**GENERAL MEDICAL COUNCIL**

**FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)**

Friday 17 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

**BARTON, Jane Ann**

(DAY TWENTY-SEVEN)

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

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

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

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A

THE CHAIRMAN: Welcome back, everyone. I am sorry if I should have given you a later start time than I did yesterday. I also find it very hard to gauge how long a Panel is really going to take, but we are there now.

DECISION

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

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

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

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

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

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

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

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

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

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

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Finally, you alluded to testimony connected with an unrelated collateral matter which it is said would reflect on the credibility of Nurse Hallmann. The Panel sees no value in receiving this testimony since Nurse Hallmann's evidence on the subject of opiate concerns is already corroborated by other evidence.

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In all the circumstances, this application is denied.

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MR LANGDALE: Sir, we will continue with the evidence of Dr Barton.

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JANE ANN BARTON, Recalled
Examined by MR LANGDALE, Continued

MR LANGDALE: Dr Barton, we had reached the stage where I was going to ask you questions about Patient E, Gladys Richards, so can we turn to that now, please? In respect of this patient you made a statement, which the Panel have, and this you told us was the first statement that you made with regard to any of these patients in relation to the police inquiries?

B

A It was.

Q Once again I am going to use the chronology as the platform for my asking you questions about these matters. Patient E, Gladys Richards, looking at the chronology on page 1, we start there with 4 February 1998, assessed by Dr Banks – "severe dementia" and so on. And, as we know, that entry of hers indicated:

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> "End stage illness; not surprising considerable periods of sleep. Obviously needs some help to relieve the distress she experiences when awake."

Perhaps I can ask you this: in terms of drowsiness or being sleepy, is that something which you experienced or encountered in cases where patients were demented?

A It was often part of the picture that patients presented but when they were awake they might well be quite distressed and agitated; so they would show both aspects of the picture.

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Q Then on page 2, the fall which occasioned her going into the Royal Hospital Haslar and we do not need to go over the detail of that again. And we can pick up on page 4, on 3 August, whilst she was still there, she was reviewed by Dr Reid:

> "Should be given opportunity to try to re-mobilise. Will arrange transfer to GWMH."

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And Dr Reid told the Panel in his evidence that he felt her prospects for re-mobilising were not good.

On to page 5, this is an instance where the referral letter seemed to be – when she arrived at GWMH and transferred to Daedalus Ward – rather over-optimistic.

A Yes.

F

Q Claiming:

> "Now fully weight bearing, walking with the aid of two nurses and a Zimmer frame."

And so on. When she got to the hospital in Gosport, to go into Daedalus Ward, obviously, as we can see, you reviewed her:

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> "On examination frail demented lady. Not obviously in pain. Transfers with hoist. Usually continent. Needs help with ADL. Barthel 2. Happy for nursing staff to confirm death."

And we know if we look over the page that on that day – that is the day of admission, 11 August – you prescribed Oramorph, which was administered that day at quarter past two in the afternoon, and I think that everybody is agreed that the 11.45 is actually 11.45 p.m. And

H

A you also anticipatorily prescribed diamorphine, hyoscine, midazolam. Some haloperidol was prescribed and administered that day and also Lactulose was prescribed and administered that day. There is a lady that you have recorded as being not obviously in pain and "transfers with hoist". First of all this, in terms of the mechanical side, "transfers with hoist" would signify what?

A Quite dependent; unable to shift herself to the side of the bed even with the help of two, so needed a mechanical aid to put a sling under her body to move her across to get her

B on to a bedpan or off the bed and into a chair.

Q So that is something that would have been apparent to the nursing staff before you examined her; is that right? Is that how we picture it?

A Yes.

Q We do not know precisely how long after she arrived that you actually saw her, but

C that would appear to be consistent with that picture?

A Certainly.

Q Dealing with this particular case why did you put in this case "happy for nursing staff to confirm death"?

A That was a routine entry I made into the notes of patients who might at some time in the future die on the ward. It meant that should a patient die out of hours the nursing staff

D who had not got a certificate for confirming death did not have to bring in an out of hours duty doctor to confirm death, so that the body could be moved off the ward and down to the mortuary. Leaving the body on the ward was distressing for other patients and for the staff and it was a kindness for someone to be able to confirm the death and the body to be moved down to the mortuary.

Q Professor Ford I think in relation to that said that he did not think that the nursing staff

E note was inappropriate in those terms.

A It did not signify that at that time I felt that she was close to death; it was a fairly routine entry in the notes.

Q What Professor Ford said in his evidence was to this effect. He said he would have expected to see a plan with regard to mobility.

A Yes, I could have written "gentle mobilisation". Really the point was that we needed

F to get to know this lady to see whether over the few days she was going to get back to the level of mobility that Haslar had claimed for her or whether we were seeing a more honest picture when we looked at the lady in the bed on Daedalus Ward. So it was not really quite time yet for a proper plan.

Q You prescribed Oramorph to a patient who you described as not obviously in pain and we know that the Oramorph was administered 10 milligrams possibly not that long after you

G had seen on her admission, if this was a lunchtime admission, as it were, and a further 10 milligrams later on that evening. I would like you to deal with this: why prescribe Oramorph and it is administered soon after with a patient who is not obviously in pain?

A The snapshot view that I gained of that patient when I examined her on the bed that afternoon was that she was not obviously in pain; but I knew perfectly well that she had just had a transfer from another hospital, she had not long had fairly major surgery and she was very frail anyway. She was going to be very uncomfortable for the first few days and I was

H minded to make available to the nurses a small dose of oral opiate in order to make her

A comfortable during that time – not to be administered regularly but at their discretion if they felt she needed it.

Q You indicate a small dose. The dose range was 5 to 10 milligrams.
A Yes.

Q In a case like this, when 10 milligrams are administered by the nursing staff at quarter
B past two in the afternoon and indeed in the evening that would be within their discretion, as it were?
A Totally.

