GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 21 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-NINE)

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

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

(Transcript of the shorthand notes of T. A. Reed & Co Ltd.
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A THE CHAIRMAN: Good morning everybody. Welcome back. Mr Kark, before we begin, can I for the record indicate that our Panel Secretary, Christine Challis, will be away for a couple of weeks and in that time we are going to be looked after by Lola Babatunde? Thank you.

JANE ANN BARTON, Re-called
Cross-examined by MR KARK, Continued

B MR KARK: Dr Barton, I was going to turn to the issue of note making and I was going to be quite short about it because you have already made admissions in relation to those charges. May I ask you this? When did you first recognise that your note making was a problem? When did you first realise that you had insufficient time to make proper notes?
A I imagine that it started to become apparent to me after the first complaint made by the family in 1998, which resulted in a police inquiry in the year 2000.

C Q Up until then you had not been aware that you had been making inadequate notes, is that right?
A I had not given it thought, otherwise obviously I would have attempted to address the problems sooner.

Q And you would have been well aware, in broad terms at least, that good medical
D practice required you to keep – I am going to read it out. It is at the back of our folder, Bundle 1 and you perhaps do not need to turn it up unless you want to. It provides,

> "In providing care you must keep clear, accurate and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed".

E You accept, I think, that there were significant failings in your note making. Is that right?
A Entirely.

Q In some cases we have heard the patients arrived at your hospital without the previous hospital notes. Can I suggest to you that more often than not you did have the relevant notes for the patient and it was a small minority of patients where you did not have the previous hospital notes?
F A Obviously at this remove of time I am unable to give you a percentage, but I would say that probably 75 per cent, everything arrived in order and with the correct x-rays and notes, and possibly 25 per cent meant that the transmitting hospital had to be contacted and they had to be asked for any relevant notes, drug charts and x-rays.

Q Where you did not have the previous hospital notes, it would make it even more important, would it not, to perform a proper and accurate assessment and make a note of it?
G A Yes.

Q It would be important to record the patient's current condition, symptoms and signs, previous diagnosis and a plan of treatment.
A Yes.

Q So far as assessment of these patients is concerned, the initial assessment would not
H usually be done as part of your normal ward round, would it?

A A The patients tended to arrive at lunch time, or unfortunately sometimes later on in the day, so that too much time would have elapsed to wait to clerk those patients in until the following morning, even if I had had time in that hour and a half to do a full clerking.

Q So you would return, as you told us, at lunch to do that.
A And sometimes later in the day to do that.

B Q When you talk about a "clerking in", would that also mean an assessment of the patient's condition?
A Yes.

Q When you were assessing a patient's condition, are you telling this Panel now that you would have done a full examination in each case?
A I am.

C Q So in every case we have looked at, you would have performed a full and proper examination?
A Except for two of them, one of whom I had watched Dr Lord examine him in the day hospital, and there was one gentleman who had been clerked in by Dr Ravi.

Q Absolutely right.
D A So there are two that I did not actually perform the initial assessment on.

Q But in relation to the other 10, when you clerked them in you would have performed a proper examination.
A Yes.

MR LANGDALE: Just while we are on the figures, may I remind my friend that there is one
E other of course that Dr X clerked in. Just so we know.

MR KARK: My learned friend is quite right. I am grateful for the correction. Can you just help us, please, with what your practice was in making a full examination of a patient and assessing their condition? What would you actually go through?
A The same formula that you had done since being a medical student, since being a house officer: examine the patient at the side of the bed; look at their general condition and
F then go through a system examination, albeit brief in some areas.

Q If you were aware that a patient had, for example, had a hip operation, would you have examined the wound site?
A If it was uncovered. Obviously I would not have asked the nurses to take the dressing down at that point in time, but I would have made myself available to look at it at another time if it was appropriate.

G Q You would also expect blood pressure to be checked?
A Yes.

Q Heart rate to be checked?
A Yes.

H

A Q And you would have performed an examination of the chest and the lungs?
A Yes. I would have a nurse with me to help me sit the patient up or roll them over in order to examine the back of the chest, having listened to the front of the chest.

Q Again, we will look at our individual patients as we go through them and the notes that you made, but do you accept that you failed to make a note on those patients where you did clerk them in, of that examination?
B A Yes.

Q If you were assessing a patient on a course of palliative care, would that minimise the necessity to make a full note?
A No.

Q If you were assessing a patient on a course of palliative care, it would be all the more
C necessary, would it not, to make a note of that decision and why it was made?
A I agree.

Q Can you turn to the 1991 issues raised by some of the nurses, please? These events back in 1991 – and we will look at the notes in a moment – must have caused you considerable concern.
A Yes.
D

Q You appreciate, I expect, that the matters raised first in July 1991 almost mirror the issues which have arisen in the cases that this Panel is examining? Do you want to have a look at them before you answer that question? Let us go to File 1, Tab 6, page 2.
A I think the issues were quite different in 1991. The issues were difficulties between existing night staff and a new day sister, and attitudes towards care of patients at the end of their lives.
E

Q Let us have a look at the concerns that were being expressed and see whether or not they are relevant to the issues that this Panel are now considering? Do you have page 2?
A I do.

Q The following concerns were expressed and discussed:

F "1. Not all patients given diamorphine have pain".

That is an issue that has been raised in this case, is it not?
A I agree.

Q "2. No other forms of analgesia are considered, and the 'sliding scale' for analgesia is never used".
G A I disagree.

Q Let me ask you the question. The issue of the sliding scale not being properly used is certainly an issue in this case, is it not?
A I agree.

Q "The drug regime is used indiscriminately, each patient's individual needs are not
H considered".

A

Do you accept that that is an issue that has been raised in this case?
A I do not agree.

Q Why not?
A Because my drug regime was not used indiscriminately. It was used perfectly
B appropriately in these 12 cases that we are looking at.

Q I understand that that is your case. But you understand that the suggestion is being made to you that in some cases people were being put on opiates quite unnecessarily. You understand that that is part of the case against you?
A Yes.

C Q "4. That patients' deaths are sometimes hastened unnecessarily".

That is an issue that has been raised in this case, is it not?
A I agree.

Q "5. The use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting dose to suit patients' needs".

D

It has not been expressed in exactly those terms in this case, but there is the suggestion that once a patient was on a syringe driver, of the 12 that we have looked at, it was never reduced or adjusted down.
A Except in one case.

Q We will look at that.

E

"6. That too high a degree of unresponsiveness from the patients was sought at times".

You appreciate in this case that the allegation is that some patients were so over-dosed that they become wholly unresponsive, unconscious; yes?
A I do not agree with the fact that they became unconscious and unresponsive purely
F because of the dosage of the drugs.

Q Those issues were raised, and others, back in 1991, and you presumably were alerted to those quite quickly. Yes?
A I was aware that there was concern raised by the night staff.

Q Did you become aware that what the nurses' representatives wanted was a written
G policy?
A Not at that time. I thought that the issue had been resolved by Mrs Evans and the management team. It was only when one of the night staff was attending a course at Portsmouth University and came in contact with the Clinical Tutor, Gerry Whitney, that it became apparent that their concerns had not been fully addressed and the issue raised its head again.

H Q These concerns bubbled on into December 1991, did they not?

A A Yes.

Q We can see if we go to page 18 of this section of the file that here is somebody called Keith Murray, Branch Convenor for the Royal College of Nursing, writing to Beverley Turnbull saying,

> "I think I have made it quite clear that unless you receive confirmation at your
B meeting that a policy will be drawn up which addresses all of the concerns that you first brought to Mrs Evans' attention back in July then a grievance will be lodged".

I have to confess that I am not quite clear what the significance of a grievance being lodged is.
A I was not at that time aware of that letter or what he was intending to do or not to do. That letter was not copied to me.
C

Q Were you aware that some of the nurses at least, and those representing them, wanted a written policy?
A No.

Q If we go to page 23, we can see that on 17 December 1991 you were present at a meeting with Mrs Evans, Dr Logan and a number of the nurses. Yes?
D A Yes.

Q And none of the nurses in fact spoke out, did they?
A No.

Q If we go on to page 25, we can see just a summary of the comments raised during the discussion. All staff had great respect for you; did not question your professional judgment.
E The night staff present did not feel that their opinions of patients' conditions were considered before prescribing of diamorphine. The patients were not always comfortable during the day even if they had slept during the night. There appeared to be a lack of communication causing some of the problems. Some staff feared that it was becoming routine to prescribe diamorphine to patients that were dying, regardless of their symptoms. All staff agreed that if they had concerns in future relating to prescribing of drugs, they would approach Dr Barton or Sister Hamblin in the first instance".
F A Staff were asked if they felt there was any need for a policy relating to nursing practice on this issue. No one present felt that this was appropriate.

Q So far as you were concerned, did that resolve the issues that had been raised?
A I felt that the majority of the night staff were much more comfortable about how decisions about end of life care were being made on the unit and how they were to be involved in those, if at all possible.
G

Q When we heard from some of the nurses who described how their understanding and perception changed, but the practice did not appear to, would you agree with that?
A Because the practice was appropriate and they now understood what the practice was and what it was aiming to achieve.

Q The practice did not change one jot, did it?
H A No.

A

Q As a result of these concerns raised in 1991.
A No. If opiates were appropriate at the end of life, they were given to patients.

Q The answer is, I think, that you agree that the practice did not change one jot.
A Yes.

B

Q Mrs Hallman, in 1999, had a meeting with you, when she came to speak with you because she had been told by Sister Hamblin that she had upset you in some way, and she reported that you said to her, "You do not understand what we do". First of all, I expect you remember that piece of evidence.
A I have a vague recollection of the incident and I have the evidence here in front of me. What I meant by "You do not understand what we do here", was that I felt that Shirley was

C

quite inexperienced in palliative and terminal care. She freely admitted that, that the unit she had worked in previously did not do palliative and terminal care in the same way that we did. I felt that a move back to Queen Alexandra would allow her to receive some training in how to become more proficient in this. It was not an attempt to get rid of her, or belittle her or reduce her grade so that she earned less money. It was a genuine attempt to help her increase her experience in the job that she was doing, and I think that she chose to misunderstand what I said.

D

Q First of all, I just want to establish with you that those were the words that you used, "You do not understand what we do here".
A I have no recollection at this distance of time what the actual words were, but the sense of the words sounds correct.

Q What you were saying to her in effect was that she did not understand appropriate

E

palliative care?
A She was inexperienced in appropriate palliative care, yes.

Q Before we turn to the individual patients, can I just also put this to you. Do you accept that some people are prepared to live with a degree of discomfort or pain provided they are allowed to stay alive?
A I beg your pardon!

F

Q Do you accept that some people would prefer to live with a degree of pain or discomfort provided they are allowed to remain alive?
A What an extraordinary question.

Q Could you answer it.
A Are you suggesting that in any of these twelve cases I was instrumental in ending

G

these people's lives?

Q Well, we will come ---
A All these people were dying from the various conditions from which they suffered, and the management that I gave them was palliative and then terminal care for the conditions which killed them. In no way did I contribute to their deaths.

H

Q Do you agree that some people are prepared to live with a degree of pain?

A A I am just completely flawed by that question.

Q It is not a complicated one, Dr Barton. We know that in one case at least, one of the relatives wanted you to reduce the dose, to discover whether his step-father in fact wanted to remain conscious as opposed to dying in effectively the state of a coma, and I want to ask you: do you accept that some people are prepared ---

A That was not Mr Cunningham's choice. That was Mr Farthing, his step-son's, choice, B who was not his next of kin and who I did not feel that it was appropriate to even ask that question of a dying relative.

Q I understand that is your evidence. Do you accept – I will ask for a final time – that some people are prepared to live with a degree of pain?

A Yes.

C Q You were interviewed in 2005, I think it was, and in fact earlier in 2000, by the police. Yes?

A Yes.

Q You were interviewed over many, many, many hours and days. Yes?

A Yes.

D Q And you chose to answer none of their questions?

A Not on the first occasion. I prepared statements for the police and I felt, under legal advice, that that was the most appropriate way to answer the allegations, by carefully thought-out, prepared written statements.

Q Those statements which you described as being carefully thought out, and I am not going to disagree with you for a moment about that, were they made – and I do not want to E know what advice you actually received – but were they created with the assistance of a solicitor?

A They were created by me.

Q Yes. Were they put to your solicitor before they were handed over to the police?

A They were seen by my solicitor before they were handed over to the police, yes.

F Q Can we take it that you put into those statements everything that you could then remember after having had access to the notes?

A You can. I did.

Q And you did not, and would not have, deliberately left anything out?

A Not at all.

G Q And can we take it that your recollection when you made those statements would, if anything, be slightly better than your recollection now?

A Possibly. It was still a couple of years later. It was still quite difficult to remember, particularly confrontations with relatives.

Q But so far as a patient's condition is concerned, can we take it that you put everything into your police statements that you possibly could remember?

H A I did.

A

Q Can we turn then, please, to Patient A, Mr Pittock. You will need the chronology. You can have his notes as well if you want to, of course. Just to remind you in relation to this patient, you told the police that you had now no real recollection of him?
A Yes.

Q And your comments thereafter in your statement – and I am looking at your paragraph
B 15 – were all based on comments such as "I believe that I would have"?
A Yes.

Q "I would have", "I anticipate that"?
A Yes.

Q All of which reflect that you could not – and I am not criticising you for this – but all
C of that reflects that you could not actually remember the patient. Yes?
A Yes.

Q Can we just have a quick look at this patient's admission. I am going to avoid as much as I can going right back through all of the notes, but could we start, please, on the chronology at page 9. This is the day before his admission. He was reviewed by Dr Lord, who made a note that he was suffering from:

D

> "Chronic resistant depression. Very withdrawn. Completely dependent – Barthel 0. Superficial ulceration of left buttock and hip. Hypoproteinaemia. Suggests high-protein drinks and bladder wash-out of hours. Happy to take him to GWMH. RH [rest home] place can be given up as unlikely to return there.
>
> All nursing care given."

E

Can we just pause for a moment. Dr Lord was suggesting that he needed bladder wash-outs. Yes?
A Because he had an indwelling catheter by this time.

Q Was that something that could be performed at the GWMH?
A Certainly.

F

Q And high-protein drinks. Those could be given?
A They could be ordered from the kitchen, yes. Those were both nursing duties to organise for the patient when he arrived on the ward.

Q Yes. If we look below in the correspondence, we see that there is, I think, a transfer letter:

G

> "Has recovered from recent chest infection, but is completely dependent with Barthel of 0. Eating very little, but will drink moderate amounts with encouragement. Overall prognosis poor. Happy to arrange transfer to Dryad Ward."

Dr Lord told us that she would not have transferred any of her patients unless they were sufficiently stable for her to do so.
H A Yes.

A

Q Can we look at what happened to him on admission. You made a brief summary of his conditions. Can I just ask you this. You recorded no plan and no mention of the high protein diet?
A That was a nursing procedure which the nurses taken from the transfer letter and organised. It was not necessary for me to set that up.

B Q Then, if we can read on, he is given Arthrotec. Then if we go to the bottom of page 12, please, of the chronology, he is reviewed there by Dr Tandy, who records that he is depressed, catheterised, he had superficial ulcers and a Barthel of zero. Professor Ford described this gentleman as nearing the end of his life.

