, tab 11 and 48), Lynne Barrett (GCF6, tab 12) and Freda Shaw (GCF6, tab 13) say they have been asked if recall any conversation with Hallman about these matters and say no.**
Tina Douglas	GCF2, tab 37	Nurse at GWMH 1993-2003. Worked on Daedalus Ward. General patient care very good. From early stage, concerned about syringe drivers. Hamblin good at general care, but would belittle and bully staff. *Barton and Hamblin had close working relationship. Drugs including diamorphine and midazolam were prescribed to patients more or less on their arrival, so it became a nurse's decision as to when a patient would start a particular drug. I had never seen this practice before. Analgesic ladder not followed correctly. Some staff lacked full knowledge of it. However, at no stage did I feel that any member of staff did anything to harm a patient. Is a small hospital culture, small turnover of staff and poor practice can continue. I did not share my concerns with CHI because I was not asked.* **Useful.** **Obtain detail of comments to CHI – likely to undermine.**
Code A	GCF2, tab 38	Nursing auxiliary 1995-9. Concerned about indiscriminate use of syringe drivers. Seemed to me that euthanasia was practiced by the nursing staff on Daedalus Ward. I learned that all patients on admission were written up for syringe driver if appropriate, enabling any member of the nursing staff to set up a syringe driver without further reference to the doctor. I didn't challenge it at the time. I can't say why. **Evidence fits our complaints, but seems to be more received wisdom than first hand – she was nursing auxiliary rather than nurse. This evidence comes better from those more directly concerned – nurses.**
Margaret Brennan	GCF2, tab 42	Nursing auxiliary to 1995. Hamblin very kind to patients, but put them on syringe drivers very early in their treatment. Other types of pain relief not tried first. Would go from aspirin to diamorphine with nothing in between. Should be used as last resort – I consider them death machines. Barton came every day – very friendly. Moved to Daedalus Ward, started working nights, concern about syringe drivers

		became less. **Fits case, but little detail and pre-our period. Seek further info?**
Valerie Webb	GCF2, tab 47	Nurse. At Redcliffe Annex, was a practice of pre-prescribing syringe drivers and diamorphine in case the patient became in need of stronger pain relief during the night. **Little detail. Adds nothing.**
Sheelagh Joines	GCF2, tab 49	Pro-Barton. Sister on Daedalus Ward to 1997. Barton is one of the best doctors I have worked with. Very caring. Still my GP. [This is equivalent to Gill Hamblin].*** *It was agreed by Lord, Barton and me that Barton would prescribe medication prior to it being required. This was done in case a patient deteriorated and needed the drugs that had been prescribed. The prescriptions were written up on admissions in case they were needed. If the patient deteriorated I would inform Barton and tell her I thought time had come for the drugs to be given. I would speak to family, then speak to Barton again if they approve the syringe driver, then on her authority I would commence syringe driver on minimal dosage given the scale as laid down by Barton. Any increase in dosage could only be authorised by Barton. Barton was fully aware of the medical condition. At no time did Barton and I ever disagree about the use of syringe drivers.* **Evidence is in fact quite unintentionally damning of Barton and the process, but appears too pro-Barton and at odds with medical records to use.**
Agnes Little	GCF6, tab 4	Health Care Support Worker, Dryad Ward. Pro-Barton. No concerns. But – never discussed patient care with her. **Not in position to comment. Note pro-Barton views.**
John Grunstein	GFC6, tab 6 + 7	Consultant Geriatrician at GWMH until 1992, at Redcliffe Annex. There when Barton joined. Barton applied for job of Clinical Asisstant on 17/3/88. She was very good, heart was in it. Attended initial training of 10 half-day sessions assiduously. Attended Clinical Assistant Training Program – Elderly (CATPE). Routine ward rounds would review new patients and assess existing patients. I would advise. Barton's role required her to exercise considerable amount of autonomy. She was assiduous in making herself available – role was to be available 24/7 (others from her practice covered when she was not). Incredulous at allegations against Barton – an outstanding, caring and compassionate physician. **Quite useful in describing Barton's role, but we need (a) description of her role in 1996-9 and (b) more detail of her day-to-day responsibilities and actions. Also – very pro-Barton indeed.** **JAHG/1: Barton's application for the job.**