Q What sort of judgment would you be expecting the nursing staff to make as to how much of the Oramorph you prescribed should be administered? In other words, what is going to make them start at 10 as opposed to 5?
C A The level of discomfort that they encountered when seeing to her, putting her on the commode, getting her back into bed, looking at her bottom, all of the general nursing duties that they would have had to do when she first arrived on the ward.

Q And the Oramorph would last for about four hours, I think you said.
A Four to six hours.

D Q Something like that, so four hours after the administration at quarter past two takes us to quarter past six in the evening, and maybe a little bit later; and what would you expect to have happened in terms of the administration later on that evening? That she would have been monitored?
A She would have been very carefully monitored; she would have been given her supper, she would have been made ready for bed. Presumably at that time she was sufficiently comfortable that they did not feel they needed to give another dose of opiate but
E it was there available to them if they felt clinically it was needed.

Q I would like to ask you about the anticipatory part of the prescription, the diamorphine and midazolam in particular. Why write out that prescription on that day with this patient?
A Because I felt that this lady – her outlook on the background of her very severe dementia and this fool and the major surgery, that her general outlook was poor. She was quite possibly going to need end of life care sooner rather than later.

F

Q Here we have the dose range of 20 to 200 and midazolam 20 to 80; did that fall within the usual bracket that you envisaged for cases of this kind?
A It did.

Q We have already dealt with the question of the dose range generally speaking and I am not going to go over that again. In general terms if it was the case that the post-
G operative analgesia was inadequate or had been inadequate, was that something which would occasion you any surprise or not? If at the hospital the post-operative analgesia had been inadequate?
A I regret that often post-operative analgesia appeared inadequate.

Q And with a lady of this age and this sort of condition, having had an operation of such a type, would you expect pain post-operatively, as it were, to continue for a period of time?
H A I would.

A

Q What sort of period of time?
A I would certainly expect her to have still been in pain when she was transferred across to me.

Q At the top of that page, with regard to the prescription we have just been looking at, we can see the assessment by nursing staff:

B

"No apparent understanding of her circumstances due to impaired mental condition. Barthel 3. Waterlow score 27."

Waterlow score of 27 is?
A High. Her skin was at risk of breaking down.

Q Moving on to the following day, the 12th, which was a Wednesday:

C

"Reviewed by the nursing team.
Requires assistance to settle and sleep at night."

What does that mean, "Requires assistance to settle and sleep", is that talking about analgesia or what?
A She had had analgesia. They were hoping that that would help her sleep. She was probably not very comfortable on the bed and she was probably very anxious being in a strange ward with nursing staff who she was not familiar with, so it was a combination with unfamiliar circumstances and probably pain as well.

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Q "Nursing action: Night sedation if required. Observe for pain. 23.30 haloperidol given as woke from sleep very agitated. Did not seem to be in pain."

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Would that be an indication that the Oramorph had been appropriate or not?
A Yet, 15 minutes later it looks as if they administered the Oramorph, so they must have initially at 23.30 ---

Q It depends when that note was made. It is apparently made on the 12th, but quite on the basis of what information by the author of the note we are not sure. You can see that Oramorph was administered at 6.15 in the morning and on that day you also prescribed 5mg four times daily and 10mg at night PRN?
A Yes.

F

Q That would be a total of 30mg, but as we all know the Oramorph which was administered at 6.15 in the morning was the last administration at that time?
A Yes.

G

Q Again, that would be the nursing staff deciding that in fact she did not need any further Oramorph after that administration?
A Yes.

Q It would further confirm that she had seen that patient that morning apparently on your usual morning visit?
A Yes.

H

A

Q On Thursday, the following day, Thursday 13th, she had the accident where she had fallen off a chair or something of that kind and was found on the floor at half past one in the afternoon. There is a note by Code A

> "Found on floor at 13.30. No injury apparent on checking. Hoisted into safer hair. Pain right hip."

B

It appears, Dr Barton, that you were not available because Dr Briggs was contacted and he advised an X-ray and analgesia?
A Yes. From my recollection he did not advise – he was not contacted until out of working hours. I would not have been around at 1.30 in the afternoon on the Thursday afternoon, I would have been doing an antenatal clinic. After that I would have gone home, but I think Dr Brigg was contacted early evening by which time our little X-ray department was closed and the X-ray was going to have to wait until the following morning.

C

Q Perhaps we can pick up what is said about the drug charts on page 8 relating still to the Thursday. The nursing staff gave her 10mg of Oramorph, haloperidol was also administered and it records that you also prescribed:

> "0.5ml/1mg 'if noisy' (in the regular prescription section, crossed out with 'PRN' written in)."

D

Would that mean you would have been present at some stage on that day, or is it open to question?
A I would have been present at some time that day, but it would have been in the morning not later on in the day.

Q So that prescription in relation to her haloperidol ---
E
A Was before the accident.

Q --- was in the morning?
A Yes.

Q You did not play any part in what happened in terms of her treatment after the fall it seems. The nursing staff and Dr Brigg were involved, and the following day, the following
F
morning, when you came in in the normal way, obviously you saw the patient as we can see from the chronology?
A Yes.

Q You noted down:

G

> "Sedation/pain relief a problem. Screaming not controlled by haloperidol but very sensitive to Oramorph. Fell out of chair. Right hip shortened. X-ray. Is this lady well enough for another surgical procedure?
>
> Later note:
>
> Appears to have dislocated right hip. Referred for relocation."

H

A There is no criticism by Professor Ford in relation to this. Clearly, she is in a lot of pain, he said, at this stage and analgesia was justified, but why was it you put "very sensitive to Oramorph" because this lady had been on Oramorph, on your prescription, on the day that she arrived, Tuesday 11th, on Wednesday morning, not on Thursday before the fall and on Oramorph after the fall. What was it that caused you to say, "very sensitive to Oramorph"?
A I was aware of two things. There was a mention in the Haslar notes to a sensitivity to morphine, if not Oramorph, and it was one of the things that was mentioned by her daughters.
B They felt she was sensitive to Oramorph, so I made a note of that in the clinical notes.

