GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 9 June 2009

Code A

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.
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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 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 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:

"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 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.

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 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 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.

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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.

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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

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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 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.

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.

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 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. 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 Code A during the previous five years, and she thought he may have developed early dementia.

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 could have died quite quickly.

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.

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.

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 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 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 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.

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

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.

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 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 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.

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 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 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

surgeon called Code A 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 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.

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.

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 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.

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.

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 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 Code A 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 Code A 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.

Code A 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 H

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 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 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, 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."

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. 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.

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 no indication in the notes as to why Dr Barton thought it appropriate to start the patient on

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."

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."

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 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.

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 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 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.

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. 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 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 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, 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.

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 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 had acted in the way alleged.

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.

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 ---

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.

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)

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?

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.

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.

(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 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 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 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:

> "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."

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

A 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.

B 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.

C 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:

> D "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 E irrelevant but to take account of that which is relevant.

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 G 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.

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

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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.

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 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 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 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 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 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 doctors before him. His evidence coming at that stage, this Panel will be very familiar indeed

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

"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

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 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 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 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?

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.

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 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 transcript and have a look. There is nothing to prevent your doing that and indeed there is

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.

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.

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 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.

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.

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 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 statement, but in this case the defence state that there are particular reasons why you should

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 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.

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.

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 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 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.

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 paragraph 3 of Mr Kark's skeleton, referring to a transcript used by a jury to follow the pre-

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.

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 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.

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.

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 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.

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.

STRANGERS WITHDREW BY DIRECTION FROM THE CHAIR AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

DECISION

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.

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.

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

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.
- 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.

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.

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.

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 [Code A] 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.

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.

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.

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.

THE CHAIRMAN: The Panel have indicated that they are quite happy to proceed on that basis, Mr Kark.

(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.

This is the statement of Code A 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:

> "I am the daughter of 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.
>
> My father was a submariner in the Royal Navy. Whilst in Canada he met and married my mother Audrey. They had my Code A and the family came to England in 1947. My parents had three children. Paul is the eldest and I have a Code A Virginia Cresdee.
>
> My father suffered from severe depression for a great deal of his life. He made

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.

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, Code A whose surname escapes me). Because of this, a decision was made that my father would be discharged to a rest home.

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.

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.

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.

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.

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

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.

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.

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."

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.

MICHAEL BRIGG, Affirmed
Examined by MR KARK

(Following introductions by the Chairman)

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.

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.

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.

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.

Q I want to ask you particularly, please, about your involvement with a patient whom we know as Code A 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.

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.

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.

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?
A No.

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.

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?
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?
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.
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 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?
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

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.

Q The time is 15.15.
A Yes.

Q The dose is 50 mg.
A Yes.

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.

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.

Q That is another 50 mg of Nozinan being put into a syringe driver at 1500 hours?
A Yes.

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.

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.

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

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 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 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 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?
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.

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 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.

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.

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.

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 Code A 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 Code A 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.

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.

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.

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.

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

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.

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.
A My concern for **Code A** 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?
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.

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?
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?
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 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 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

C 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".

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

E were in the habit of contracting a deputising service, usually between the hours of ten and seven each night when they were on duty.

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

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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?

B 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

C were; prescriptions being written in advance for patients.

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.

D

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

E by a syringe driver at the time.

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

F deterioration might require an incremental increase in the dose in the first place.

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

G you are seeking to deal with the patient's distress.

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.

H Q If a patient is opiate naive, would the range have to reflect that?

A 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
B 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.
C

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.

D 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
E 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
F 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
G 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?
H A Just this one.

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.

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.

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.

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.

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.

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.

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.

A 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.

B 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
C 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?
E 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.

F 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
G 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.
H

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?

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 **Code A** 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.

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 ---

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.

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.

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.

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.

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?

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.

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?

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.

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.

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 Code A in the run-up prior to this event. He was

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.

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 ---

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.

Q Was this high-risk management?
A There is a high risk that their life will be shortened by it, yes.

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?

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.

THE CHAIRMAN: Mr Kark?

Further re-examined by MR KARK

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

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.

H

Q And the reason – just coming back to the questions, I think asked by Code A – 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.

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.

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?

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.

(The Panel adjourned until Wednesday 10 June 2009 at 9.30 a.m.)