"Will eat and drink. For TLC [tender loving care]."

C A Yes.

Q Over the page, we can see that he was seen by you and Dr Tandy.

"To commence Oramorph 4 hourly this evening."

Can we also look at the next prescription that you wrote after the Oramorph: diamorphine,
D 40-80 mg. Yes?
A Yes.

Q I am sorry. And midazolam, of course, 20-40 mg. Up until that day this patient, I do not think, had taken any form of morphine at all, had he?
A No.

E Q He was not, in fact, at this time, recorded as complaining of pain other than, as we see at the top of page 12, saying that he has generalised pain. Yes?
A Yes.

Q And Professor Ford described the use of Oramorph as appropriate, but I want to look at the level of diamorphine that you prescribed.
A Yes.
F

Q This is the first one of these prescriptions, so we are going to have to look at it in a little more detail that we will, perhaps, later on. The purpose of these prescriptions was, as we understand it, to allow the nurses to initiate, if it was necessary, diamorphine and midazolam at the lowest level. Yes?
A Yes.

G Q Once you have written a prescription like this out, it allows the nurses to initiate it at any stage that they feel right?
A Yes.

Q It allows them to initiate the dose either at the minimum dose, or at any dose along the range?
A Yes.
H

A Q The minimum dose in this case would have been – was – 40 mg of diamorphine?
A Yes.

Q Which would have been the equivalent of 120 mg orally?
A By your calculations, using a third, yes.

Q It is not my calculations, no. It is the BNF's calculations.
B A Right.

Q And the Wessex Handbook's calculations. It is not my calculations. The equivalent on the BNF calculation would be 120 mg orally, would it not?
A Yes.

Q What would you expect would happen to this patient if the nurses started him on that
C day with 40 mg diamorphine?
A If he had been in quite an appreciable amount of distress and psychological pain and some physical pain, I hope that it would have relieved his symptoms.

Q Would you have expected it to have a profoundly depressing effect on his vital systems?
A It was possible, but it is in individual judgment looking at a particular patient how
D they are going to respond to the opiates and anxiolytics and what dose to try for them. At this point in his life, he had left the palliative care pathway, for which you are given guidelines by the BNF and Wessex Handbook. He had entered the terminal care pathway. He needed sufficient analgesia to keep him comfortable, and the estimation of the amount of drug you are going to use would be made by looking at the patient, standing at the bedside, nursing him, tending to him, seeing him, not from a handbook or a BNF.

E Q Did you take into account when you wrote out this prescription the Oramorph prescription that you were writing at the same time? In other words, were you presuming that the patient would have started on Oramorph before he started on the syringe driver?
A I was assuming that he would use the oral route if it was appropriate, and he could manage it.

Q You see, if that had happened, let us just look at what you were prescribing on that
F day, but looking at the Oramorph first of all. Five milligrams five times daily obviously would be 25 mg. Yes?
A Yes.

Q Your prescription for diamorphine, was it predicated on the basis that he might require the whole of that Oramorph dose?
A Yes.
G

Q And he would require it because of the degree of pain that he would be in?
A Yes.

Q Presumably it would also be predicated on the basis that he was in such pain that he required subcutaneous drugs to relieve it, or he was unable to swallow?
A Yes.
H

Q And that by the time the syringe driver would be used, he would require a substantial increase from 25 mg orally?
A Yes.

Q And that such an increase would be at a minimum level of at least four times what he had been receiving?
A Yes. And that was on clinical assessment of the patient.

Q Yes.
A And the severity of the bed sores, and the degree of rigidity and immobility of the patient, and the mental anguish of his ongoing depression and withdrawal.

Q Where, please, have you ever red that it is acceptable to start a patient on a subcutaneous dose which is four times the previous dose that they had received?
A It is not written in guidelines, but you do it on the assessment of the patient, not what you read in the text book.

Q Let us not worry about the guidelines for a moment. Have you read any report, any proper piece of research anywhere, that would justify that approach?
A I think it would be very difficult to perform research on patients at the end of their life, as this man was. I think it would be very difficult to do double-blind trials and cross-over trials. This man was dying.

Q At the time that you wrote this prescription you had never read anything that could conceivably support it, had you?
A No.

Q And if in fact the nurses had gone up to 80 mg, that would have been an eightfold increase, would it not?
A Certainly.

Q Why to that did you feel the necessity to add midazolam?
A Because of its anxiolytic properties, because of its preventing terminal restlessness, because he was on antipsychotic drugs before he went on to the syringe driver and I wanted those symptoms controlled by the midazolam.

Q You would appreciate, would you not, as you have already told us, I think, that to add midazolam to diamorphine would substantially increase the level of sedation?
A I would.

Q Can we look at what actually happened to this patient? He was given Oramorph on the day that you prescribed it, on 10 January, and he was given, I think, 5 mg at night. Yes?
A Yes.

Q Let us go over the page to page 14. During the day, from 6 o'clock in the morning of 11 January, he was given first of all a dose of 5 mg, and then three further doses of 5 mg – that is 20 mg – and then 10 mg administered at 20.00 hours. Yes?
A Yes.

A Q So he is getting 30 mg a day?
A Yes. The equivalent of eight co-proxamol tablets on the second layer of the ladder.

Q On that second day, before he had even started his first syringe driver of a minimum dose of 40 to 80, you doubled the minimum dose.
A Yes.

B Q In evidence you told the Panel that you did so, as I understand it, because of the intensity and depth of his pain, his rigidity and discomfort.
A And mental distress.

Q Do you now remember that?
A I have told you that I do not actually remember the case, but that is what I would have done faced with that situation with that man dying.

C Q What you actually said in your police statement at paragraph 23 was this:

"I would have been concerned, although it was not necessary to administer the medication at that stage, Mr Pittock's pain, anxiety and distress might develop significantly".

D A Yes.

Q "And that appropriate medication should be available to relieve this if necessary". Yes?
A Yes.

E Q There is no indication there that his pain, anxiety and distress had in fact increased; it was simply a feeling by you that it might.
A It was.

Q That is not the same as saying that you did that because of the intensity and depth of his pain, his rigidity and discomfort is it?
A It is anticipating these symptoms.

F Q So you were anticipating the depth of his pain, his rigidity and discomfort?
A Yes.

Q You thought those things might happen, but actually they had not?
A They had not at that moment in time, no.

G Q What had changed between 10 January and 11 January which caused you to double the minimum dose?
A I had made a further medical assessment of him.

Q Had you?
A On the Friday morning.

H Q Why do you say that?

A A Because I went in every morning and I would be looking at him and how his condition had changed since my previous examination of him.

Q If, in fact, he was not displaying pain rigidity and discomfort, why would you feel the need to double the dose? Nothing had happened.
A Yet.

B Q You felt it appropriate to give him a minimum starting point of 80 mg of diamorphine and let us not forget midazolam which you also doubled.
A Yes.

Q This is a man who was then on 30 mg of Oramorph.
A Yes, and I relied on the nursing staff reporting to me that at that moment in time he did not need any more than that 30mg of Oramorph.

C Q An exact equivalent dose subcutaneously would have been 10mg, a slight increase would have been 50 mg of diamorphine.
A Yes.

Q This now before he started the syringe driver at all is an eight-fold increase is it not?
A Yes.

D Q Have you read anywhere that that sort of increase is in fact appropriate and justified?
A No.

Q You said that with a sense of astonishment.
A No, I say it with a sense of perfect honesty. I have never seen it written down how somebody not standing at the patient's bedside can make an assessment of what level of

E analgesia and anxiolytic treatment they are going to need as they approach death. Guidelines are fine.

Q You have relied on this, Dr Barton, on a number of occasions.
A I have.

Q As have your representatives, that it is crucial to stand by the bedside. Yes?

F A It is.

Q Do you think that the editors of the BNF and those who wrote the Wessex Guidelines had never stood at a patient's bedside?
A I sometimes wondered.

Q The guidelines would have been based on the treatment of patients suffering pain

G would they not?
A Yes.

Q Doctors standing by the bedside watching patients in pain and prescribing to them.
A Yes.

Q To deal with pain.

H A Yes.

A

Q No doctor wants to see his patient in pain.
A No.

Q You must have known that the Wessex Guidelines - because you apparently wrote something, I cannot now remember what you did for the Wessex Guidelines - you knew that the Wessex Guidelines ---
B A Very appropriate in palliative care, not always appropriate when dealing with an individual patient requiring terminal care, dying.

Q Help us with that, palliation ---
A [Palliation] is the relief of symptoms that you know are possibly not going to be curative but are going to make the patient comfortable. This is at the far end of the process. This is all systems shutting down, the patient in front of you dying.
C

Q Doctor, at this stage this patient was not, unless you failed to note it, displaying great symptoms of pain was he?
A I was minded that it quite possibly would be necessary and not very long in the future judging by his condition.

Q Can we take it that if you had the palliative care hand book in your pocket at the time
D that you wrote out this prescription you did not look at it?
A No.

Q Because if you had, you would not have written out this prescription.
A I would have written exactly the same prescription whether or not I had consulted the little green book.

E Q Was there any point in keeping the little green book in your pocket?
A It was very useful for doses of other drugs that I was not particularly familiar with, rather than the drugs that I used most regularly.

Q The section on palliative care using opiates and the section in the BNF on the use of opiates you might as well just have ripped out and thrown away because you were not looking at those were you?
F A Not on this particular occasion, no.

Q Let us look at what happened to the patient. On page 15, we are now on 15 January, his catheter had been bypassing and the patient is described as being in distress. A catheter bypassing can be very unpleasant, I expect, for a patient.
A I imagine that the distress she was referring to was not just caused by the fact that his catheter was leaking. He was in general distress and I actually saw him that morning.
G

Q On 15 January, you instituted a syringe driver.
A I did.

Q Up until this point, he had been on 30mg orally a day.
A He had.

H

A Q From 11 January?
A And he had not been assessed over the weekend.

Q When you say he had not been assessed over the weekend?
A The 15 January was a Monday morning, so I would have come back from the weekend and been appalled at the condition that he was in.

B Q You then instituted a syringe driver.
A Yes.

Q You now had the opportunity not just of following your own prescription but you could have written out a completely new prescription, could you not, to deal with a patient's symptoms then?
A I could.

C Q We know that you did not do so because there is no further prescription; we are still relying on the prescription that you wrote out on 11 January. Yes?
A Yes.

Q Let us imagine for a moment that we are going to use the guidelines. The patient is on 15mg equivalent, but you want to increase it because the patient is in pain and distress. Yes?
D A Yes.

Q If you want to increase it, because a measure of flexibility is allowed within the palliative care guidelines and the BNF, instead of reducing it by a third, you could reduce the oral dose by half when converting it. Yes?
A Yes.

E Q That would give you 15mg with an increase in pain relief.
A Yes.

Q Can you just tell us your thinking when you decided to give this patient five times more than that?
A Because that was the dose that he needed.

F Q How did you assess that?
A By assessing his clinical state that morning.

Q It is extremely unfortunate, I expect you would agree, that you made no note whatever about it.
A Yes.

G Q If the patient had deteriorated to that extent, that is something, undoubtedly, you should have made a note about is it not?
A Yes.

Q Did you use the concept of titration at all for this patient?
A No.

H

Q The nursing staff, who you have roundly praised and told us that you relied on, had in their patient notes a prescription from you over that weekend for a syringe driver to instituted.
A Yes.

Q There was absolutely no reason why, either on the Saturday or the Sunday, if the patient's distress was such that it was felt to be needed, they could not institute that syringe driver was there?
A None at all.

Q Do you know why they did not?
A I have no idea.

Q It rather makes your anticipatory prescribing slightly pointless in this case does it not? The patient is apparently reduced to great pain and distress, such that by the Monday morning you have to give him what I am going to describe, frankly, as a huge dose of diamorphine and midazolam and the nurses have not done anything about it.
A I cannot comment on what happened over the weekend. I can only tell you what I saw at 7.30 that Monday morning.

Q The dose was started at 8.25 in the morning and by the afternoon/evening he was unresponsive. Yes?
A Yes. You would expect that as the initial level began to build up that there would be a period possibly of reduced consciousness. By the next day some agitation noticed when being attended to.

Q What does that actually mean.
A He did not like being turned, nursed or washed or his dressings changed on his sacral ulcers, although if he was left alone he was probably reasonably comfortable on that level of analgesia.

Q When he was being moved, you say he exhibited some distress, presumably through pain?
A Yes.

Q Why did you choose haloperidol to add to the mixture?
A Because it is an antipsychotic and I thought that the agitation that he was showing might have been part of his depression and dementia and that that would be a better approach to controlling his symptoms than increasing the diamorphine at that point in time.

Q If patient is unconscious ---
A Well he was not.

Q Why do you say that?
A Some agitation was noticed when being attended to; he was not unconscious.

Q Are you saying that some agitation means that he was responsive in speaking?
A He was responsive. I do not say he was speaking.

A Q I do not think we have put haloperidol into the section in our file from the BNF. May I pass a copy of it please to you and also to the Panel. (Same handed) There are two pages that need to go in and I will ask your Panel assistant to pass them out.

THE CHAIRMAN: These are to go into Panel volume 1 behind tab 3. Would you like to indicate a page positioning for them, Mr Kark?

B MR KARK: We might as well put them at the back after co-codamol. I have not paginated these. It would be 52 and 53. We added co-codamol a couple of weeks ago and that is page 51.

THE CHAIRMAN: We did add a co-dydramol reference and we put that in at page 51. We will mark these pages 52 and 53.

C MR KARK: Do you have that, Dr Barton?
A I do.

Q I am putting it because I think it is appropriate that we have this available to us. We can see that it is for schizophrenia and other psychoses, mania, short-term adjunctive management of psychomotor agitation, excitement and violent/or dangerously impulsive ---
A These are all indications by mouth; I was not using it orally. You do not have the
D subcutaneous indication in there. It will be in the palliative care hand book.

Q I have copied the wrong bit. You can put that aside. I will find the right bit and we will come back to it. Let us go back to the chronology. At page 16, Mr Pittock is now on a syringe driver with 80mg of diamorphine, 60mg of midazolam and 5mg of haloperidol. Would you expect his level of consciousness to be much reduced?
A No.
E
Q Why not?
A Not with haloperidol. It was not very sedating.

Q Diamorphine and midazolam at those levels would reduce his conscious level considerably, would it not?
A It would.
F
Q Can we go to the following day, the 17th first of all, the diamorphine has now been increased by 50 per cent. Yes?
A Yes

Q The midazolam has been increased by slightly less than 50 per cent. The haloperidol has been quadrupled.
G A Yes.

Q Can we take it that you cannot now remember your thinking behind that prescription?
A I was aiming for a balance of the different drugs I was using to keep him as comfortable as possible.

Q If we go on through page 20, I think that remains as it was before, and page 21 we can
H see that on 20 January he was on 120 mg of diamorphine, 80 mg of midazolam. The

haloperidol was discontinued, but he was now on Nozinan. The Nozinan you had added, I think, on the 18th.
A Yes, on the Friday.