Q This would come after you had initially prescribed Oramorph, this information?
A Yes.

Q There is no criticism made of your consideration of the question, "Is this lady well enough for another surgical procedure?" Then your later note relating to, "Appears to have
C dislocated right hip", in what circumstances would that have happened, a further note made in the same morning or later on in the day or what?
A Certainly later on that morning. I would have come back to contact the hospital having looked at the X-ray and written a referral letter and gone back to Haslar.

Q The X-ray would have been taken where?
A At the Gosport War Memorial, the first thing that morning, I think it was a Thursday
D morning.

Q It was a Friday, this particular day?
A Friday morning.

Q When would you have seen the X-ray?
A That morning.

E

Q Why was it that you would have seen the X-ray and it had been taken that quickly, if I can put it in that way?
A Because one of the nurses would have gone down and said, "Please, we need this X-ray doing urgently, we have a patient with a possible dislocation", and they would have very kindly done it for us straight away, the radiographer would have done it straight away.

F Q How would it come about that you would know that the X-ray had been taken and be in a position to look at it, would somebody contact you?
A They would probably have contacted me at the surgery and say it has been done, but I would have been sufficiently concerned about this lady that I would have come back anyway.

Q We can see the X-ray report at the bottom of that particular page. Over the page, still
G on the same day, Friday 14th, we see that that you saw a daughter of this lady, "Informed of situation", so you your updating the relative about what was happening about transfer and so on.

"Letter from Code A to Haslar A&E."

He points out what the position is and records the fact that Oramorph was given that morning:

H

A "Happy to take her back following reduction of dislocation."

We can see what the drug chart shows with regard to the administration of Oramorph and there is no criticism made of that. "Readmitted to Haslar for relocation". It gives the details of what was done.

B "Given splint to discourage further dislocation. Can however mobilise, fully weight bearing."

What is your view as to that, bearing in mind you saw her on the Monday when she was transferred back?
A My understanding of that note was that the surgeons at Haslar felt that it would not compromise the procedure they had done to the hip if she was fully weight bearing on it. I was not of the understanding that she was fully weight bearing, but if we were able to do it
C she could, it would not harm the prosthesis.

Q Over the page, page 10, would you bear in mind the reference to what drugs she was given at Haslar. There were the 2mg of midazolam in connection with the sedation required for the procedure and so on. We have heard evidence about that, and at Haslar they wrote up Oramorph, but it was not given. Co-codamol was actually given there. "Transferred back on Monday 17th". It appears that this would be a lunch time transfer in terms of your arrival and
D review?
A Yes.

Q Reviewed by you. Apparently, it would seem that you did have the information from Haslar to take on board what had happened. Is that right?
A Yes.

E Q "Closed reduction under IV sedation. Remained unresponsive for some hours".

You would only know that from the hospital?
A Yes, I understood that she was unconscious for most of the day following a single dose of midazolam intravenously which led me to think that perhaps she had not responded well to the anaesthetic.

F Q If you realised that she had remained unresponsive for some hours, and knew that there had been an administration of 2mg of midazolam intravenously, did you not say to yourself, "I do not think prescribing midazolam is going to be a good idea for this lady"?
A I did not think the two forms of administration of the drug were comparable.

Q Would you explain that a bit more please?
A An intravenous bolus of midazolam in order to induce anaesthesia and pain relief to
G have a procedure done, is a completely different matter from a slow subcutaneous infusion through a syringe driver for terminal restlessness, agitation, anguish and anxiety.

Q "Only give Oramorph if in severe pain". No criticism is made of that, but I am wondering why you said it. What caused you to say, "Only give Oramorph if in severe pain"?
A This was because of the perception of the daughters that they did not want her given
H overly amounts of analgesia or sedation.

A

Q At this time it is apparent you were seeing, I think there were two daughters present at the hospital, maybe not both of them together at the same time every time, but you were seeing them every time you paid a visit to the hospital?
A Yes.

Q In general terms, we will come on to some later events, what was your manner towards them and their manner towards you in general?

B

A Polite.

Q Polite on both sides?
A Yes.

Q Did they at any time ever criticise you when they saw you?
A No.

C

Q Did they ever question, either of them actually question, what you were doing when they spoke to you?
A I think they were very concerned about what drug management their mother should be given.

Q Did you explain it to them when you spoke to them?

D

A Yes.

Q What was their reaction?
A They seemed content.

Q That is just dealing with you and you obviously cannot speak as to what was said between them and any of the nursing staff unless you were present. If we move on to

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page 11, we can see what the nursing staff had recorded for this same Monday, Monday 17th, the day that she is back at Gosport. Code A

"Patient very distressed, appears to be in pain. No canvas under patient."

This is the problem with the transfer by the particular ambulance crew it would seem. Nurse Couchman's evidence was that she had just had come back from a holiday break that day and

F

she has recorded:

"In pain and distress – agreed with daughter to give her Oramorph 2.5mg. Daughter reports surgeon to say she should not be left in pain if dislocation occurs again. Dr Barton contacted and has ordered an X-ray."

Is that what happened to the best of your recollection?

G

A Yes.

Q Because of this unfortunate transfer back carried out in the way it was, there was this further problem and this further cause of pain?
A Yes.

Q Hip X-ray and the situation was reported that it was in fact relocated and therefore

H

there was not a dislocation. Is that right?

A

A No further dislocation.

Q As far as the drugs that were administered, Oramorph 5mg administered three times during the day and 10mg administered at 20.30; haloperidol. May I ask you this: there is no criticism of the administration of those drugs by Professor Ford but why, when one had seen the remarks about sensitivity to Oramorph and so on, did you carry on giving Oramorph?
A Because it was the most appropriate and effective analgesia in this unfortunate lady who had undergone another surgical procedure and was in a lot of pain.