Robert Logan	GFC6, tab 8	Consultant Geriatrician with responsibility for Redcliffe Annex of GWMH, 1991-2/3. I would conduct ward round once a fortnight, with the Clinical Assistant and senior nurse. I was also available for consultation advice between ward rounds. At that time, ward round done on Tuesday afternoon. Out of hours consultation advice was provided by on-call Elderly Medicine Consultant between 5pm and 9am. Clinical Assistant's responsibility was to provide day to day medical care for the patients. Talks of advantages of syringe drivers. Clinical Assistant should prescribe in accordance with BNF. In 1991, no policies re dosage of diamorphine in Portsmouth and South East Hampshire Health Authority. Patient care was of high quality. I cannot recall a single patient whose care was inappropriate. I had full confidence in Barton's clinical abilities. RFL/1 and 2: Notes/corres re concerns raised in 1991. Can't say how many times Barton called for advice. Don't recall ever having a serious disagreement with her. She ran ward in same way as other CAs. Don't recall Barton ever saying she had a problem with her work load. Nothing I saw on the ward caused me any concerns about her work load. **Quite helpful in describing Barton's role, but still not applicable to our period, plus very pro-Barton.**
Barbara Robinson	GCF6, tab 16	Service Manager for Fareham and Gosport Elderly Services, based at GWMH, 1996-2000. General nursing care excellent. Access to physiotherapy. Never heard any concerns re syringe drivers. In event of medical emergency, would give first aid and call for ambulance. No complaints made against Hamblin or Barton. During time at GWMH, syringe driver training was part of basic core skills training for qualified nurses. Shirley Hallman never complained about syringe drivers or diamorphine, she was highly strung and highly critical. Barton was Clinical Assistant for Dryad and Daedalus Wards. She would be in at 7.30am, Monday to Friday. Very attentive to patient needs, always came in when called. Excellent doctor. **No assistance. Very pro-Barton.**
Bee Wee	GCF6, tab 19	Consultant in palliative medicine, 1995-2003, providing advice to GWMH (and other locations). Colleagues and I ran a 24-hour telephone advisory service for healthcare professionals in our catchment area. From 1998, started an outreach programme providing information and advice for primary care teams, rotating around different venues. Attended Dryad and other wards at GWMH. Gave training on syringe drivers, dose of diamorphine (says does of 50mg would probably not be appropriate in one dose),

		and analgesic ladder. Don't recall specific questions at GWMH. **Only assistance – availability of 24-hour advice and provision of advice on analgesic ladder to GWMH.**
Jeffrey Watling	GFC2, tab 62	Pharmacy Services Manager, Portsmouth Hospitals NHS Trusts. Produces JJW/7 – handbook on palliative care giving guidance on clinical management of patients who are dying.
Irene Dix	GFC2, tab 63	Produces ID/F&GPCT/1 – Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion. Received it from telephonist at Queen Alexandra Hospital on 26/10/04.
Yvonne Farmer	GFC2, tab 64	Faxed ID/F&GPCT/1 to Dix. PA to Dr Reid, Medical Director for East Hants PCT. Dug out the (draft) Protocol at Dix's request. Reid told me where to find it. In a file headed "Medicines and Prescribing Committee II" – earliest paperwork in it is from January 2001.
Valerie Vardon	GFC6, tab 20	Doctor in Department of Medicine for Elderly People at Queen Alexandra Hospital, 1991-9. Shown ID/F&GPCT/1 – it is a draft, may have my writing on it, would have had to be referred to a medical committee who would discuss and determine future policy.
Wendy Jordan	GFC2, tab 84	Personnel. Produces job description for Clinical Assistant – WJ/CA/1. Being available on call, responsibility for day to day medical management of patients, notes and reviews.
Richard Baker	GFC2, tab 88	Professor Baker. Tasked with investigation into practices at GWMH. Explains how audit done. Produces report – RHB/GWMH/1. An attitude or culture of limited hope and expectations of recovery. Probable that a small number of patients might, if not given opiates, have recovered and been discharged from hospital.
Vincent Richards	GFC2, tab 89	Photographer. VGR/1 – 10 photos of Daedalus Ward, 29/6/00.
Chris Donohoe	GCF6, tab 17	Produces Barton's application form for role of CA – CD/JB/1. Letter of confirmation of appointment – CD/JB/2. Data form showing employed as CA from 1/5/88 to 30/6/00 – CD/JB/3.
Simon Wills	GCF6, tab 21	Drug Information Pharmacist in 1998, within Portsmouth Hospitals NHS Trust. SW/CDG/1: Compendium of drug therapy guidelines, 1998.
Geoffrey Quade	GCF6, tab 59	DC. Interviewed Barton on 21/4/05. JB/PS/5 – Prepared statement. CSY/JAB/6 – Interview tape.
Christopher Yates	GCF6, tab 58	DC. Produces transcript of Barton's interview of 21/4/05 – CSY/JAB/6A.

	+ 70 + 71	Produces transcript of Barton's interview of 14/7/05 – CSY/JAB/8A. Interviewed Barton on 23/3/06 – tapes CSY/JAB/17, 18, 19, 20.

Production of Medical Records etc –

Janet Peach – GCF2, tab 19 + 20 – Controlled Drug Record Books, Dryad Ward and Daedalus Ward.

Beverly Carter – GCF2, tab 51-53 – Complete medical records of patients who died at GWMH – BJC/2-75. BJC/1 is spreadsheet of them. Admissions books also produced – BJC/88-90.

Janice Rix – GFC2, tab 55-58 – Haslar Hospital notes for Elsie Lavender, Robert Wilson, Enid Spurgin, Leslie Pittock, Ruby Lake – JR/11-19A.

Theresa Stephens – GFC2, tab 61 – GP records – TAS/2-10.

Jacqueline Spragg – GFC2, tab 67-75 – Cause of death certificates – JAS/CODC/1-14.