Q The Nozinan was to do what?
A That is a much more sedating, anxyolitic anti-psychotic.

Q That would have what?
A Stopped the restlessness and agitation.

Q It would have considerably increased his level of sedation, would it not?
A It would.

Q When Dr Briggs reviewed this patient, he would have been reviewing an unconscious, but apparently agitated patient.
A Yes.

Q You would not have expected him to review this patient's treatment overall, would you? You would not have expected him to go right back to the beginning of your prescriptions and review the entire programme, as it were.
A No, but I would have expected, if he felt there was anything inappropriate about any of the prescriptions, he was at liberty to change them.

Q Of course, all of the prescriptions that you wrote out and administered, you say were based upon your observation of the patient or on the nurse's observation of the patient.
A During that week, yes.

Q Can we just have a look at the charges together, please? Do you have those available to you?
A Yes.

Q Head of charge 2 is dealing with this patient. We can see what you have admitted and all of the administration of the drugs, of course, is admitted. Can we go down to (b)(i)? The suggestion is that,

> "the lowest doses prescribed of Diamorphine and Midazolam [on 11 and 15 January] were too high".

You do not accept that.
A Too high for what?

Q For the patient's condition at the time.
A The patient's condition required those levels of both those drugs as you can see from the fact that he continued to need increased dosages for several days afterwards.

Q Do you nevertheless accept that they were dramatically over any form of guideline that you could have been relying on?
A I do, but I still say that they are appropriate for that man in that condition on that day.

A Q On reflection, just thinking about the dose ranges, do you accept that an eight-fold increase, which would have been the top of your range, must have been too high?
A No.

Q You do admit that the prescription created a situation whereby drugs could be administered to Patient A which were excessive to his needs.
A Yes.

B Q On what basis do you admit that?
A That if one of my nurses had decided to institute the syringe driver at the dose of 200 mg of Diamorphine, that could have been excessive to his needs.

Q I think they could not, on these prescriptions, have started at 200, could they? But they could have started at 180 or 120 with Midazolam.
C A That is not considered to be appropriate for nurses to be able to prescribe that level of medication, although it was appropriate for me to prescribe that level, because I thought it was appropriate.

Q I just want to pause on the thinking behind that. You accept that prescriptions created a situation whereby drugs could be administered by the nurses which were excessive to his needs. Yes?
D A Yes.

Q Does that not mean that the dose range was too wide?
A Yes.

Q Can we look at (b)(ii) again? In relation to 2(a)(ii) and 2(a)(iii), it is alleged that the dose range was too wide. Do you now admit that that is so?
E A Yes.

Q Right. You do not accept that the doses of diamorphine administered to the patient on 15 and 17 were excessive to his needs.
A No.

Q Do you accept that your prescription described at paragraph 2(a)(vi), which was the
F addition of the Nozinan which you have just described, I think, as a strong sedative, effectively, in combination with the other drugs already prescribed, were excessive to the patient's needs?
A No. It did not work, but it was not excessive to his needs.

Q Then (e) charges you as follows,

G "Your actions in prescribing the drugs as described n paragraphs 2(a)(ii), (iii), (iv) and (v)" –

Just to remind ourselves, that is Oramorph and diamorphine 40 to 80 on 5 to 10 January, and then the prescription on 11 January, the diamorphine and midazolam, and then the prescription on 15 January, then on 17th and then on 18th, were inappropriate. That is the charge. That is the allegation. You accept that in relation to 2(a)(iii) at least, it was
H potentially hazardous. Yes?

A A Yes.

Q Again I just want to understand your thinking. If a prescription by you is potentially hazardous, and now you have admitted too wide, how can it be appropriate?
A It is not the same question. The starting dose that I gave him from the range I had written out, I felt was appropriate to that patient at that time.

B MR KARK: The stem of the charge reads,

"Your actions in prescribing the drugs as described".

MR LANGDALE: Sir, I feel I must interrupt because the question is being put on a basis which may possibly be confusing and may indeed run contrary to the evidence that has been heard by the Panel.

C

Going back to Charge 2(b)(ii), the dose range was too wide, that is something about which Professor Ford gave evidence. He said in relation to the dose range,
"If the starting dose was correct" -- in relation to Code A we are not talking about the 20 to 200 case – he said,

"If the starting dose was correct, then the dose range was not too wide".

D

In other words, if one goes, by way of illustration, to the prescription shown on the history at page 13, the dose range on that prescription, 40 to 80, was not too wide; in other words, if you prescribed a dose range at a level and the highest was simply double that level, that was not in itself too wide. Questions are being put to Dr Barton on the basis that the dose range was too wide in those circumstances, which Dr Barton's indication at the start of the case was that that was not correct. Similarly, when one looked at the diamorphine on 11th, the range
E was 80 to 120. If 80 was the correct starting dose, then 120 was not too wide a range, because it allowed for an increase.

So the evidence adduced by my learned friend from his own witness is not that the dose range was too wide. The criticism made by Professor Ford was that the starting point is too high.

So I think, sir, that these questions are running the risk of actually creating a confusion and
F possibly resulting in unclear answers, because it is very important – I say this by way of illustration in relation to 2(b)(iii),

"the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs".

That is the case if, for example, a nurse, given a range, wrongly started at the top of the range,
G when the patient's needs did not require it. That is the whole point about the "could be", in relation to these charges. We are running into the same problem in regard to the question of "potentially hazardous". I would like my friend to frame his questions, if he would, very carefully in terms of the evidence that we have heard and what the charge items actually say.

MR KARK: I am grateful for that reminder of Professor Ford's evidence, but this is now Dr Barton's evidence, and she may well admit charges, and she is entitled to admit charges if, on

H

A reflection, in her view, her doses – we have heard she was standing by the patient at times – were in fact too wide. She is perfectly entitled to admit that.

MR LANGDALE: What I am objecting to is my learned friend putting forward as part of his case something that his expert witness does not state. It is not Professor Ford's evidence, and therefore unless my learned friend is seeking to say that we ignore Professor Ford's evidence for these purposes, my learned friend should not be putting a case different to the one he has
B called through his own witness.

MR KARK: I am sorry, but Professor Ford's whole premise on this was that the starting dose was wrong in the first place. Dr Barton should not have been writing these prescriptions at all. If Dr Barton is going to give the evidence that her starting point is acceptable, she is still entitled to be asked, or I am still entitled to ask her, well, even on that premise, that the starting point is alright, if that is your evidence, Dr Barton, "Do you accept the range is too
C wide?" I will pursue that unless stopped. I think it is a perfectly legitimate point to put to her, but I will move on on a ruling.

THE CHAIRMAN: Before I turn to the Legal Assessor and ask for his view, I think what Mr Langdale was saying was that the evidence that Professor Ford had given was that "if", and he did not accept it, that starting dose had been correct, then it would follow from the doubling up principle that the range in this case would not necessarily have been too wide.
D He was concerned that the witness might inadvertently have been confused by these two different elements.

MR KARK: I do understand that. This is rather circular. I keep coming back to Professor Ford's starting point which is that we should not be starting from here anyway. Dr Barton is saying we should be starting from here and I want to ask her whether her view is that, if she is starting at that range, nevertheless in her view the dose is too wide. She has
E accepted that it was. Maybe a correction is now going to be forthcoming, but I do not think it is inadmissible to ask her, because the whole premise of Professor Ford's evidence was that this was wrong in the first place.

MR LANGDALE: May I make a suggestion to avoid what sometimes is quite properly put, but sometimes a little cumbersome when the Panel has to take advice from the Legal Assessor? This is not cloud cuckoo land. The witness has been sitting there and has heard
F what has been said. If my learned friend wants to put his questions in the circumstances, I think he can, but I made it clear that he must make it clear on what basis he is suggesting the range is too wide if it is contrary to his own main witness on the subject. I think we are going to be wasting time unless, my friend having considered what has been said, he rephrases his questions or proceeds in a way that he thinks is appropriate.

THE CHAIRMAN: I am grateful for that. I think the real point, Mr Kark, is that we need to
G avoid confusion at all costs. Even if the witness is not confused, the Panel may well be.

MR KARK: Certainly sir. Dr Barton, having heard that short interchange, do you want to go back to 2(b)(ii)?
A I was very confused about what you were trying to ask me. I do not agree that the lowest dose that I prescribed was too high, and I do not agree that the dose range that I prescribed on that chart was too wide.
H

A Q But you do accept that the prescription did create a situation whereby drugs could be administered which were in fact excessive to the patient's needs.
A Yes.

Q So far as that is concerned, you still stick by your guns, do you, that you say that these prescriptions were, nevertheless, in Patient A's – Mr Pittock's – best interests?
A They were.

B MR KARK: That is all I seek to ask you about Patient A. You have been giving evidence for an hour and a quarter and I expect a break would be good for both of us.

THE CHAIRMAN: Perhaps the business of the incorrect photocopying could be dealt with before we move on to the next patient.

C MR KARK: I will certainly try, sir.

THE CHAIRMAN: We will break now and return at five minutes past 11.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Yes, Mr Kark?

D MR KARK: We have been looking at haloperidol. Perhaps we could just flag this up in the Palliative Care Handbook which you referred to. Perhaps we should go to Tab 4 to see what it says about it. We can turn to page 15 of the file numbering and page 26 of the internal documents. The heading is, "Drugs used in the syringe driver". About half-way down the left hand column we see haloperidol. So this is obviously to be used by subcutaneous injection;

E "2.5 – 10 mg over 24 hours. Antidopaminergic".

A "Antidopaminergic antiemetic".

Q Which is what?
A Antiemetic is anti-sickness.

F Q That bit I understand.
A It is anti-the sorts of things you get in Parkinson's Disease, rigidity and stiffness.

Q "Higher doses occasionally used for sedation".
A Yes.

G Q "Extrapyramidal side effects occur with high doses".

What does that mean?
A Dystonic, odd movements. That is what the nurse at that weekend was concerned about with Mr Pittock, hence calling Dr Bates in.

Q Then if we go to page 21, under the general heading of "Confusion", on the right hand
H side, under "Management", we see "6. Drug Therapy",

A

"If paranoid, deluded, agitated or hallucinating, haloperidol 1.5 – 3mg up to three times a day orally".

A Yes.

Q Then we see underneath that,

B "Review early as symptoms may be exacerbated by sedative effects".

A "Watch for extrapyramidal side effects", which is what they thought he had that weekend, and the next two drugs are much more appropriate for the condition that we were in, in the next paragraph, the midazolam, between 10 – 100 mg over 24 hours or the Nozinan 25 – 100 mg over 24 hours.

C Q And,

"Review early as symptoms may be exacerbated by earlier sedative effects."

That means what? That it can ---?

A We were not particularly concerned about the sedative effects in this patient, in the terminal care of his condition. They are talking here about using it orally for schizophrenic

D and psychotic patients.

Q Right.

A Which was not really relevant for using it in a syringe driver.

Q All right. Finally we have part of the BNF, which we need to punch. This is from the 1998 BNF. We have a heading "Prescribing in Palliative Care". I am going to see if we may

E already have this, in fact. We do. We do not need that, because we can go back. I am afraid I just had not seen it earlier – I beg your pardon. Let us go back to tab 3. We did not look at this earlier, Dr Barton, and you may want to do so. At page 3 of tab 3 – page 13 of the BNF but page 3 of our file – "Restlessness and Confusion":

"Restlessness and confusion may require treatment with haloperidol…"

F and that is dealing with 1 – 3 mg by mouth every eight hours. Then, on the right hand side of page 4, under the same heading "Restlessness and Confusion" under "Syringe Drivers":

"Haloperidol has little sedative effect; it is given in a *subcutaneous infusion dose* of 5-30 mg/24 hours."

A Yes.

G

Q That deals, I think, with that. You can put it away. Can you turn, please, to Elsie Lavender and Patient B. You may want to get the chronology out for Patient B. This lady, we know, in February had a fall and she was X-rayed apparently at the Royal Haslar. She was treated over a fairly lengthy period of time and then came to you on 22 February, as we see form page 7 of the chronology. I think you agree with Professor Ford in essence when he said it was too early to say that this patient's chances of recovery were small. Do you accept

H that she had a reasonable chance of recovery?

A I accept that she had a chance of recovery, but that she had a number of comorbidities and she had only just been managing at home before she came into hospital, so that her outlook was probably residential or nursing home, certainly not home.

Q Right. You said, I think, in evidence to Mr Langdale, "I felt that she deserved the opportunity to try to remobilise".
A Yes.

B

Q This patient, up until her transfer to Daedalus Ward had been on co-proxamol and dihydrocodeine, I think.
A Yes.

Q If we need to, we can go back in the chronology. Would you go to page 2. At the bottom you will see:

C

"Prescribing co-proxamol and dihydrocodeine. Administered until transfer to GWMH."

A Yes.

Q So she does not appear to have been on anything stronger than that?
D A Which, in the palliative care guidelines, is an equivalent of 30 mg of oral morphine.

Q Quite. You told the Panel that the problem with her wrists may have been pre-existing. Is that right?
A There was mention somewhere in her notes of her having had a carpal tunnel syndrome problem previously, and she also may have had a neuropathy, a nerve damage, in the arms due to her diabetes.

E

Q Did that not require an evaluation by you?
A It would have been assessed in the general examination of the patient on arrival, but not recorded.

Q Was not recorded. On 23 February she is reviewed by you. On 24 February she is reviewed by you again. On 24 February there is a note by Nurse Joines that her pain was not
F controlled properly by DF118 – that is dihydrocodeine?
A Yes.

Q Did you consider at this stage, as Professor Ford said you should have done, that there should be an evaluation because the pain should not have been worse at that stage?
A I did not feel at that stage that transfer back to the unit that had discharged her to us would have been productive in any way for this lady. Had she been put through the MRI
G scanner and had a fracture of the cervical spine being found, there was no specific treatment for it. Her treatment was not palliation of her symptoms.

Q Does that mean in effect that she would have been on a terminal pathway?
A Yes.

Q So your view was, from 24 February when this patient is continuing to complain of
H pain, that she is on a terminal pathway?

A A Yes.

Q Did you consider asking to see the X-ray or the X-ray report which had been done on 5 February?
A No.

Q Before you decided to institute opiate medication to deal with her pain, did you not
B consider that an assessment of the cause of her pain would be a good idea?
A Any assessment of the cause of her pain would not have been germane to her management. It would not have altered our management in any way.

Q You started this patient, as we see, on 24 February on 20 mg a day of MST. Yes?
A Yes. Which was in effect a step-down from the equivalent dosage of step two analgesia that she had been having previously, but it was a good starting dose for MST.
C

Q At the bottom of page 9, we see that when moved she was screaming "My back", but she was uncomplaining when left alone?
A Yes.

Q On 26 February, if we look at the top of page 11, I just want to examine with you by this stage what she had actually been on. Up until this point, this patient had been on 20 mg
D MST a day?
A Yes.

Q Yes?
A Yes.

Q You then wrote out a prescription for diamorphine of between 80 and 160 mg per
E day?
A Yes.

Q Together with 40 to 80 mg of midazolam. Yes?
A Yes.