B

Q There is no criticism of the administration of that drug. I am going to move on to page 12, the 18th which was a Tuesday. You saw her again that morning.
A Yes.

C

Q "Still in great pain. Nursing a problem. I suggest subcutaneous diamorphine/haloperidol/midazolam. Will see daughters today. Please make comfortable."

What was the significance of your writing in that particular review, "I suggest subcutaneous diamorphine" and so on?
A It was because at that point it was going through my mind that the lady was deteriorating. Pain relief was still proving to be an enormous problem and together with the pain relief, there was obviously a lot of restlessness and agitation. I needed to be able to control that with the use of midazolam and diamorphine, so I needed to be thinking about using a subcutaneous infusion and get the daughters on side, get the daughters' permission to do that for their mother.

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Q If we look at the note that follows:

E

Code A : 7 am: Reviewed by Dr Barton. For pain control on syringe driver. Code A Later: Treatment discussed with both daughters. They agree to use of syringe driver to control pain and allow nursing care to be given. 20.00: Patient remained peaceful and sleeping. Reacted to pain when being moved – this was pain in both legs."

F

We can move on to look at the prescriptions that were written that day: Oramorph 10mg administered twice – that was an administration rather than a prescription – in the early hours; you then prescribe in relation to diamorphine 40-200 and 40 was administered at 11.45 in the morning after, obviously, your morning visit; midazolam was administered 20mg at 11.45, the same time; haloperidol, we can see what is there, also administered at 11.45.

G

There does not appear to be any record in the nursing notes or in your review about agitation. I will come back to the question. Why prescribe and have administered midazolam when only pain is recorded, I would like you to deal with that?
A It goes back to that entry on page 11, Code A : In pain and distress", and she remained in pain and distress.

Q The figure of 40 for the diamorphine as opposed to 20, why 40 as the minimum dose in this case?

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A I calculated the number of doses of Oramorph she had had in the preceding 24 hours and the conversion for that should have been approximately 20mg, but her pain was not controlled so I was minded to increase it, hence 40mg.

Q So, in effect, if the figure with regard to the Oramorph was a total of 45 in the previous 24 hours - all right?
A Yes.

B

Q If you have done the half calculation, taking it down to 22.5, and the increase from the direct conversion of half the Oramorphine would have been, therefore, from 22.5, to be precise, up to 40?
A Yes.

Q Did that in any way seem to you to be an excessive starting dose?
A It seemed a very appropriate starting dose for her symptoms.

C

Q If it had been appropriate to prescribe 20 as the starting dose, would there have been any difficulty or problem with your doing that if that was your view?
A Not at all.

Q Did you consider as to whether the administration of those two particular drugs – I am leaving out anything else for the purposes of these issues – did you consider that there was a risk with the administration of diamorphine and midazolam that there would be adverse effects which would outweigh the benefit to the patient of relieving her pain and her agitation?
A I considered that there were potential hazards and side effects to it but my overriding priority was to make her as pain free as possible.

D

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Q Then 19 August, the following day, diamorphine was administered at the same dosage and also midazolam, haloperidol also and hyoscine was added. Hyoscine we have covered more than once as to what the purpose of that was and
I do not think anybody is suggesting that was an improper medication to provide at that stage. In relation to this lady, having come back on the 17th, the Monday, Tuesday the 18th, we are now on Wednesday the 19th. At what point had she reached a terminal care stage, in your view?
A Overnight on the Tuesday when she started to become bubbly and was probably developing bronchopneumonia.

F

Q One appreciates that these are not absolutely hard and fast lines, the line between palliative care and end of life care, but that would be a significant development, in your view?
A A significant downturn in her condition.

G

Q Why not have some further examination of her hip, either on the 17th, the Monday, when she is brought back, or the 18th, the Tuesday, or the 19th, the Wednesday? Why not carry out some sort of examination of the hip and have some discussion with the orthopaedic team?
A She was not well enough to return to the acute orthopaedic ward. We knew she had a large haematoma, or bruise, around where the dislocation had been put back. I knew that nothing surgically could have been done for this condition and that it would just have to be allowed to heal in its own time, if her condition permitted and she remained well enough.

H

A Q We can see that it is recorded in relation to the contact record that in the morning of the 19th, the Wednesday, she was comfortable, daughter was seen, she was unhappy with various aspects of care. Is that something that was ever brought to your attention, that either of the daughters was unhappy with aspects of her care?
A Yes.

Q What did you do when that was brought to your attention, if anything?
B A There was very little that I could do. We had explained to the family what was going to be our course of action and what was going to be the likely outcome. There was nothing further - I did not feel that a transfer back to an acute unit at that point was in Mrs Richards' interests. She probably would not have even survived the journey back, so we had to continue on our route of palliative care, becoming terminal care.

C Q I think the evidence of one of the daughters who gave evidence to the Panel, Lesley O'Brien, was that you at some stage told her that in your opinion it was not appropriate for a 92 year old to be transferred back to Haslar for a further procedure. Is that something that you remember saying or is it something that you think you may well have said or what?
A I think it is something I might well have said. It would accord with how I felt about her condition.

Q Did either of the daughters ever complain to you about any aspects of her care?
D A No.

Q On page 14 of the chronology, the syringe driver administration of the subcutaneous analgesia and the haloperidol and the hyoscine continue. Right?
A Yes.

Q There is no note by you on 20 August, but would it be the case that you would have seen her on that day?
E A Yes.

Q The 20th?
A Yes.

Q On an ordinary morning visit?
A Yes.

F Q Would you have reviewed her case?
A Yes.

Q Nothing written by you but on the next day, which is Friday 21st, reviewed by Dr Barton. You wrote:

G "Much more peaceful. Needs hyoscine for rattly chest."

A Yes.

Q Nurse Joice:

"Patient's overall condition deteriorating. Medication keeping her comfortable."