Gillian Llowarch – GCF6, tab 23 – Death certificates – GL/112-121.

Dawn Whitehead – GCF6, tab 24 – Death Certificates – DW/1-14.

FURTHER ISSUES:

1. Use of evidence about concerns re Barton's conduct towards other patients and other periods – eg 1991/2, when nurses concerns first aired?

    - We are restricting case to our examples, to avoid trawl of all people ever treated. So can't focus on other examples.

    - What about earlier period? May want to use evidence about how things worked at the hospital, if that was continuing in 1996-9 (our period). But not concerned with conduct not continuing in our period.

- So: Focus attention.

2. Protocol for Prescription and Administration of Diamorphine by Subcutaneous Infusion (exhibit ID/F and GPCT/1) – produced by Irene Dix, issued by Dr Reid (it seems) at end of 1999. Seems to set out a very lax approach – see summary at front of Generic File 2. Was this really the earliest Protocol? Does it have any effect on our case? It is produced AFTER our cases – showing that even management had it wrong – a matter of mitigation?

3. Use of nurses who had concerns? There are two tribes here – those with concerns, who talk about exactly our case, and the others who back Barton completely. There is a good deal of antagonism between them. Plus, there are inconsistencies with the nurses who did express concerns (eg whether the problems were solved by 1996-9). Do we go down this route, or present the case without such evidence?

4. Use of nurses who paint picture of use of syringe drivers? They can clearly give evidence of how the system worked – ie prescription by Barton and use by nurse. But can they give *general* evidence of the overuse of diamorphine? Surely we are concerned with the specific examples in our charges? Discuss – can we use this evidence?

5. Gill Hamblin – what is her position? Any proceedings before her professional body. Much of the problem seems to have stemmed from her spic and span handling of the wards. If we call the nursing witnesses, Hamblin will be at the centre of the complaints.

6. Should we prepare for having to XX those nurses et al who are very supportive of Barton?

7. Clarify whether nurses did continue to complain about syringe drivers into mid-late 1990s. Get whatever material there is on this. Defence will suggest that any problems appear to have been resolved in 1991. Statements seem to suggest that after 1991/2, although there were concerns, not further complaints were made.

8. Report of Professor McQuay (GCF6, tab 2) on effects of opiate drugs on the elderly – consider use, for clarity on seriousness of failings in this area. Alternative is simply reliance on Professor Black. McQuay's points:

    - Professor of Pan Relief at Oxford University.

- Morphine has potential to depress that rate at which we breathe. 40mg of diamorphine over 5 mins for a normal adult would stop breathing. This action is more apparent if given to a patient who is not in pain.
- Excessive doses, doses bigger than needed to relieve pain or doses given when there is no pain, will cause respiratory depression.
- Clinical message is that opioids need to be titrated against pain.
- Opioids used to control severe pain.
- Severe chronic pain is usually managed by giving the opioid by mouth.
- Analgesic ladder set out. It underpins pain management and palliative care.
- Syringe drivers – if patient can no longer swallow.
- Diamorphine given intravenously is twice as potent as morphine by injection.
- Increased age and general poor health lower the minimum lethal dose of diamorphine. The older you are, the greater the effect of the drugs. Previous exposure acts in the opposite direction, due to tolerance.
- There is no quality evidence to show that effective pain relief shortens life [presumably if administered properly].

9. Nurses going through the medical records and describing what they did – eg setting up syringe drivers – simply explain the notes. Can anyone explain for an individual patient how the decision as to when to start the medication and the dose to be administered was made? (Rather than general description from some nurses as to Hamblin's role). NB. The likes of Sharon Ring say that Barton decided he starting dose, but does not explain how she did this and when. **Consider going back to nurses who describe administration of drugs in 1996-9 period for detailed account of Barton's methodology and practices on the ward, if possible by reference to our specific patients.**

10. Eva Page & Alice Wilkie: No statements. Do we need them?

11. Do we need doctors at previous hospitals (eg Haslar, QA) to make statements dealing with the prognosis of each patient at time of transfer to GWMH – to make clear the unexpected deterioration – or can we rely on Prof Black's analysis of the notes? At present, doctors simply go through and explain their parts of notes.

12. Use of statements of nursing staff – does at least show the way in which the Wards were run and Barton's role on them. But – can we deal with this by just one statement?

13. Robert Wilson – example of deterioration when went to GWMH. Lots of statements from family and GPs re relative good health before admission, then from doctors at QAH prior to transfer to the same effect. What is the point of the evidence? (a) Seeking to show contrast

in health, and deterioration in GWMH, showing hastened death? (b) Merely showing that in light of previous decent health, approach taken at GWMH (taking death as foregone conclusion) was inappropriate? Or both? Q: How far back do we go with such evidence?

14. Evidence about assessment and review: Can we identify the person in each case who conducted the initial assessment of the patient to assist Barton? Can we use any witnesses to demonstrate the lack of assessment/review (they are likely to say all done properly)? But consider calling likes of Hamblin who may unwittingly show this was not the case.

15. Professor Baker – any prospect of use?