Q From what she had been on to that point, that would as a starting point, have been an
F eightfold increase, if administered immediately. Yes?
A Yes.

Q You agree with that?
A Yes.

Q And she had never had midazolam before?
G A No.

MR LANGDALE: I am sorry. It may save me re-examining and taking more time. Is this on the basis that she is receiving MST 30 mg per day, because I think the right figure is 40. I may have misunderstood what was being put. If you look on page 10, you can see it is 20 twice a day.

H

A MR KARK: I am sorry. What I was putting to the witness – and I do not mind the interruption at all – was that up until that day she had been, I think, 20 mg per day. If you go back to page 9 of the chronology, you can see 25 February, do you see 10 mg twice daily administered? Take your time because it is important.
A That is the weekend again. That is a Sunday, so that when I came in on the Monday morning and reviewed her, I increased the MST and wrote up the anticipatory prescription for the syringe driver.

B Q I understand that, but up until the Monday she had been on 20 mg a day?
A Yes.

Q Right. At the point that you wrote out that application for diamorphine and midazolam. If administered immediately that would have been an eightfold increase?
A Yes.

C Q Let us go back to what happened about the MST. You then increased her MST to 20 mg twice daily. Yes?
A Yes.

Q And that was started at 10 o'clock that evening. Yes?
A Yes.

D Q So on that day she receives 30 mg and on the following day the prescription takes effect and she receives 40 mg a day?
A Yes.

Q Again, on the basis of a prescription that you wrote out, the nurses could at any stage have instituted those prescriptions which you had directed subcutaneously?
E A Yes.

Q And they could have done so either by reference to you or they could have done that of their own volition and normally, but not always, they would have let you know afterwards?
A Yes.

F Q Would you agree that that, in effect, would have been a massive increase in the amount of morphine that this patient was receiving?
A Yes.

Q Can we take it that when you wrote out that prescription on the 26th you would not have been referring, or at least taking any account, of the Palliative Care Handbook or the BNF?
G A Yes.

Q That prescription of yours continued to the 4 March, if we go to page 12, where we can see that the MST dose – I think this is a Monday again – was increased again and she was put up to 30 mg twice daily, 60 mg a day?
A Yes.

H

A Q We look at what happened on 5 March, page 13 of the chronology. You describe in your notes how this patient has deteriorated over the last few days?
A Yes.

Q You know that Professor Ford criticises you for a lack of evaluation, or re-evaluation of the patient?
A Yes.

B Q But you accept, I expect, that there is no note of any proper evaluation here?
A No.

Q And there should be?
A Yes.

C Q If one took place.
A Yes.

Q Are you saying that you would nevertheless have re-assessed the patient and performed a proper examination of her?
A I would.

D Q But made no note ---
A Made no note of it.

Q --- of it. Nor indeed has any nurse made any note of any such examination. Yes?
A Yes – or no. Yes.

Q On 5 March there is a note in the nursing care plan, at the bottom of page 13:

E "Pain uncontrolled - patient distressed. Syringe driver commenced…."

Apparently the patient had had a very poor night?
A Yes.

Q This patient had previously been on 60 mg of morphine. The equivalent would be 20 mg. If you wanted to give her an increase in the dose and stay within the BNF guidelines, you would have halved it and given her 30 of diamorphine. Yes?
F A Yes. On the palliative care guidelines, yes.

Q On any guidelines you care to mention. Yes?
A Yes.

G Q What you in fact decided to administer to this patient was 100 mg, which is three times the dose recommended, which would have included an increase?
A Yes.

Q In fact, just more than three times, is it not?
A Yes.

H Q To that you have added midazolam?

A

A Yes.

Q Again, this is the last question: nowhere in any literature are we going to find any sort of teaching or guidance that justifies such a dose, are we?
A No. But I was the patient's carer. I was standing at the bedside. I was assessing the level of pain and discomfort and terminal distress she was suffering, and I considered that was an appropriate dose to give her in the syringe driver.

B

Q You told the Panel that when you wrote out this prescription, you had over-sedation in mind. Yes?
A Yes.

Q And so you were well aware, were you, that this patient could become over-sedated?
A Yes.

C

Q With potentially fatal consequences?
A Yes.

Q In fact the syringe driver, I think, was commenced on 5 March by Code A (Code A); and what she told the Panel was that the pain was uncontrolled, the patient distressed, the syringe driver commenced. She said, "I think I remember from my interview
D that I was told by the night staff how distressed she was, so the note was based on what I was told by someone else."
A At the handover at eight o'clock that morning she would have been told that the patient had had a terrible night, which is an example now of the same night staff working on that ward, communicating with the day staff and agreeing that terminal care should not be given.

E

Q Yes. She said, "If I had spoken to the patient and she had complained herself about pain, I probably would have noted it." Yes?
A When?

Q So she is relying before she starts this patient on what is effectively her terminal pathway, as we have chosen to describe it, she is relying on a report by the night staff?
A Yes.

F

Q Yes?
A Yes.

Q Not upon anything she has seen?
A Because she is still having the handover in the office at eight o'clock in the morning, or quarter to eight.

G

Q And not upon anything that you have seen?
A Not until I went in then to see the patient when I arrived on the ward.

Q She said, "Dr Barton would have come in, and I would have told her how distressed the patient was and how much pain she was in."

H

A A Yes. And instead of relying on a snapshot view taken by myself that morning, those are the observations of the night staff who had been caring for and turning her and seeing to her throughout the night, which were entirely valid.

Q And it was on that basis that you started this patient on, would you accept, a massively increased dose of diamorphine together with midazolam?
A I accept that it was an appropriate dose of opiate and anxiolytic to give her that
B morning.

Q Do you accept it is a very large increase indeed?
A It was a large increase over what she had been receiving orally, yes.

Q You cannot now claim that you performed any re-assessment can you?
A I am sorry?
C
Q Do you claim that you performed any re-assessment?
A I went in to see her that morning.

Q And made no note about it.
A And made no note about it.

D Q It can have been no surprise to you that this patient died the following evening can it?
A No --

Q She died at 9.28 pm. Alan Lavender's evidence was this:

> "I attended daily, I met with Dr Barton after two to three days. She said to me, 'You can get rid of the cat. You do know that your mother has come here to die'".

E

Do you accept that that was the sort of conversation, if you were being blunt and brusque about it, that you may have had with him?
A I certainly would have suggested that if we were considering a rest home or a nursing home that an alternative home would have to be found for the cat, but I deny that I would have used as quite as blunt language as that when talking to the son of the patient.

F Q He said,

> "It was as if her death had been pre-determined soon after she was on a syringe driver. I assumed it was for pain. She deteriorated quite quickly. She appeared unconscious and smelling terrible and leaking faeces".

Can I ask you this, and we will come to this with another patient, is the loss of control of
G bowels and bladder sometimes a consequence of sedation with diamorphine?
A It is sometimes a consequence of being on the pathway to dying.

Q Is it also sometimes a consequence?
A If you are giving people large doses of opiates you are much more likely to make them totally constipated than make them loose control of their bowels and, again, you have the problem of retention of urine if you are giving high dose of opiates. A lot of these people
H were catheterised so that that situation did not arise. Mrs Lavender put herself on the

A terminal care pathway when she fell top to bottom of her flight of stairs at home before she ever came into hospital. I did not put her on the terminal care pathway.

Q You say she put herself on the terminal care pathway; what you are saying is by the time she reached your hospital she was on the terminal care pathway. Is that right?
A Yes.

B Q Her son described her as,

"Appeared to be making a full recovery, she was alert, lucid and other than a little pain in her shoulder not complaining of pain. It was obvious that it was a little tender and she did not like people touching it".

A I suggest that is a tribute to the dose of MST that she was having prior to the last day
C of her life, it was giving her that degree of pain relief without any sedation.

Q From the time that she arrived at your hospital, did you consider or suggest any alternative treatment other than palliative care?
A No.

Q Can we turn to the heads of charge briefly, please. We take it looking at 3(b)(i) that
D you do not accept that the lowest commencing dose prescribed on 26 February - which was 80mg of diamorphine and 40mg of midazolam, and on 5 March, which was 100mg and 40 mg respectively - that those were too high?
A No.

Q Over the page you do not accept, presumably, that although the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to her
E needs, that it was inappropriate to prescribe those drugs?
A No.

Q Or that it was not in her best interests?
A No.

Q In relation to your management of Patient B it is alleged you did not perform an
F appropriate examination and assessment of Patient B on admission.
A I do not agree.

Q You did not conduct an adequate assessment as Patient B's condition deteriorated.
A I do not agree.

Q Let us just pause here for a moment; you did not provide a plan of treatment.
G A There was no plan of treatment. She was being given palliative care and end of life care.

Q So the plan of treatment was palliation?
A Yes, make comfortable.

Q When we look at your notes and we consider your answers about performing
H assessments but not noting them, how is that meant to work with the partners in your GP

practice on a day when you are not working, on a course, or you are chairing a discussion somewhere and one of your GP partners is called to come in to assist a patient, what are they meant to be basing their care upon?
A They are basing their care on the expert guidance they are given by the nursing staff in charge of that patient. It is exactly the same situation if you are asked to do a house call on a patient in their own home or a patient in a nursing home or rest home, you do not have in front of you a full set of comprehensive case notes, but you rely on the person looking after that patient to give you the information you need.

Q But you accept, do you not, that their task would have been made very much easier if you had been making proper notes?
A In none of these cases would comprehensive notes have made any difference to the care of the patients given by Dr X, Dr Briggs or Dr Brook.

Q Do you not accept that by failing to make a proper note of your assessments which you say you were conducting, you were leaving any doctor who came after you in a worse position in order to deal with that patient than they should otherwise have been?
A Yes.

Q Can we move on please to Patient C. Patient C was quite ill when she arrived at Queen Alexandra Hospital - his is Eva Page.
A Yes.

Q In the clinical notes of 12 February when she was still at the Queen Alexandra Hospital there is a note that the aim in the management of this patient should be palliative care.
A Yes.

Q She was recorded as not for CPR.
A Yes.

Q So one has to be realistic about the prospect of this patient.
Can we turn to the chronology at page 4. She was reviewed by Dr Lord On 25 February. Perhaps we ought to look brief at the entry of 19 February, the page before. Plainly at that stage she is described as being tired and thirsty. There is a plan that oral fluids should be encouraged, but she was still eating relatively solid food. Yes?
A Yes.

Q She was given a little midazolam, 2.5mg to help her to go to sleep. Can we go to page 4, please.

> "Reviewed by Dr Lord. Confused and some agitation says she's frightened. Not sure why. Tends to scream at night. Not in pain. Try Thioridazine. Transfer to GWMH" –

and in fact it should reveal for continuing care. That is what she was coming to you for. Yes?
A Palliative care, continuing care.

A Q On 27 February she was transferred to you. You did make a note and Professor Ford is not critical of this particular note of yours that we see at the bottom of page 4. She was able, as we see from the top of page 5, to hold a beaker and pick up small amounts of food, but she needed a lot of encouragement. Your prescription when she arrived was a relatively small dose of Oramorph given the patient's condition.
A Yes.

B Q Which Professor Ford I think described as being reasonable.
On 28 February we can see that she was very distressed and calling for help and she was given Thioridazine with no relief. She remained distressed and Oramorph was given and then Dr Laing apparently prescribed regular Thioridazine and heminevrin.
A Yes.

Q What would heminevrin do?
C A It is a sedative.

Q Then we see (page 6)

> "Can make her wishes known quite well. Does as she is asked. Pain: Yes on movement. Pegasus mattress. Independent turning in bed. Two members of staff for bath/shower. Encourage fluid intake".

D

It then goes on to say that she should be encouraged to do for herself what she can in terms of personal hygiene.

We can see through the notes that she is then regularly receiving though Thioridazine and heminevrin. Can we then go to what happened on 2 March. This is a Monday. Your note reads,

E

> "No improvement on major tranquilliser".

The major tranquilliser would have been Thioridazine would it?
A Yes.

Q Then,

F

"I suggest adequate opiates to control fear and pain. Son to be seen by Dr Lord today". She was then reviewed by Dr Lord and said to be,

> "Spitting out Thioridazine, quieter on prm, SC diamorphine. Fentanyl patch started today. Agitated and calling out ..."

G That review by Dr Lord appears to have been after she was started on the Fentanyl patch. Do you agree?
A After she had the first dose of subcutaneous diamorphine and the Fentanyl patch had been put on. She then had a subsequent dose during the ward round.

Q If we go over the page, we will have to come back to page 8, we can see what happened about the patch. You prescribed it. It was a 25mcg patch and it was administered
H at 8 o'clock in the morning. Yes?

A A Yes.

Q A Fentanyl patch is rather slower to kick in is it not than an immediate injection?
A Yes, it takes approximately 24 hours to reach its steady state level.

Q You also knew that it would remain in the system for longer and the effects of it would build up over time.
B A To the 24 hours and then remain at steady state until it was taken off on the third day.

Q You also told us that if a syringe driver was started you would see to it that the patch was removed immediately.
A I would not remove the patch myself by hand, but I would ensure that the nursing staff knew to remove the patch.

C Q Why would that be so important?
A Because otherwise the Fentanyl level would remain at that steady state while you were adding in the diamorphine in the syringe driver.

Q Which could lead to?
A It would give a higher dose than you in fact wanted from the syringe drive.

D Q And could lead to an overdose and over sedation; yes?
A It could do, yes.

Q Even when you remove the Fentanyl patch, you know that that does not remove the Fentanyl from the system.
A The Fentanyl level slowly degrades back down again over the subsequent 24 hours.

E Q It takes that long to get rid of it does it not?
A Yes.

Q You also agree that you would not want to run both together; you would never want to run a syringe driver and a Fentanyl patch at the same time would you?
A No.

F Q That is in fact precisely what happened here is it not?
A We do not know what happened because none of the nurses have actually signed for taking off the patch, but I would assume that having our normal protocol was that when a syringe driver was started, the patch was removed.

Q We have seen in a later case that it is specifically recorded.
A Sister Hamblin recorded that she had taken the patch off. I can only assume that
G whoever took this one off did not record it on the drug chart.

Q That is a significant failing is it not if that happened?
A It is.

Q A Fentanyl patch may be put on the body where you would not normally see it. If the patient is lying in bed where would you expect the Fentanyl patch to have been put? It can be
H put on any hairless part of the body can it not?

A A She did not have a very hairy body.

Q Can you remember where it was?
A I have no idea where they put it.

Q If the Fentanyl patch was administered, as it appears to have been at 8 o'clock on 2 March, we can take it that there would be no reason to remove that until the syringe driver
B started.
A Yes.

Q So on 3 March when the syringe driver did start, it would be pretty much at its peak would it not?
A Yes.

C Q By that I mean at its most potent.
A Yes.

Q We see that following the administration of the syringe driver at the bottom of page 9, it is recorded that there is a rapid condition this morning - I may be putting this wrong, so just pause for a moment before answering - the syringe driver was started at 10.50 in the morning and in fact this note must post date that because it is a note by **Code A**
D

"Rapid deterioration in condition this morning. Neck and left side of body rigid - right side flaccid. Syringe drive"

it should be commenced "at 10.50".
A Yes.