H Then over the page the same subcutaneous analgesia being administered at the same rate and

A so on, and she died that evening shortly after nine o'clock. Is there anything that you would seek to change, looking back at this case and, having heard the evidence of Professor Ford, is there anything else you would seek to change about your view and judgment as to how this lady was cared for by you as her doctor?
A Nothing.

Q There is no record of her being unrousable or in any particular situation as a result of
B the administration of the subcutaneous analgesia. Do you actually remember what the position was over the last two or three days? Was she rousable at all?
A I cannot remember.

MR LANGDALE: The next patient is patient ---

THE CHAIRMAN: Mr Langdale, we will take a short break there. Fifteen minutes, please.

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MR LANGDALE: Yes.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everybody. Mr Langdale, before we hear from you again, an observation I would like to make, please, for our guests in the gallery. We are, as
D I have had occasion to say before, always delighted to have members of the public, press and others attending and watching the process in action, but the fact is, given where the public gallery is situated, the members there are facing directly into the hearing and if there is excessive movement, talking, gesturing, whatever, it can be extremely off-putting to the parties, the panellists and others that are in this part of the room. I am saying this now really for the record, it is not the first time I have said it and it may not be the last, but can we please ensure that movement and talking and other gestures are kept to the minimum. Thank you.

E

MR LANGDALE: I am afraid I must begin this session with an apology because we have to go back to the case of Gladys Richards. There is one matter that needs clarification which Mr Jenkins has brought to my attention and I would like to deal with it now.

I am sorry for going back to this patient. Patient E again and, Dr Barton, I am going to ask you to be looking at page 10 of the chronology, first of all. I also need Dr Barton and,
F indeed, the Panel if they would, please, to look at Dr Barton's statement with regard to this patient. Do you have a file with your statements in it to hand?
A Yes.

Q Looking to the statement with regard to Patient E, looking at the statement, first of all, I would ask everybody to go to paragraphs 21 and 22 in the statement and, bearing in mind that page 10 of the chronology shows the note made by you on review when she was
G transferred back from Haslar on Monday, the 17th, we can see in your statement you set out what it was had been said in your clinical notes:

> "Readmission to Daedalus from RHH. Closed reduction under iv sedation. Remained unresponsive for some hours. Now appears peaceful. Plan: Continue haloperidol. Only give Oramorph if in severe pain. See daughter again."

H Then your statement goes on:

A

> "At the time of her arrival back on the ward Mrs Richards appeared peaceful and not in severe pain. This was however an initial judgment made on an assessment shortly after her arrival on the ward. I was concerned that she should have opiates only if her pain became a problem, and I altered her drug chart accordingly. I was not aware at that time that she had been having intravenous morphine at RHH until shortly before her transfer. This would have explained why at this time she appeared to be peaceful and not in pain."

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We appreciate that you made that statement quite some time ago. We know from the records that we have looked at and which are set out on the chronology that, in fact, she was not given intravenous morphine at RHH, so that, clearly, is an error in your statement. All right?
A Yes.

Q In the light of that I need to try and piece together the history. When she was readmitted into Daedalus one of the daughters, as I recall it, I think it was Lesley O'Brien,

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was present and she was obviously in pain. This is what I have described as the "ham-fisted" transfer back, and we have heard the evidence of Nurse Code A as to her coming on the scene at about half past one, or one o'clock, something like that, which is recorded over the page in the chronology at page 11:

> "13.05: In pain and distress - agreed with daughter to give her Oramorph ..."

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It appears you were not present at the time she was readmitted, although her readmission was round about lunch-time, something like one o'clock or something of that kind. All right? I am just trying to piece together the history so we can make sure we have it right. So it would appear that when you saw her to review her, in terms of the clinical notes, she was at that time peaceful. Right?
A Yes.

E

Q Which must mean some time after her arrival and perhaps it is a situation which had been achieved as a result of the Oramorph she was given. Does that make sense? If you look at page 11, Nurse Code A records:

> "1305: In pain and distress - agreed with daughter to give her Oramorph 2.5 mg. Daughter reports ... Dr Barton contacted and has ordered an X-ray."

F

Does it look then like you came in later to deal with the readmission?
A Yes.

Q By the time you saw her she appeared peaceful?
A The Oramorph had kicked in and she was more comfortable.

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Q Yes. Then I wonder if we could just look, please, because it may help in piecing this together, in the file itself, the notes, at page 47. Page 47 in the nursing records, the medical notes, shows the contact record completed by Nurse Code A timed at 1305:

> "In pain and distress - agreed with daughter to give her mother Oramorph", and so on.

We can see the sequence:

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"Dr Barton contacted and has order an X-ray."

P.m. another nurse records:

"Hip X-rayed at 1545",

– seen by another doctor in your practice –

B

"... For pain control overnight and review by Dr Barton in morning."

Does that seem to be the sequence of events?
A It seems to be the sequence of events.

Q Indeed, you did see her the following morning, as we have already looked at.
A Yes.

C

Q As we know, the Oramorph had been stopped on the 14th, I think it was. I am sorry. It was last administered on the 13th.
A Then it was reinstituted.

Q Yes, and there had been the earlier cessation before the fall?
A Yes.

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Q That is all I am going to deal with there but I thought it right to clear up that particular part in your statement, which, obviously, was an error. Having dealt with that, may we move on, please, to Patient F. Patient F, Ruby Lake, another case where one had a fracture. If you look, please, at page 2 of the chronology, into Haslar following a fall at home and a fractured left neck of femur, and we have already looked at the history with regard to this patient more than once. Also, I am going just to call it heart problems, or heart concerns. All right? Then we can see the various notes covering quite a period of time in her case at Haslar, setting out the problems and so on. Then perhaps we can move on to page 9 of the chronology, where there was a referral on 13 August to Dr Lord, asking her to assess the lady. She was then, I think, 84 years old. Over the page we have Dr Lord's review which we heard from Dr Lord about yesterday, hemiarthroplasty on 5 August, and so on, ischemic heart disease:

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"Overall she is frail and quite unwell at present";

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Last sentence:

"Uncertain as to whether there will be a significant improvement."