E Q The time at which that note had been made it would appear that the syringe driver had already been commenced. Yes?
A Yes, but it does not tell you at what time that morning the rapid deterioration in condition occurred. It was certainly before she recommenced at 10.50.

Q On 2March when that Fentanyl patch was started, and the day before the syringe driver was started, this patient was effectively opiate naive.
F A Yes.

Q What do you say is the purpose of the Fentanyl?
A I am sorry, she was not opiate naive; she had Oramorph. The purpose of the Fentanyl was to give her palliation of her symptoms of pain and distress and in a terminal cancer patient it appears that it was quite appropriate to use that kind of opiate administration in this lady.
G

Q Can we just go back to the issue of whether or not she was opiate naïve? She transferred to your hospital on 27 February.
A Yes.

Q Up until then she had received no opiates at all, right?
A Yes.
H

A Q On 28 February she receives one dose of Oramorph 5mg at 4.20.
A So she is quite opiate naïve, not totally.

Q Just a moment, let us finish this. She gets no opiates on 1 March, yes?
A Yes.

Q By 2 March you would not expect the Oramorph to be having any effect whatever,
B would you?
A No, it would be out of the system.

Q That is why I put to you that she was effectively opiate naïve.
A Yes.

Q Thank you. Can we look at the charges in relation to Patient C, please? You have
C admitted that the prescription that you wrote out on 3 March was too wide, yes?
A Yes.

Q You have admitted that the prescription created a situation whereby drugs could be administered to the patient which were excessive to the patient's needs.
A Yes.

D Q What is alleged against you is that,

"Your actions in prescribing the drugs as described in paragraph 4(a)(ii)" –

that is the diamorphine and the midazolam in that wide range, "were inappropriate". Can I just ask you to think about this? How can that prescription be appropriate?
A You are talking about the subcutaneous prescription in a patient already receiving and
E about not to be receiving a fentanyl patch. Because I wished to deal with the terminal distress. We thought that she had probably had a stroke, a cerebral metastases. I was concerned that she might well suffer from terminal restlessness and agitation and I wished to add midazolam so in order to use midazolam, I wanted to use the diamorphine with it and cease using the fentanyl patch.

Q I just want to make sure that we all follow this. Even though you accept that the dose
F range was too wide; even though you accept that you created a situation whereby drugs could be administered to this patient which were excessive to the patient's needs, nevertheless you stand by your case that such prescription was appropriate.
A It was appropriate.

MR KARK: Thank you. We can move on to Patient D. I am not sure how long we have been going.
G

THE CHAIRMAN: We have been going over an hour already so we will break for 15 minutes.

(Adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Yes, Mr Kark?
H

MR KARK: Dr Barton, we were just about to deal with the case of Patient D, Alice Wilkie. She had been admitted to the Queen Alexandra Hospital at the end of July 1998. She is described as having dementia. She had then an unresolved urinary tract infection. She was 81 years old. She had been prescribed and administered a small amount of haloperidol whilst she was at that hospital on 1 August, and then she comes to you on 6 August. This was the clerking in that you spoke about earlier, although I think we heard from the doctor that he did not regard this as an assessment. He regarded it simply as notifying that the patient was arriving at the hospital. In any event, certainly up to the point of her arrival at your hospital, we should regard this patient, should we not, as being opiate naïve?

A Yes.

Q She was transferred to your hospital, I think my record is, for four to six weeks' observation and then to decide on placement.

A Yes.

Q There is a note on 10 August by Dr Lord that her place at Addenbrooke's was to be given up. What is RV?

A Review in one month.

Q If no specialist medical or nursing problems, patient to a nursing home. Then on 17 August there is a record of deterioration. The 17 August was a Monday.

A Yes.

Q Up until this point, I do not think we have any note from you at all, do we?

A No.

Q How often would you have seen this patient?

A During that preceding week I would have been on the ward, but as I explained in my evidence-in-chief, the ward was in a certain amount of chaos.

Q Because of Mrs Richards.

A Because of Mrs Richards, and I neglected to make any note of any change in Mrs Wilkie's condition during that preceding week, or she may have remained quite stable during that week.

Q But also with other patients when Mrs Richards was not on the ward, I think you have accepted that there was a singular failure to make notes of any of your assessments, was there not?

A Yes.

Q Then on 17 August there is a contact record. That would be made by a nurse, would it?

A Yes, that was made by **Code A**

Q Her condition generally deteriorated. There is no mention of pain, is there?

A No.

Q In fact the last mention of any pain was back on 6 August. I will just find it for you. It is on transfer when there is a note, "Does have pain at times but unable to ascertain where".

A There is another one on page 6,

A "Does have pain occasionally but cannot advise us where".

Q That is right, but that is on the same date, is it not?
A Yes.

Q Then can we look at your prescription? On this occasion I am going to ask that we
B actually look at the copy of the original. That is in Bundle D and it is page 145. I am trying to avoid doing this too often, but it may be appropriate in this case.
Our chronology reveals, or has put this prescription on to 17 August. I just want to ask for your assistance. If we look at page 145, is this a prescription written up by you?
A Yes.

Q How much of this is written out by you?
C A All the left hand side, the drug doses were written up by myself, and the right hand side, the administration was written by Code A

Q Would this be your normal practice, to write a daily review prescription in this way without putting a date on it?
A My assumption would be that with this lady I wrote that on the morning of 20 August, the day it was started, and that I would have expected Philip Beed to write in the date it was
D administered at the top of that column on the 20th, which is why I did not date it, because he was going to date it that day.

Q That is why I am asking about the date and where we have it on the chronology. Looking at this now you cannot say, can you, when you wrote it?
A No.

E Q We have not looked at this aspect and I have not got the relevant statute in front of me, but when you are writing out a prescription for a controlled drug, is it not a requirement that it is dated?
A I do not know.

Q In any event, whenever you wrote it, whether it was on 17th or later, you have made no record in any note of why you wrote it out.
F A No.

Q Apparently you thought it was appropriate to start this patient at 20 mg of diamorphine. We have become rather inured, perhaps, to seeing these prescriptions, but 20 mg of diamorphine to an opiate naïve patient is not a small amount, is it?
A No. It is the equivalent of, by your calculations, 60 mg of morphine orally during the 24 hours. By my calculations in those days it was 40, which is 5 mg of Oramorph five times
G a day and a double dose at night, so it is a reasonable starting dose even for an opiate naïve patient if you are considering that they are at the point of terminal care.

Q Can I just pick you up on that? Whether or not a patient is at the point of terminal care does not justify you putting them on a syringe drug with opiates in it, does it?
A Yes. This lady, at that point in time, on the morning of 20 August, the Monday morning, required terminal care and she required subcutaneous analgesia, so I wrote the chart
H up that morning and it was administered by Code A.

A

Q Just pause for a moment, Dr Barton, and think about that answer. Because a patient is on a route to terminal care, that is cause enough, is it, to prescribe opiates by way of syringe driver.
A Because the daughter had reported to Code A that her mother was in pain and distress and because we had noted over the previous few days that her general condition had deteriorated. I wrote down, "Marked deterioration over the last few days". Not an excuse to
B write up every person reaching the point of terminal care for a syringe driver with opiates, but appropriate for this lady that Monday morning.

Q That is precisely why I asked you to clarify that.
A I am sorry, I did not mean to give you a carte blanche to give everybody – I do apologise.

C Q What you are saying is that for this patient it was appropriate.
A That Monday morning it was appropriate.

Q If it was written up on the Monday morning.
A Yes.

Q Let us look at what happened on the Monday morning, and that is 20 August.
D Marilyn Jackson gave evidence about this. She said this:

> "I went in one lunch time and mum was really very sleepy. She was flinching in her face. I asked her if she had a pain. She said yes. I told a nurse. Beed eventually came and said, 'We did not know your mother was in any pain and we will give her something to relieve her. You may find when you come in this evening that your mum is sleepy'".

E

Let us just pause there for a moment before I read on in that lady's evidence. A relative reports that her mother is in pain. Would that of itself have justified you writing up a syringe driver prescription of between 20 and 200 mg of diamorphine?
A Not under normal circumstances, if the ward was being run with its normal level of efficiency, but I think at that particular time I think the situation, the circumstances were not normal. I think Philip paid great heed to what the very sensible daughter, who had been
F spending quite a lot of time with her mother, said, in the absence of having been able to have the time to make the observations himself.

Q I want to come back to your prescription. When do you say you wrote this?
A I started the syringe driver at 13.50 on 20 August.

Q Sorry, when do you say you wrote up this prescription?
G A I anticipate that I wrote it that morning. I have no recollection at this distance of time of when I wrote the prescription.

Q We see this word of yours, "anticipate", all the way through the police statements. What it means is that you are guessing on the basis of the notes.
A It is an educated guess, but I am guessing, yes.

H Q Yes, on the basis of the notes. So you anticipate that you wrote that up when?

A A On the Monday.

Q When on the Monday?
A There are two alternatives.

Q That would be the 17 then, not the 20th.
A Yes, all right.

B

Q It is your words.
A "Condition generally deteriorated over the weekend", but I did not write anything up until,

"Marked deterioration over the last few days".

C I made an entry on 21st, "subcutaneous analgesia commenced yesterday".

Q That is not, with respect, what I am asking you about. Can you help us as to when you wrote up this prescription?
A The answer is I cannot.

Q If Marilyn Jackson saw her mother at lunch time and went to find Code A you
D certainly normally would not have been there at lunch time to write up any prescription, would you?
A Unless I was either clerking in a patient or about to attend a ward round.

Q If you had been there on that day and decided that that is what the patient needed that day.
A After examining her.

E

Q Of course after examining her, would you not have written in the date, 20 August?
A You will notice that I wrote it up on a daily review prescription page, which is the back page of the chart. There is not a space for me to write the date that I prescribed the prescription.

Q There is a date.
F A There is the date when it was administered.

Q There is a date when you are saying, not when it is administered, but when you are saying it should start. Is that not what a regular prescription is all about?
A No. On a daily review prescription, there is not a start date box for me to fill in. The box is filled in by the prescriber prescribing the drugs.

G Q If you had been there on 20 August would you, do you think, have written up when that syringe driver commenced?
A Sorry?

Q If you had been there on 20 August, you had become aware of this conversation between Code A and Marilyn Jackson, would you have put in the date?
A Not on that page of the drug chart because there was not a space for me to put it.

H

A Q Philip Beed then apparently reacted to that comment by Marilyn Jackson?
A Yes.

Q And he instituted this patient on 30 mg of diamorphine?
A Yes.

Q The equivalent of a 90 mg by my or the BNF's or the Palliative Care Handbook's
B calculation?
A Yes.

Q Of oral morphine. Yes?
A Yes.

Q Would you agree that would be a very high dose in these circumstances?
C A It was a dose that he felt at that time was appropriate.

Q Do you agree it is a very high dose to start a patient on the equivalent of 90 mg oral morphine? That is a large dose, is it not?
A It is a large dose.

Q And higher than the minimum that you had prescribed?
D A Yes.

Q Marilyn Jackson said this: "I went back at about eight o'clock and she was unconscious. I tried to rouse her but she never regained consciousness. She died the following evening. Why did they use a high dose of diamorphine in a syringe driver? The syringe driver was never mentioned to me." First of all, in relation to communication with Marilyn Jackson, do you agree that if that is right, that is an extremely unsatisfactory state of
E affairs?
A Had it occurred like that, it would have been extremely unsatisfactory.

Q And you would not be surprised, would you, with this patient who was opiate naïve if she was started, as we know she was, on a dose of 30 mg of diamorphine and 20 mg of diamorphine, if she quickly became unconscious? That would not surprise you?
A She became comfortable and pain free, is the entry.
F

Q Your description is "comfortable and pain free"?
A Yes.

Q She is unconscious, is she not?
A I have no idea whether she was unconscious or not. She was certainly comfortable and pain free, which is what ---
G

Q The evidence of her daughter ---
A -Code A was aiming to achieve with the dosage in the syringe driver.

Q I will not go back to it, but that should not necessarily be the aim of palliative care, should it?
A This is terminal care, we are talking here. This lady was dying.
H

A Q Are you say that doses can therefore be higher, and that a state of unconsciousness is the goal?
A I am saying the doses may well have to be higher. A state of unconsciousness is not the goal but relief of symptoms is the goal.

Q The goal, surely, is the relief of symptoms but if possible keeping the patient alert and conscious?
B A But it is a constant balance between the two, and it is very difficult with the severity of the symptoms always to maintain alertness and consciousness at the cost of pain relief.

Q If this patient was complaining of pain to her daughter – she was flinching in her face – is there any reason why she could not be given a 5 mg or 10 mg dose of oral morphine that you can think of?
A If she was not by then able to swallow, or she was unwilling to take fluids, I
C have no idea.

Q Presuming for a moment that she was conscious enough to speak to her daughter, if she was able to eat and drink – at least to drink – there would be no reason, would there, not to give her oral morphine?
A Unless you were minded to give the midazolam in order to deal with any restlessness.

D Q If she could not eat or drink and she needed immediate relief from pain a syringe driver, as you told us yesterday, was not the appropriate method, was it?
A Go through that statement again.

Q If she could not eat or drink, but she needed immediate relief from pain, then the institution of a syringe driver was not the appropriate method to give her ---
A It depends whether the pain was an acute situation or whether the pain was a chronic
E situation which had been building up, in which case the subcutaneous route would have been absolutely ideal for her.

Q But not necessarily of this high dose?
A Quite necessarily in his opinion at this high dose.

Q Wha[Code A] told us was that he could not remember the patient at all.
F A No.

Q "30 mg would have been based on the level of pain the patient was experiencing. I had no other reason for giving diamorphine," and then he spoke about hydration.
A Yes.

Q Here is a nurse, albeit a senior one, on the basis of your prescription setting a higher
G than minimum level of diamorphine.
A Yes.

Q Adding midazolam to it?
A Yes. And had he consulted me either before or after putting up that syringe driver, I would have agreed with his clinical judgment.

H Q How do you know? How do you agree with ---

A A Because I had worked with [Code A] for five years. I knew that he was a very competent senior nurse and his assessment would have been accurate at the bedside of that patient on that day.

Q His comment to Marilyn Jackson apparently was that he had not realised that the mother was in pain.
A But this is what he did once he realised that she was in pain, as was a perfectly
B appropriate line of treatment to take once he realised that she was in pain.

Q He also, however, appears to have made no note of that?
A No.

Q That is an extremely satisfactory position, is it not?
A The whole situation at that time was extremely unsatisfactory.
C

Q And the first note that you have made about this patient was on 21 August?
A Yes.

Q At the top of page 9:

"Marked deterioration over last few days. SC [subcutaneous] analgesia commenced
D yesterday."
A Yes.

Q Sorry, I should finish that.

"Family aware and happy."

E A Yes.

Q And she died that day, that evening at 6.30?
A Yes.

Q Do you accept that with this patient the opiates that she was given are very likely to be a prime cause of her death?
F A No.

Q I was going to refer to the charges which are the charges on page 6. Perhaps I should do so in any event. I expect your answer is going to be the same. You have admitted that the dose range was too wide. You have admitted that they created a situation whereby drugs could be administered and which were excessive. You have admitted that the prescriptions were potentially hazardous but you say, do you, that such a prescription was appropriate?
G A I do.

Q And in the patient's best interest?
A I do.

Q I would like to move on please, to Patient E. I am sorry; there is something else I ought to ask you, and it is this. There are two matters, actually. We do not need the notes
H

A for that. You told us that it was to your regret that your attention was focused on Gladys Richards. Yes?
A Yes.

Q Are you saying that as a result of that, your care of this patient, Alice Wilkie, suffered?
A I think in retrospect had both Code A and I been aware a few days earlier of the
B deterioration in Alice Wilkie, that we would have instituted the more normal pathway of giving her a small dose of Oramorph and then moving on to the syringe driver when her pain and distress merited it, rather than going straight for subcutaneous analgesia on that 20 August.

Q Does it follow that because it was left to the relative to point out to Philip Beed that her mother was in pain, that if you were going to institute opiate analgesia there is an even
C higher level of responsibility to review whether that level of analgesia was correct?
A Yes.

Q Because there is a great danger here if people's minds are elsewhere, that the patient could in fact be over-sedated?
A Yes. But she was not.

D Q Let me turn to Patient E, please, about whom we have just been speaking. We have spent quite a lot of time in this case, of course, looking at the case of Gladys Richards and we know that she was taken to the Royal Hospital Haslar. She had fallen at her nursing home. She had fractured the right neck of her femur on 29 July. She underwent an operation. She had some morphine, I think, on the day of her operation and also two days later, on 2 August. There is a note on 3 August that she had a little discomfort on passive movement, but she was sitting out in a chair and she should be given the opportunity to try to remobilise. She is
E going to be transferred to you. On the 8th there is a note that she was a bit distressed but had some haloperidol and had a bit of breakfast and ate a good lunch. Then, on 10 August, we have this referral, that she is now fully weight bearing, walking with the aid of two nurses, which I think you doubt.
A It was not what I saw when I admitted her to the ward on 11 August.

Q Why did you not reveal in your note any concern at this significant change in the
F patient's state of health?
A Because I was making an assessment on admission of the patient, and our plan for the future was going to be based on my assessment and that of my nurses. What was found – allegedly found – at the previous hospital was not relevant to that assessment. We would give her our own assessment and it was perfectly possible that the act of transferring her had in fact set her back and her mobility quite a lot. She might then improve.

G Q We heard from, I think, more than one witness that although patients can deteriorate on transfer, it is quite often a temporary situation?
A Certainly.

Q And so can you just help us? Why do you say that the earlier assessment was effectively irrelevant to your considerations?
A Because I had now a baseline assessment with a Barthel of 2 and usually continent
H and needing help with ADL on which my nursing staff were then going to work. It was not

relevant whether Haslar said or did not say that she could walk with two people and a zimmer.

Q What about the fact that when she became fidgety and agitated, it meant she wanted the toilet?
A I am sure that my nursing staff were very experienced and adept at recognising non-verbal clues in demented patients when they wanted to use the toilet.

Q Apart from the morphine that she had received at the time of her operation and very shortly after it, this is a patient whom we should regard as opiate naive?
A Yes.

Q A patient who needed to mobilise if she was to recover. Yes?
A If possible, yes.

Q Can we just have a look, please, at what you prescribed. You prescribed 5 to 10 mg of Oramorph.
A Yes.

Q This was presumably on admission?
A Yes.

Q At the time that you assessed her?
A Yes.

Q So the first prescription that you wrote out for this lady who, up until this point was opiate naïve, was 5 to 10 mg Oramorph is required. I presume that in fact should be four times daily?
A Yes. Four hourly, I would think it was.

Q Four hourly. All right, yes. Then you also wrote out your usual – if I may all it – very wide dose of diamorphine?
A Yes.

Q And midazolam?
A Yes.

Q And haloperidol?
A Yes. And hyoscine.

Q And hyoscine. Did you regard this patient as being on a terminal pathway?
A No.

Q Did you regard this patient as being in your hospital purely for palliative care?
A No.

Q Can you explain, please, why you thought it appropriate to give the nurses the power immediately to institute a syringe driver with this patient?
A Because I anticipated with the severity of the dementia in this patient and the insult to her that the fractured neck of femur had caused she could, at some stage in the future, become

A palliative and then terminal. I was not anticipating it happening that day or that week even, or even that month, but I wanted the drugs written up in anticipation so that they could be used. Had I done that for Alice Wilkie, Alice Wilkie would have had a more comfortable few days taking Oramorph before she needed subcutaneous analgesia.

Q So you wrote this prescription up not on the basis of anything that was actually happening?
B A No.

Q But because, as you put it, you anticipated ---
A I did.

Q --- that they might one day need palliative care?
A I did.
C
Q And might one day become terminal?
A I did.

Q I suppose it could be said of anybody in this room.
A No. Not today.

D Q Let us see what happened to her. She was given Oramorph pretty much immediately?
A The nurses felt that after that journey, and probably my assessment of her, that she was quite uncomfortable, so she was given a dose that afternoon and late that night to settle.

Q And the following day, 12 August, she is given Oramorph again. yes?
A At 6.15 in the morning.

E Q And haloperidol was given?
A Yes. Just before midnight.

Q And the reason why the Oramorph was not given again that evening is because the patient was drowsy. Can I just ask you to turn up a particular note. It is bundle E, of course, page 64. I am afraid it is a very poor quality copy. It may be that we can do better.
A Page 64 is "Exceptions to Prescribed Orders".
F
Q Yes.
A Is that what you want?

Q That is right.
A All right.

G THE CHAIRMAN: It may be that this is a replacement copy, but it is usually fine.

MR KARK: Oh yes – I have stupidly left the old one in as well. (To the witness) Page 64, 12 August, 18.00 hours. "All medications – Patient drowsy".
A Yes.

Q Is that an indication that she was not given any medications because she was drowsy?
H A Yes.

A

Q So on the evening of the day after her admission ---
A Yes.

Q --- when she had been prescribed Oramorph and given Oramorph, and also haloperidol, she was so drowsy that the nurses did not think it appropriate to give her any more?
B A Yes.

Q Is that a fair way of describing that?
A Yes. She had had a dose of haloperidol that morning and she had had her lactulose that morning, and that evening she was too drowsy to take the lactulose or the haloperidol, and they quite appropriately did not give any Oramorph because it did not seem to be indicated. She was not in pain and she was not uncomfortable.
C

Q And she was drowsy?
A I do not think you can blame the Oramorph for the drowsiness that evening.

Q Would the haloperidol cause her to be drowsy at all?
A Possibly.

D Q On 13 August as we know, this patient was found on the floor by Code A Apparently he checked her and put her into a chair and Dr Brigg contacted and advised an X-ray and analgesia. She was given Oramorph and haloperidol. It is plain from what follows that she would have been actually in some considerable pain because she dislocated her hip.
A Certainly.

Q Is that something which normal would be fairly visible?
E A I never saw the X-ray; I do not know which way the hip dislocated.

Q On 14 August, she was reviewed by you.
A Yes.

Q She was screaming. It was not controlled by haloperidol, but she is said to be very sensitive to Oramorph.
F

"Right hip shortened. X-ray query is this lady well enough for another surgical procedure".

She was in fact taken back to hospital and operated upon.
A Yes, she had a closed reduction of the right hip, not an open operation, no cutting.

G Q It was manipulated?
A It was pulled and manipulated under intravenous sedation.

Q Lesley O'Brien told us this:

"It turned out she had a fall. She dislocated her new hip. It took them 24 hours to transfer her back to the Haslar. She was admitted there and operated on successfully. She recovered consciousness the next day, took fluids and she was eaten and drinking.
H

A She only had minor discomfort. Within 24 hours she was up standing and weight bearing again, back to how she was before".

Is that evidence with which you are prepared to accept?
A I cannot accept or deny it. I was not there. I did not see her at the Haslar Hospital. I did not know what state she was in after being 24 hours unrousable after the midazolam.

B Q This was the lady who was previously a nurse.
A Yes.

Q The patient comes back to you on Daedalus ward and you knew on her transfer that this patient had been affected more than most by the midazolam that she had received.
A I knew that.

C Q So you knew that she was sensitive to morphine and you knew that see was sensitive to midazolam.
A No, I did not know that she was sensitive to midazolam. This was midazolam being used in a entirely different way. It was being given as a bolus intravenously to cause anaesthesia.

Q As a pre-med?
D A She was very slow to recover from that which I felt was the significant point to make a note of, in that she had been very slow to recover from another anaesthetic insult.

Q Perhaps it is misunderstanding, but if you say that somebody is sensitive to a drug does it not mean that they are going to react more than the normal person to it?
A Her brain reacted more than the normal way to a bolus of intravenous midazolam, not the midazolam itself but the way that her brain reacted to it.
E

Q Do you still have your notes available to you? Could you turn up page 31 to look at the readmission. You describe her in this note as, "Now appears peaceful".
A At that moment in time when I examined her she appeared peaceful.

Q What time do you say this was?
A I am sorry, I have no idea. I would imagine that it was lunch time, but I did not put a
F time on the admission note.

Q Because she is coming back from the main hospital, is she not, so she is not going to be arriving at 8.30 in the morning; the normal time of arrival would be lunch time.
A Yes.

Q Can we keep a finger there please and go to page 47. Do you see at the top
G "17 August 1998 13:05"?
A Yes.

Q This is a nurse note by **Code A**
A Yes.

Q "In pain and distress. Agreed with daughter to give her mother Oramorph 2.5mgs.
H Daughter reports surgeon to say she must ---

A "Mother must not be left in pain".

Q "Mother must not be left in pain if dislocation occurs again".
A Yes.

Q "Dr Barton contacted and has ordered an X-ray".
A I imagine that at 13:0 5 I had been and gone and that when I saw her and readmitted her, she was comfortable, but she became subsequently uncomfortable at 13:05.

Q If she had been transferred in the way that has been described ---
A I have no explanation as to why when at the moment in time that I saw her she seemed comfortable, but that is the note I made.

Q I understand that. You are telling us that you believe that that was prior to the note made by Margaret Couchman. Is that right?
A Yes.

Q A further X-ray was to be taken.
A Yes.

Q Did you order it by telephone?
A And viewed by one of the partners.

Q When you came in on the 18th, had that X-ray been taken?
A Apparently it had and it had been viewed by one of the partners and Code A report that there was no dislocation seen. I understand that it showed a large haematoma at the site of where the dislocation had occurred.

Q Would you have asked to see that X-ray?
A No.

Q Why not?
A Because I am not an orthopaedic surgeon. I would accept what my partner and the radiologist said about the X-ray.

Q What about the radiologist's report?
A That would come back to me in due course.

Q Let us look at what happens to this patient hereafter. You make a note,

"Still in great pain, nursing a problem. I suggest subcutaneous diamorphine, haloperidol and midazolam. Will sees daughter today. Please make comfortable".

If we turn over the page, we can see your prescription at the top of page 13, Oramorph, diamorphine to start at 40mg and midazolam. As you know, Professor Ford has said about your prescription for diamorphine that that was high but not unreasonably so.
A Yes.

Q In relation to the midazolam, his view is that that was simply unjustified. What do you say was the purpose of giving this patient midazolam?

A A It was to provide her with relief of any restlessness and mental distress and to act in conjunction with the haloperidol which I swapped over because she had been having it orally and therefore continued to give it. Midazolam would also provide some sedation for her.

Q The diamorphine should take away her pain should it not?
A It should take away her pain.

B Q Which is what she was immediately complaining of.
A Yes.

Q You knew that so far as the midazolam was concerned when she had it in a different setting that she had taken rather longer than normal to recover from it.
A It was still an appropriate drug to use under those circumstances in that patient.

C Q Can we take it that you would have appreciated reading the hospital note, as apparently you had, that with this particular patient it was likely to have an extra sedatory effect?
A Possibly.

Q There was no need at all, I suggest, to add midazolam to this mix.
A In my clinical judgment there at the patient's bedside, it was an appropriate drug to
D add to the diamorphine and the haloperidol.

Q Lesley O'Brien told us,

"On 18 August Dr Barton came in the doorway and folded her arms, lent on the wall and said, 'The next thing will be a chest infection'".

E So far as this patient is concerned, that is in fact exactly what happened is it not; she did get a chest infection?
A She did.

Q Do you accept that is something you may have said to Lesley O'Brien?
A I cannot imagine that I actually couched it in those terms, but I certainly would have been minded to tell the daughters that in view of the prolonged immobility and her general
F state that she was going to develop a chest infection.

Q This lady's problem was a haematoma.
A It was a huge haematoma around the site of the operation, the prosthesis.

Q What active steps could be taken to relieve a haematoma?
A Nothing.
G

Q Does it depend on the type of haematoma?
A Nothing could have been done for that haematoma.

Q Why do you say that?
A Had she survived, the body would eventually have resolved it and it would have hopefully drained away, but there was nothing surgical or acute or immediate that you could
H do to relieve it. You certainly would not stick a needle into it or something like that.

A

Q Dr Barton, you had not seen it.
A I knew it was on the X-ray.

Q But you had not seen the X-ray.
A I knew what the X-ray showed and I was not minded to stick a large bore needle into the thigh of a lady who had recently had surgery to that hip to remove a collection of blood
B which in itself was not doing the patient any harm.

Q Why are you describing this as a massive haematoma?
A Because I think that is what was said on the X-ray report.

Q You are saying that there were no active steps that you could have taken?
A Nothing.
C

Q What can happen with a haematoma, as you have said, is that it can resolve itself.
A Yes.

Q But that takes time.
A Yes.

D Q Did you think that provided you palliated her symptoms of pain carefully that this haematoma might resolve?
A Yes.

Q Would it be important to avoid bronchopneumonia to keep the patient in at least semi-conscious state, so that they could clear their own secretions. Would that help?
A Yes, but she had to have adequate analgesia and she had to have haloperidol for her
E terminal dementia and she had to have midazolam for her restlessness otherwise she would make the haematoma worse I imagine.

Q Lesley O'Brien said this:

> "The amount they gave her caused her never to wake up again. She was not conscious; she was not screaming or moving or doing anything".

F

A She was not in pain and she was peaceful and she was comfortable which was the aim of the prescriptions, nothing else.

Q For peaceful we should read unconscious and unrousable.
A For peaceful you should read comfortable and free of pain.

G Q Do you agree with Dr Lord when she says that sometimes what one has predicted does not happen?
A Are we talking about this?

Q No, she made a general comment.
A Yes.

H

Q One of the dangers of putting a patient on a terminal pathway, ignoring this patient for the moment, is that you might get it wrong. Do you agree?
A Yes.

Q Was this patient on a terminal pathway?
A When she came back having been unrousable for 24 hours approximately after her intravenous midazolam, she was on a terminal pathway.

MR KARK: Sir, perhaps that is a convenient moment.

THE CHAIRMAN: We will rise and return at 2 o'clock.

(Luncheon adjournment)

THE CHAIRMAN: Mr Kark?