As Dr Lord puts it, there were a number of medical concerns about her.

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"Unable to mobilise at present due to chest pain. Notes to physio in relation to the Haslar."

Then we can go on to the transfer to Dryad, which is shown on page 14 of the chronology. That transfer takes place on 18 August, that is a Tuesday. The review at Haslar describes her at the top of the page as:

H

A

> "Well, comfortable and happy. Last pm spike temp, now 37.3. Mobilising well. GWMH today."

At 2 o'clock in the morning there is a note:

> "Recommenced on oxygen therapy."

And so on. Then the transfer. The transfer letter describes her as:

B

> "Has had a slow recovery, exacerbated by bouts of angina and breathlessness. This appeared to be secondary to fluid overload, now resolved, it appears. Presently she is slowly mobile with Zimmer frame and supervision."

Last two or three lines:

C

> "Usually lucid, only very occasionally seems confused at night. Hearing aid appears to have gone missing."

Then your review of her on that day, your notes record:

> "Transfer to Dryad Ward continuing care."

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And you set out the position and the previous medical history – CCF and so on:

> "Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death."

Professor Ford indicated that she had had a very variable medical course and in his view, albeit he was not there at the time but looking back on it – she was not really fit for transfer. When she came in and you reviewed her did you carry out your usual examination?

E

A I did.

Q Did the nursing staff carry out their usual tasks, checking blood pressure, pulse and so on?

A Yes.

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Q What view did you form, bearing in mind the prescriptions that you wrote on that date at page 16, as to the picture with regard to this patient? You had of course put "get to know; gentle rehabilitation". And we know in relation to what was prescribed, either immediately or anticipatorily was Oramorph and 5 mgs were administered at 2.15 that afternoon – and certain other things I am not going to trouble you with, but other medications for other situations – and a proactive or anticipatory prescription for diamorphine, 20 to 200; midazolam 20 to 80. Professor Ford indicated that that was inappropriate in his view and potentially hazardous and so on.

G

In that context – and I am sorry, that was rather a mouthful from me – what is the picture as you saw it and why are you prescribing those drugs either immediately or anticipatorily?

A My impression of this lady was that although her Barthel was 6, which would have meant that she was suitable for nursing home, this was not a medically stable lady; this was potentially and quite quickly a very unwell lady, and that was borne out in the message in

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A Dr Lord's transfer letter. Although she had not had a temperature since the night before and she had not actually gone into congestive cardiac failure the night before she arrived she was quite likely to be going to do so fairly shortly.

Q What was the real problem? What was the worst of the problems, as you saw it, that she was facing?
A Not her repair to her hip, unfortunately, but her incipient congestive cardiac failure

B and the likelihood that she would go downhill very quickly, again following a transfer on top of major surgery.

Q You said Dr Lord's transfer letter – to what were you referring there? The transfer letter on the day I do not think is Dr Lord.
A Had Dr Lord not seen her earlier on? We would try and mobilise her.

C

Q This is the one on page 10.
A Yes, that her feeling was ---

Q If I can just interrupt, that is on 13th, the Thursday.
A "Uncertain as to whether there will be a significant improvement." And that would have been borne out by my examination of that lady when she arrived.

D

Q That is what you are referring to?
A That is what I am referring to.

Q But it looks as if you would have seen the transfer letter as well, perhaps.
A Yes. "Slow recovery; bouts of angina, breathlessness. Confused at night."

Q What is the Oramorph for? Not in immediate pain.

E

A Again like the previous patient, likely to be in some considerable pain when seen to by the nurses, so it was written up "prn" for their use if they felt that she was uncomfortable and distressed and they wanted to give her something for pain relief.

Q What about any possible with regard to opiates, whether Oramorph or otherwise in relation to a patient with these heart problems, as I am describing it?
A Likely to be of benefit rather than detriment to somebody with incipient congestive

F cardiac failure.

Q Why not send her back or contact the hospital, Haslar, and say, "This lady should not be here; she should not have been transferred"? I would like you to deal with that suggestion if it is being made.
A It was not my place to turn down acceptance of a patient who had been accepted by my consultant into one of my beds. I was responsible for the day to day care of these patients

G but I was not responsible for the politics behind why they came to me.

Q Can we just deal with that while we are on the point with regard to this particular patient in a more general way. What if a patient who you clerked in at Gosport had a problem which, in your view, needed some kind of medical intervention – a medical intervention that you could not provide at Gosport? Assuming that the patient was not so unwell in your view that they could not go back? I would like to ask you about what it was

H that you could do and would do.

A The majority of these patients, particularly this lady, came into the category that they were already too frail to go back and if they did go back there was nothing further that could be done for them.

Q I am trying to see in terms of what powers you had or what you actually could achieve, given the fact that the consultant had said, "This patient is to be admitted to Gosport"? Assuming it is a patient who is not too frail to be transferred back and your view on admission is that there is a problem which needs a medical intervention – an acute intervention, whatever one properly describes it as – which you cannot provide at Gosport?
A It was open to me to contact the duty geriatric consultant or the consultant who had been responsible for the transfer of this patient and say, "I wish you to take them back."

Q So it is the consultant in effect, or the duty geriatrician who says, "This patient is to go back"?
A Yes.

Q You cannot just send a patient back yourself?
A No. They were not my beds. I was responsible for the day to day care of them but the beds did not belong to me, and I would not under normal circumstances have arranged a transfer without consultation with my consultant or a consultant in the department.

Q What about the case of Gladys Richards when she went back as a result of the fall?
A I contacted the consultant under whom she had been at Haslar directly because that was a slightly different problem.

Q But that consultant was the person who had to say that it was all right for her or it was proper that she comes back?
A Yes.