MR KARK: Can we turn to the case of Mrs Ruby Lake, Patient F. This lady had been living alone. She is described on page 2 of our chronology as mobile, independent and self caring. and then she had the misfortune to fall and fracture the left neck of her femur. Post-operatively she suffered a degree of left ventricular failure.
A Yes.

Q She remained fairly unwell and she had bouts of breathlessness. On 12 August, if we go to page 8, we can see at the entry one above the bottom, that being 11 August, that she had a wash, her a bottom and sacral area were very red and breaking down. She was incontinent of faeces. She complained of stomach pain and remained very sleepy. Then on 12 August she is described as "Much improved. Has sat up today. Developing sacral bed sore". Would you agree that the picture of this lady is somewhat up and down; she has her good days and she has her bad days?
A Yes, and very slow to recuperate from the surgery.

Q Then on 13 August, page 9 of hour chronology, she was assessed by Dr Lord for her future management.

> "Post-op recovery was said to be slow with periods of confusion and pulmonary oedema. Over last two days she has been alert and well, now our intention to work in her mobilisation".

The physio has visited her for the past six weeks. That was a referral to Dr Lord and then the review by Dr Lord takes place over the page at the top at page 10. She is said to be catheterised.

> "Appetite poor. Eating and drinking very small amounts. ECGs show atrial fibrillation. Ischaemic heart disease, LVF [left ventricular failure] have been problems recently. Still dehydrated, hypokalaemic and has normochromic anaemia. Problems with chronic leg ulcers and recently buttock ulcers. Overall she is frail and quite unwell at present. Happy to arrange transfer to continuing care bed at GWMH. Uncertain as to whether there will be a significant improvement".

The lady was obviously fairly poorly.

A A Yes.

Q In the following entry on 14 August she is described by the physio as, "Brighter today. Sitting out. Walked short distances with a frame + 1 - managed very well" and then the plan is to gradually increase her distance of walking as her energy increases. Again, it is the same picture, up and down days; she can be brighter and better and moving with a frame. Do you agree?

B A Yes.

Q On 15 August, page 12, she is given codeine phosphate, no doubt that would be for pain would it not?

A Yes.

Q "L [left] sided chest pain in ribs through to back - since being manhandled". I do not

C want to be critical of anybody outside this room, but the day before she had been reviewed by a physio who had plainly walked her for a distance with a frame.

A Yes.

Q I suppose it is not inconceivable that that manhandling by the physio might in fact the next day have been causing her problems. Yes?

A It is possible, yes.

D

Q If that is right, if it is the manhandling that had caused her some pain, it is the sort of pain, hopefully, that would resolve itself.

A Yes.

Q It is not a chronic sort of pain; it is the pain as a result of the exertions of the day before.

E A Yes.

Q I should go on, she is also said to have pain in her left shoulder from arthritis, but she has paracetamol to good effect, which would mean that the paracetamol appears to have controlled the pain.

A Yes.

F Q Go to page 13, over the page, please. On 17 August she is described as being "well. Mobilising slowly. Awaiting transfer to GWMH". She is described by the physio as,

> "bright. Sitting out in a chair. Independent to sit and stand. Mobile with Zimmer frame and supervision. Managed well".

So again I am not going to try and make out that this woman is going to be dancing down the

G steps the next day, but again it is a picture of this lady being capable of movement and having her good days.

A Slow improvement.

Q Then we can see at the end of that day's entries that at 20.15 she seemed confused in the afternoon. She had had a spike in temperature, 38.8. That is not a very high temperature, is it?

H A No.

Q She had been given some paracetamol. The next day,

"Reviewed by SHO at the Royal Hospital, Haslar. Well, comfortable and happy. Last pm spike temp, now 37.3",

So that is relatively normal, is it?
A Yes.

Q "Mobilising well. To go to GWMH today".

There is then an entry at 02.00,

"Increased shortness of breath. Recommenced on oxygen therapy".

I suppose that must have taken place before the entry I have just read. They are the wrong way round.
A I cannot tell you whether it happened the morning she was transferred or the morning before the day she was transferred.

Q I am presuming this note is made on 18 August at 2 o'clock in the morning.
A In which case it is the day before.

Q Why cannot it have happened on 18 August when she is transferred?
A I do not know. It could be either. It is not clear from the chronology.

Q If we need to we can have a look at the note, which is page 614. That would appear to be a note made at the Royal Haslar, would it not?
A Yes.

Q It is 2 o'clock in the morning, as we can see, on 18 August.
A So it is the day she was transferred and she had an episode of shortness of breath in the night.

Q Did you have the ability to give oxygen therapy at Gosport?
A Yes.

Q So these entries are, I think, the wrong way round. The next entry is,

"Reviewed by SHO at Royal Hospital Haslar. Well, comfortable and happy. Last pm spike temp, now 37.3. Mobilising well, go to GWMH today".

She is then transferred to your hospital, Dryad Ward.
A Yes.

Q We see there is a fairly lengthy transfer letter:

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

A independently but requires help to wash back and bottom. Bilateral leg ulcers redressed every 4-5 days. Has broken area on left buttock and in cleft of buttocks – improving. Has small appetite, oral fluids need encouraging. Urinary catheter in situ. Diarrhoea resolved. Usually lucid, only very occasionally seems confused at night. Hearing aid appears to have gone missing".

That is not a particularly gloomy outlook, is it?
B A No.

Q Then she is reviewed by you on the same day as the entries we have just looked at.

"Transfer to Dryad Ward continuing care".

Then you set out her history. Past medical history angina, CCF. I cannot again remember
C what that is.
A Congestive cardiac failure.

Q I am grateful.

"Catheterised. Transfers with 2. Needs some help with ADL. Barthel 6. Get to know. Gentle rehabilitation. Happy for nursing staff to confirm death".
D

What you told us about this lady, as I understood it, is that this is a lady who is at the end of her life and is likely to be on a terminal care route before too long. You said your comment about gentle rehabilitation was slightly tongue in cheek. Can you help us with that?
A No. She was entitled to come to the ward. She was entitled to be considered for gentle rehabilitation, but with her co-morbidities and risk factors, I was not enthusiastic as to whether rehabilitation would work for her. It follows on from Dr Lord's note that she had
E cardiac problems and might not make a full recovery.

Q I understand that, but did you regard her, I think you said – I should have checked the transcript – as a lady who was at the end of her life?
A She was certainly towards the end of her life, but whether it was days, weeks or months I was unable to say on that first assessment of her on the ward.

F Q Likely to be on a terminal care route before too long. Why?
A With her past history of angina and congestive cardiac failure, with her dependence. Her Barthel 6 does not really give a good assessment of medical co-morbidities. It only refers to the activities of daily life. This was a potentially very ill elderly lady.

Q Potentially very ill.
A Yes. I saw them week in, week out, year in, year out. I looked after hundreds and
G hundreds of these ladies. The fact that you fall and fracture your neck of femur is often a very strong pointer to the fact that you are nearing the end of your life.

Q It can be, can it not?
A It can be.

Q It is certainly an unfortunate event for any elderly person.
H A It is a very major life event for some of these people with major health problems.

Q Many recover, do they not?
A Many recover.

Q This lady again, as with many others that we have looked at, up until this stage, her pain had, I think, been controlled by paracetamol.
A It had.

Q Apart from the early days, no doubt when she had to have her operation, totally opiate naïve, yes?
A Yes.

Q Can we look at your prescription, please, page 16 of the chronology? You prescribed Oramorph, 5 – 10 mg as required. Temazepam, 10-20 mg as required. Was that to help her sleep?
A Yes.

Q Diamorphine by syringe driver, 20 – 200 mg. Hyoscine and midazolam, 20 – 80 mg. Yes?
A Yes.

Q This was one of your anticipatory prescriptions, was it?
A It was.

Q It allowed the nurses at any stage thereafter to initiate effectively what would have been the end of this patient's life, the beginning of the syringe driver.
A Yes.

Q You thought that was appropriate, did you?
A I did.

Q Her Barthel was 6, rather better than many that we have seen.
A But as I said, the Barthel only refers to a measurement of the activities of daily living. It does not give you a score as to frailty of the cardiovascular system, or severe dementia, which she did not have. It is only a measure of one of the strengths of the patient. It does not measure all of them.

Q But can we take it, from the fact that you were prescribing as a minimum dose, 20 mg of diamorphine and 20 mg of midazolam to a lady who I think it would be right to describe as elderly and frail, would it?
A Yes.

Q That you were once again ignoring the Palliative Care Handbook.
A Yes.

Q And the BNF of course.
A Of course.

Q On the day of her admission – let us look at what happened if we go back to page 15 – it looks like she was given 5 mg of Oramorph as soon as she arrived. Is that right?

A A At 14.15, fairly shortly after she arrived, I imagine.

Q She had not been given any Oramorph at the previous hospital, had she?
A She had not, but she had undergone the trauma of a transfer across, being unloaded into a bed, being assessed by myself and the nurses. She probably deserved a small dose of adequate analgesia at that point.

B Q This is a comment that you have made previously, "She deserved Oramorph". Can you just explain to the Panel what you mean by that?
A My patients did not have to suffer pain unnecessarily.

Q There is no suggestion that this patient was in pain, is there?
A The nurses would not have given that dose of Oramorph if they had not felt that she required it for pain.

C MR LANGDALE: You say no sign of pain. Perhaps you should look at page 15, Barrett.

MR KARK: Thank you.
A She had leg ulcers. She had a sacral pressure sore. She had undergone a journey and she had had a fractured neck of femur repaired. It is quite possible she was in quite a lot of pain.

D Q You concluded that she, as you put it, deserved Oramorph.
A Yes.

Q Let us look at what happens to her in the evening.

E "Settled and slept well 22.00 until midnight. Woke very distressed and anxious, says she needs someone with her. Oramorph 10 mg given 00.15 with little effect. Very anxious during the night. Confused at times".

Yes?
A Yes.

F Q If a patient is confused, Oramorph is not something that is likely to assist them, is it?
A No, but if she is beginning to go into a little bit of congestive cardiac failure, lying flat in the bed at night, it is a very appropriate drug for the night staff to give at that time.

Q How would you diagnose congestive heart failure?
A It is something the nurses would assess when they saw her. They knew her history from the notes. They knew that it was possible that it was going to happen to her and they would act appropriately.

G Q How do you diagnose it?
A You have got to listen to the chest and see if they have got any creps at the basis of the lungs. Night staff do not normally carry stethoscopes. They would be making a clinical judgment that this lady needed Oramorph.

H Q Would they be looking at this patient without a stethoscope and saying to themselves, "I reckon this lady has got congestive heart failure"?

A A Yes. They knew she had congestive heart failure. They knew that she had been breathless the night before her transfer.

Q That is something the night staff would be doing, is it, diagnosing congestive heart failure?
A It is quite appropriate for them to deal with it in that way at that time of night.

B Q What she actually wanted, this lady, was for someone to sit with her.
A That is what she said, yes.

Q Yes. That is what she said. Of course we do not know what the staffing levels were like on that particular night, but it would not be an appropriate response to this patient if somebody could just sit with her, to give her morphine, would it?
A If that is what she said, is what she meant and was the only problem she had that
C night, it would have been very nice if there was someone available to sit with her. But she remained confused and very anxious. I would think it was the confusion that made her say she wanted someone with her. I was not there. I cannot tell you what the situation was clinically, but I feel it was appropriate that the night nurses gave her a dose of Oramorph at that time of night to settle her and make her more comfortable.

Q But which might, do you agree, have increased her confusion?
D A Not a dose of 10 mg orally, no.

Q You do not think so?
A No.

Q An elderly frail patient just moved to new surroundings.
A I do not think so. She had no problems with the first dose after her arrival in the
E afternoon.

Q How do we know that?
A Because they would have mentioned it in the nursing report had they had any major problems.

Q Do elderly patients sometimes hallucinate with small amounts of morphine?
F A Occasionally.

Q Page 16 again please. Just looking at your syringe driver prescription, I mean if the nurses had given that prescription, administered that prescription, even half-way up the scale, at 100 mg diamorphine and 40 mg of midazolam, might that have killed the patient?
A Certainly.

G Q Shall we go over to see what happened to the page, over to page 17? Nurse Hallman has made an entry at 11.50,

"Complaining of chest pain, not radiating down arm – no worse on exertion".

Is that an indication that it may not be a heart problem?
A She felt that it might not be a heart problem.
H

A Q "Grey around mouth" would indicate what?
A That it might be a heart problem. It was more serious than a musculoskeletal strain that she had suffered before her transfer to us.

Q What should be the normal immediate reaction if this lady is suffering a degree of heart failure?
A Give her a dose of morphine.

B Q How would you do that?
A She had Oramorph written up on the drug chart, so she very properly gave it.

Q I think you said, so far as the syringe driver is concerned, that you may have been in hospital and you would have sanctioned this.
A I would.

C Q This lady, at 4 o'clock in the afternoon, the day after she arrived at your hospital, has a needle inserted into her and a syringe driver started.
A Yes.

Q That, so far as this lady is concerned, as you put it, she is now in her terminal stage.
A Yes.

D Q You think you were chairing a meeting at the time.
A Yes.

Q But you would have agreed to the syringe driver being started once it had happened.
A They did not put the syringe driver up until 1600 so it is quite possible I would have seen her and assessed her before they put the driver up, after they had given the Oramorph.

E Q And the dosage that she was given – I think previously – the day before, she had had 10 mg, had she not?
A Yes.

Q And then on that day she had had 20 mg. I am sorry – no. The day before she had had 5 mg. Then she gets 10 mg at quarter past twelve, so we are now into 19 August, and a
F further 10 mg at 11.15. Yes?
A Yes.

Q So the day before she was on 5 mg. At this stage she has 20?
A Yes.

Q And she started at a dose of 20 mg. The equivalent dose would be 60 mg of
G Oramorph. Yes?
A Yes.

Q To which you added midazolam?
A Yes.

Q What note is there to reflect that this lady is now in the terminal stage of her life?
H A There is no note to record that.

A

Q Either by a nurse or by you?
A No.

Q No note at all?
A No note at all.

B Q Do you think that is acceptable?
A No.

Q Was there a culture on this ward of just not bothering to make a note about these sort of significant events?
A No.

C Q You were not making notes, were you?
A I was not good at making notes, but my nurses were certainly usually considerably more conscientious about making notes than that particular day.

Q And you did not pick up that your nurses had not made a note?
A I did not, no.

D Q Some 17 hours later, if we go over the page… We should, perhaps, with the bottom of page 17.

"Condition appears to have deteriorated overnight. Driver recharged 10.10."

A Yes.

E Q

"Family informed…

Night: General condition continues to deteriorate. Very bubbly."

That would be an almost inevitably consequence of the syringe driver causing this patient to lose consciousness, would it not?
F A That would be the inevitable consequence of her congestive cardiac failure causing her to retain secretions both in the lungs and in the upper respiratory tract.

Q

"Ruby rousable and distressed when moved. Syringe driver recharged at 07.35 (on 21st)."

G A So she was not unconscious and she was not over-sedated.

Q She is rousable when moved?
A Yes.

Q The following day, at the top of page 18 – in fact it is 20 August – the diamorphine is doubled?
H A Yes.