Q I appreciate in this particular case with the patient we are dealing with at the moment that it was not your view that she should be sent back, although your view was that she was not medically stable.
A I understood from the assessment that Dr Lord had made of her, albeit several days earlier, and how frail she was when she arrived with me that it would not have been appropriate to put her through a journey again. And, to be honest, what further could they have done for this lady other than made her comfortable?

Q Again, would you deal with this patient when it is in your mind, what else could be done? What were you thinking as being something which could be done?
A There is not a further problem with her surgical procedure; that seems to have been relatively successful. Her problem is that she is at the end of her life due to her cardiac problems.

Q Are you thinking at this time, if we can try to give labels to this, that this lady is likely to be on the palliative care route before too long?
A Yes, and more than that – that she is likely to be on the terminal care route before too long.

Q You had written "get to know; gentle rehabilitation".

A A slightly tongue in cheek remark, to imply that any rehabilitation would have to be gentle; she was not fit for or capable of anything very active in the way of rehabilitation.

Q Does that mean that you are giving a slightly over optimistic view in reality?
A Yes.

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Q In terms of the nursing staff seeing that, would they understand that nonetheless, of course, if it was possible that gentle rehabilitation could take place then they should pursue it?
A Yes.

Q We can see what the nursing staff wrote. Nurse Barrett:

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> "Communicates well. Compliance – yes; pain – yes; skin – leg ulcers and sacral pressure sore."

Collins:

D

> "Settled and slept well 22.00 until midnight. Woke very distressed and anxious. Says she needs someone with her. Oramorph 10 mgs given at 15 minutes past midnight with little effect. Very anxious during the night. Confused at times. Patient's understanding of condition to mobilise slowly and feel better all round. Diet normal. Appetite poor. Needs encouragement."

Professor Ford criticised the administration of Oramorph and suggested that it would have been more appropriate to give her something like temazepam or haloperidol; what do you say to that?

E

A If as I suspect she was going into heart failure that temazepam is likely to have made that worse. Oramorph would have been a very appropriate intervention at night for somebody going into congestive cardiac failure.

Q Over the page, other records made, not yours, "Slow post op recovery" and so on:

F

> "Pleasant lady happy to be here. Complexion pale, sin dry. MI 3 years ago. Renal failure.
>
> PM: Seems to have settled quite well. Fairly cheerful this pm."

We have dealt with the prescriptions that you wrote up on that day. In terms of the diamorphine with no particular indication of the pain in any particular fashion at that time, did you have in mind any other purpose for diamorphine being administered when you wrote up anticipatorily or was it just pain?

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A To relieve distress, restlessness, fear, anxiety when approaching death.

Q We can look at the sequence of events after that. On page 17, Wednesday 19th is the note by Nurse Hallmann:

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> "Complaining of chest pain, not radiating down arm – not worse on exertion, pulse 96, grey around mouth. Oramorph 10mg given. Doctor notified. Pain only relieved for short period – very anxious. Diamorphine 20mg midazolam 20mg commenced."

A

Nurse Hallmann's evidence was that she thought she would have had permission from you, or authorisation from you, to commence the syringe driver. Are you able to remember, yourself, one way or the other?

A It says in my statement that I well may well have been in the hospital for a meeting that lunch time and I would have been happy to give my permission. I would have probably have called in to see the lady and examine her myself, but I would have been happy to sanction that prescription for that lady.

B

Q There is something we may need to take note of at this stage. I am not asking anybody to turn it up, in case anybody wants to note on the chronology, at page 384 in this file, it is part of the nursing care plan which on the 19th, on this same day, says something about an assisted wash, but we need not worry about that, "patient very breathless". That is so that we know what the nursing care plan says at page 384. What is the significance to you of the complaint of chest pain, "Not radiating down arm, no worse on exertion, pulse 96, grey around mouth"?

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A "Grey around the mouth" would tell me that it was quite a severe pain. Shirley Hallmann was thinking that possibly it was not a full blown myocardial infarction in which case the pain might have referred down the arm or up into the jaw. "No worse on exertion", I do not know, she was thinking perhaps, was it musculoskeletal or a pulmonary embolus. This lady had suffered something fairly major cardiovascular wise.

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Q That was your view?

A That was my view.

Q In terms of this decision to start subcutaneous analgesia, there does not appear to be any mention of any kind of particular agitation. Why is midazolam appropriate to administer as well as the diamorphine?

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A Because she had been very anxious during the previous couple of nights. She did become very restless when she was short of breath, and I felt it was quite appropriate, in addition to treating with an opiate, to give an anxiolytic with it to relieve her symptoms. She was now in the terminal phase.

Q Are we talking about palliative care with subcutaneous analgesia or are we in this case talking about end of life care?

A We are now talking about end of life care.

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Q Is that a decision you yourself would have been making in your head at the time?

A Yes.

Q Would you have communicated that to the nursing staff in the ordinary course of events?

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A I would, and I would have attempted, or we would have made an attempt, to contact the family to tell them that this had happened.

Q We can see what happened on the following day. I will come to that, but I would like you to deal with this. Why not make a note of some sort in the clinical notes as to that change in terms of her treatment and care?

A Again, the necessity to be chairing a meeting in another part of the building five minutes ago, I left writing up the encounter rather than examining the patient and making sure that she was comfortable.

H

A

Q So, there would have been an examination if you are right in your feeling that you were there in fact, albeit not coming in to see her specifically?
A Yes.

Q We can see what the drug charts indicate. Oramorph had been administered in the early hours of that morning also at 11.50. The diamorphine and midazolam are started at 4 o'clock in the afternoon, so there had been some kind of assessment by you?

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A Yes.

Q Professor Ford indicated that he thought it would have been appropriate to get a chest X-ray, consider pulmonary embolism and in his view the dose of diamorphine was excessive and no clear indication for midazolam. What do you say as to the suggestion that there should have been a chest X-ray?
A It would have been very uncomfortable and alarming for this lady to have been

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wheeled down to the X-ray department. We did not have a portable machine. The chest X-ray was not going to add anything to my clinical judgment of what had happened to her and how I was going to look after her. Her pulmonary embolus would not have made any difference to my management of her, neither would congestive cardiac failure.

Q Can you tell us why pulmonary embolism would not have made any difference to your management of this patient?

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A Because I was not going to anticoagulate her.

Q We move to the following day, Thursday 20 August:

> "Condition appears to have deteriorated overnight. Driver recharged 10.10. Family informed of condition.

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> Night: General condition continues to deteriorate. Very bubbly. Suction attempted without success. Position changed frequently. Ruby rousable and distressed when moved. Syringe driver recharged at 7.35am."

Which was obviously the first the following day. What about the suggestion that, in fact, her deterioration was brought by the administration of the diamorphine and midazolam. What would you say to that?

F

A I would say her deterioration was caused by the underlying reason that she had gone into heart failure.

Q Obviously it appears that she was rousable and distressed when moved. If we look over the page, in terms of any drug administration on that day, the diamorphine remains the same, the midazolam remains the same, hyoscine is added. Why is that?
A Because she is now very bubbly and we want to relieve the discomfort and distress of

G

have excess secretions in her mouth and the back of her throat.

Q Would that be something where the nursing staff would have to ask you whether to start the hyoscine or would, in the ordinary course of events, would they, or were they free to, start it if they felt it was necessary?
A They were free to start it if they felt it was appropriate.

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A

Q That was started at the same time, as we have seen, 9.15 that morning. Would you have seen this patient again on the Thursday, assuming that you did an ordinary visit in the morning?
A Yes.

Q With a patient on a syringe driver, you would always see the patient?
A Yes.

B

Q Although there is no record, that, in the ordinary course of events, is what you would have done?
A Yes.

Q The following day, the Friday, the diamorphine is increased from 20mg to 60mg, so it is trebled, the midazolam is also increased from 20mg to 60mg, so it, too, is trebled. The hyoscine is doubled from 400mcg – sorry, it had been increased to 800mcg the day before. The hyoscine remains the same as it had been the latter part of the previous day. Why triple the doses of diamorphine and morphine?

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A Because there is a step in between if you look on the previous chronology. The syringe driver was changed. Having initially been put up at 9.15, it was changed at 16.50 to reflect an increase to 40mg and 40mg of diamorphine and midazolam.

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Q Hold on, I have lost you in terms of what you are referring to?
A The top section of page 18, the drug charts indicate diamorphine increased to 40mg at 16.50, which is a perfectly appropriate doubling of the existing dose in the syringe driver, and exactly the same thing with the midazolam, 20mg put up to 40mg.

Q The previous day the diamorphine and the midazolam had been doubled. It is my misreading of the drug chart information there?

E

A Yes.

Q Why would that have been done?
A Because her symptoms were not appropriately controlled by the 20 and 20, a reassessment had been made of her and an increase started.

Q Would that have been something your nursing staff in the ordinary course of events would have checked with you?

F

A Yes.

Q Did they have authority in such a circumstance to double the dose without checking with you?
A If they could not find me, yes, but I would have agreed in this case that that was perfectly appropriate to do that having seen her in the morning.

G

Q Were your nursing staff in the habit of increasing doses of subcutaneous analgesia without a good reason in your experience?
A Never.

Q I ask the same question of you because it has been suggested that there is no good reason for increasing the doses in this way. Were you in the habit of authorising or prescribing the increased doses unless there was a good reason in your mind?

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A

A Never.

Q Mr Jenkins reminds me we have looked at these particular prescriptions showing it had gone up from 20 to 40 and from 40 to 60, so it is not a tripling from the previous day?
A A three-fold jump, no, it is a logical increase owing to the increase in her symptoms.

Q What about the consideration that this increase in the diamorphine and midazolam, first 20 to 40 then 40 to 60 over a period of two days, was in fact going to bring about over sedation and respiratory depression?
A She was not over sedated because she was rousable and distressed when moved and when having her position changed, so she was definitely not deeply unconscious, she was just comfortable.

B

Q On Friday 21, looking at that last drug chart picture, the increases from 40 to 60 in the case of diamorphine and midazolam and the maintenance of hyoscine at the same level as the previous afternoon, would that have been a day when you, yourself, would have reviewed this patient in the ordinary course of events?
A Yes.

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Q I appreciate you cannot specifically remember, but you would, if you had done a visit on the Friday morning, have seen this patient?
A Yes.

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Q It being 7.35, does that help you at all as to whether you would have specifically authorised that increase?
A They would have been just drawing up and changing the syringe driver as I arrived on the ward and I would have been happy to sanction that dosage to continue.

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Q If that is right in terms of the ordinary course of events, the nursing staff have told you that in their view ---
A She was still uncomfortable overnight.

Q --- they were thinking it was appropriate to increase the dose?
A I would have sanctioned that.

F

Q Then we can see it says:

> "Condition continued to deteriorate slowly. All care continued. Family present all afternoon."

This lady died at just about half past six in the early evening. Once again, you have heard the criticisms in relation to this patient of Professor Ford. Does that give you cause to review or question your own actions in relation to that patient?
A Not at all.

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MR LANGDALE: That is all I want to ask about Patient F. Thank you.

Sir, I can start on Patient G. I do not know what time the Panel is thinking of sitting until?

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THE CHAIRMAN: I think you had indicated yesterday that we would go on to 1.30.

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MR LANGDALE: I think in those circumstances, I know that everybody is anxious not to lose some time unnecessarily but it is only five minutes to go. It may be just to pick up a few preliminary matters I do not think is going to help anybody.

THE CHAIRMAN: Very well. We will break here and resume at 9.30 on Monday.

MR LANGDALE: Thank you.

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THE CHAIRMAN: Thank you very much, ladies and gentlemen.

(The Panel adjourned until 9.30 a.m. on Monday 20 July 2009)

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