A

Q The midazolam is doubled?
A At 16.50.

Q At 16.50.
A Yes. The initial doses are discarded and the hyoscine is also increased at 16.50 because she was increasingly bubbly.

B

Q Some 15 hours later, I think it is, the diamorphine is put up again. The midazolam is put up again. Yes?
A Yes.

Q And all of this is occurring, we need to remind ourselves perhaps, within three days of her being described as well, comfortable and happy?

C

A Yes.

Q She is now at the very end of her life, is she not?
A Yes is.

Q Let me remind you of what Diane Mussell had said about this patient. She was moved to the GWMH on 17 August. I think she is a day out in her dates, is she not? Yes.

D

"She seemed clean and well cared for. She was able to talk until late on 19 August when she was quite agitated and depressed. I felt there was a good chance she would be coming home. By the 20th there was a notable deterioration. She was unable to respond, either through hand gestures or oral communication. I think she was on a syringe driver by that time." She went on to say, "There was nothing that struck us out of the ordinary regarding her care." Anita Tubbritt gave evidence about this patient on Day 14. She said the decision to increase the dose – and this is on 21 August – from 40 to 60 would have been "a joint decision between

E

me and Nurse Turnbull. I cannot remember the basis for it. On 19 August, the patient was deteriorating. That would mean the patient's breathing. Perhaps there was discomfort or distress, physical pain, pain, agitation, probably all those things." But again, with a lack of notes, she was not able to say?
A Yes.

Q You recorded her cause of death as broncho-pneumonia. You would accept, would

F

you not, that the sort of drugs that this patient was being given could in fact effectively initiate broncho-pneumonia?
A I think that the condition she was suffering from could well end up as broncho-pneumonia. Broncho-pneumonia is a common terminal event in congestive cardiac failure.

Q Did you at any stage, if a patient had become unrousable, as I suggest this patient had according to the evidence of Diane Mussell on the 20th; she was unable to respond either

G

through hand gestures or oral communication – did you consider reducing the dose?
A I did not.

Q How often, can you help us, did you ever reduce the dose of a syringe driver?
A I would be unable to tell you at this remove of time.

Q It is not something that happened very frequently, is it?

H

A I would think probably not.

A

Q You also said about Professor Ford's evidence that the criticisms by Professor Ford "do not give me cause to question my judgment"?
A I did.

Q You said that on other occasions as well?
A I did.

B

Q Do you mean that? That they do not even give you pause for thought about your judgment?
A I do.

Q The effect of that answer is to demonstrate, is it not, that if allowed to do so, you would behave in exactly the same way again?

C

A I have not been practising palliative care in any form since 2002.

Q I understand that,
A And the whole ethos of palliative care and possibly, I suspect, terminal care, has change din the intervening ten years since I last did it. I think that staffing levels and protocols nowadays would mean that you would not practise anticipatory prescribing and syringe drivers would not be put up in the same way that we had to do them all those years

D

ago.

Q But, Dr Barton, having listened to the evidence, apart from your failure to keep notes?
A Yes.

Q You simply to not accept the criticisms of Professor Ford, do you?
A I do not.

E

Q I do not think there is any purpose, in light of those answers, in taking you to the charges. You do not accept your prescriptions were either inappropriate or not in the best interests of Patient F?
A No.

Q That is in spite of you agreeing that they were potentially hazardous. Yes?

F

A Yes.

Q Let us move on, please, to Patient G. Arthur Cunningham we know had been looked after for a while by Dr Lord at the Dolphin Day Hospital. He had been a fairly frequent visitor to the Dolphin Day Hospital and then, on 21 September, if we go to page 8 of the chronology, which is where I am going to start, he was again reviewed by Dr Lord at the Dolphin Day Hospital in relation to his sacral ulcer. He was admitted to your hospital. The

G

purpose of his admission to your hospital was for aggressive treatment of his sacral ulcer. Do you agree?
A It was.

Q Obviously you were, or should have been, better equipped to deal with his sacral ulcer than either a nursing home would have been or the Dolphin Day Hospital would have been?
A Yes.

H

A Q If we go over the page, to the top of page 9, this was the patient who had not been swallowing his tablets and we can see the plan set out by Dr Lord. His laxatives and antibiotics were stopped.

"(2) Dryad today, Aserbine for sacral ulcer, nurse on ---"

Is it "site" or "side"?

B A Side.

Q

"… on side, high protein diet, Oramorph … if pain
(3) N/Home [Nursing home] to keep bed open for next 3/52 [3 weeks] at least
(4) Patient informed of admission – agrees
(5) Inform N/Home, Dr Banks + social worker. Prognosis poor."

C

Yes?

A Yes.

Q We can see that the plan was to admit him to Dryad Ward for treatment of his pressure sores and then you reviewed him, as we see at the top of page 10 of the Dolphin Day Hospital. Yes?

D A Yes. It says reviewed by Dr Barton on Mulberry Ward. That is not correct.

Q I have crossed that through on mine.

A I saw him with her at the day hospital and then was invited to look at the sore on Dryad Ward.

Q You agreed for him to be admitted. Yes?

E A I did.

Q Your note, would you agree, is rather more pessimistic than those that had preceded yours?

A Yes.

Q "Make comfortable" – and that is code, is it not, for palliative care?

F A Yes.

Q

"Give adequate analgesia. Happy for nursing staff to confirm death."

Yes.

A Yes.

G

Q All of that note reveals, does it not, that this patient was in fact so far as you were concerned on a terminal pathway?

A Yes.

Q Did you tell him that?

A No.

H

A Q Did you tell him that the likelihood was that as soon as he got to your hospital, he would be on a syringe driver?
A No.

Q Did you have any intention, in fact, of trying to cure his sacral sore?
A I was happy to follow the plan given to me by Dr Lord with the nursing procedure, to try and get to the black eschar of the surface of his sacral wound and to try and improve his
B nutrition, which had obviously been very poor for several weeks in the nursing home, and to make him comfortable. I was entirely following what Dr Lord had laid down for me but it was the second worst sacral sore I have ever seen in my medical career, and I did not feel when I saw it that afternoon that we had a snowflake's chance of healing it. It was right down to the bone.

Q And your view was that it was not going to be practical to try and give him a high
C protein diet?
A I was happy to get the nursing staff to order the high protein diet from the kitchens, but I was much more preoccupied about making him comfortable than worrying about what the nurses were going to give him to eat.

Q Day 11, page 78 in the coroner's inquest, you said this:

D "I agreed with Dr Lord that his prognosis was poor. It was not going to be practical to try and give him high protein diet."

A This is a nursing procedure, not a medical procedure. The nurses order from the kitchens what they consider to be a high protein diet and, had it been appropriate, of course we would have given it to him.

E Q Why was it inappropriate?
A Sorry?

Q Why was it not appropriate to give him a high protein diet?
A Because he became seriously ill that evening and it was not appropriate then to try and give him a high protein diet.

F Q What did you expect the nurses to follow?
A The guidance that they had been given by Dr Lord. It was not at variance with anything I said or did. It just became impractical to give a man a high protein diet when he needs a syringe driver.

Q So when you, their resident doctor, assessed him and simply revealed than in your view he was to be made comfortable ---
G A Yes.

Q --- and had to be given adequate analgesia?
A Yes.

Q You nevertheless expected the nurses, did you, to follow a route which you considered to be impractical?
H

A I probably did not even discuss whether it was impractical or not. They had the instructions from Dr Lord, and they would have set in motion the Aserbine and the high protein diet.

Q But, Dr Barton, these things do not happen in a vacuum, do they? You were not simply making a note, and then leaving the hospital. You would have been speaking to the nurses, would you not?

B A I would. And I would have said that in my opinion he was to be made comfortable.

Q Yes. You would have reflected quite clearly to the nurses your pessimistic outlook, would you not?

A Yes. I would. I do not think it was pessimistic. I think it was a realistic outlook, faced with the sight and smell of the sore.

C Q And the reality of this patient was that before he had ever even got into Dryad Ward so far as you were concerned he was on a terminal pathway?

A Yes.

Q Let us have a look at the prescription, please, that you wrote out at page 12. You wrote him up for Oramorph. You wrote him up for diamorphine. I am not going to go through each of these any more, and you will appreciate why, and you wrote him up for

D midazolam?

A Yes.

Q In the evening of his admission, he was given Oramorph. In fact he was given Oramorph in the afternoon and then again in the evening?

A Yes.

E Q We have to look, I think, at the note on page 13 before we come back to see what happened to him that night. Page 13, at the top of the chronology, is a note made by Nurse Hallman on 22 September. It talks about an episode the evening before. Yes?

A Yes.

Q When this patient, on any view, if the note is right, had behaved very badly indeed.

A For a very good reason – probably that he was in a lot of pain and distress at that time,

F to cause him to behave like that.

Q He was certainly very confused, was he not?

A He was.

Q Whether it was pain causing his confusion or anything else, there is no reason for this man to have behaved in that way unless there was something wrong?

G A Unless he was toxic and in a lot of pain and confused.

Q You said "toxic and in a lot of pain and confused". Undoubtedly he must have been very confused, must he not. Yes?

A Remember, I had seen the sore that afternoon. I knew how toxic he was likely to be, having just stopped the antibiotics at the day hospital because they had been ineffective. He was likely to be toxic as well.

H

A Q When you talk about a patient being toxic, do you mean that they have toxins in the blood?
A Yes.

Q Is that something that is relatively easy to check?
A To ---?

B Q Check.
A If you had the facilities to do blood cultures you could check for toxins in the blood. We did not have facilities at the hospital to do blood cultures very often.

Q You could take bloods though, could you not?
A Not at that time of night, no. We had a blood lady who came on week-day mornings and took blood, and then it was taken to the main hospital at lunch times.

C Q If this was an urgent - you are a doctor you could take blood could you not?
A I would not be taking blood under these circumstances.

Q Let us see what happened. He remained agitated until approximately 8.30 in the evening. We know that he had been given Oramorph 10 minutes or so before becoming calmer. If we look at page 11, it is quite complex. You see right at the end of the entry on
D page 11, "Oramorph 10mg at 20:20". Yes?
A Yes.

Q That seems to have been effective because he remains agitated until 20:30, no doubt when the Oramorph kicks in?
A I think that is very quick. Yes, I suppose it was beginning to kick in and then at the same time they put up the syringe driver.

E Q The syringe driver was not started until 11.
A I beg your pardon, I am looking at the following night. That night it was 23:10.

Q The syringe driver was put up shortly after 11 o'clock at night.
A Yes.

F Q As requested. Have you been able to glean from listening to the evidence or reading the notes who requested it?
A No.

Q The syringe driver being set up at that time of night would be done without your verbal authority would it not?
A I would not be in the hospital. It is quite possible that they rang me earlier in the
G evening and I suggested the Oramorph to proceed to the syringe driver if they felt that they were not going to be to control his symptoms overnight, or they may have gone ahead on their own say so knowing that I would be the following morning.

Q The scenario is this: either they telephone you at the time, but you certainly do not re-examine the patient?
A No.

H

Q Or they set it up of their own volition, and obviously you certainly do not re-examine the patient.
A No.

Q The time that you would have next seen the patient at best guess would be the following morning.
A Yes.

Q Unless the patient was in significant pain, setting up a syringe driver would have been quite unjustified would it not?
A No.

Q Can you tell us why not?
A I have suggested that he was in pain; I have suggested that he was very confused, agitated, restless, frightened, all of the reasons for which I would want to put up a syringe driver to give him both diamorphine and midazolam to control his symptoms.

Q You would be content, would you, that this patient who was transferred to your hospital on that day for treatment of his sacral ulcer is started on an end of life progress by way of syringe driver?
A I would if it was appropriate and he needed it.
Q You would not say to your nursing staff "Hold on, that is going to mean the end of this patients life. Let us just wait until the morning, give him Oramorph."
A If they felt that that was the appropriate course of treatment to take that night, I would have agreed to it. I had seen him that afternoon. I knew what clinical state he was in that afternoon.

On the 21, that day, he had told Mr Farthing that his behind was a bit sore and asked for some chocolate. Yes?
A I can make no command about that conversation, I was not there.

Q It certainly appears that he was able at times to eat and certainly drink because he had two glasses of milk that night.
A Yes.

Q There was absolutely no reason not to give him Oramorph until the morning was there?
A Certainly, except the clinical impression of the night staff was that he needed subcutaneous analgesia and they put it up.

Q Let us have a look at page 13. The syringe driver has been started and the driver is said to be running as per chart. Over the page, we can see the syringe driver was continued at 20:20 in the evening. On 23 September, he is described as becoming in the evening a little agitated, "syringe driver boosted with effect". Can you help us, this was your hospital and your nurses, what would you take that reference to be?
A I was aware that there was a button on the side of the Graseby syringe driver that it says on it "start, boost" but I was not aware that you got a very large dose of anything that was in the driver if you pressed the button. I always felt that it was probably more satisfactory for the nursing staff to feel they had done something to help relieve the pain than that he had got an increased dose of opiate or midazolam, otherwise the driver would have

A run out much more quickly if you had been able to increase the rate. It would have run through more quickly which, as far as I know, it did not do.

Q Can we look later at what happened later on the 23rd, if you go to page 15. This is the morning, diamorphine continued at the same rate but midazolam tripled. Yes?
A Yes. You have missed out a day; you have missed out the point at which because he was toxic he became chesty overnight and I added hyoscine into the driver to control his
B chestiness. That is the 23rd.

Q I beg your pardon. I am going to come back to page 14 in any event, but I am just looking at the prescription and what was administered to him. I want you to deal with the tripling of the midazolam. In normal circumstances - we have looked a lot at diamorphine - midazolam would also have a very sedatory effect would it not?
A It would be very effective for terminal restlessness and agitation.
C

Q Professor Ford described this as a very high dose for this patient which would produce very marked sedation. Would you agree with that?
A It was an appropriate dose in the minds of the nursing staff and myself to give him at this point in his terminal illness.

Q Let me try it again. Do you agree with Professor Ford that this was a very high dose
D which would produce very marked sedation?
A It would produce different individual effects in individual patients and in this particular patient it did not produce an excessive amount of sedation, either at the dose of 20 or at 60mg.

Q On the 24th, we can see first of all at what happened to him and then we will look through the notes, at the bottom of page 16, diamorphine is doubled at 10.55 and then it is
E increased to 69, so in one day in fact it has tripled has it not?
A Yes.

Q The midazolam goes up to 80mg.
A Yes.

Q Let us have a look at the notes going back to page 15. You note that he remains
F unwell

> "Son has visited again today and is aware of how unwell he is. Sc analgesia is controlling pain just. Happy for nursing staff to confirm death".

That I think is actually the first explicit reference to pain except from his old back injury.
A And his knees.
G

Q Did you at any stage re-examine this patient to see what was happening with his sacral sore?
A The sore? No.

Q Did you re-examine this patient?
A I re-examined the patient, but I did not turn him over and look at his sacral sore.
H

A Q At the top of page 16, this is a note from Nurse Hamblin

"Report from night staff that Brian was in pain when being attended to, also in pain with day staff, especially his knees. Syringe driver renewed at 10.55 with diamorphine 40mg, midazolam 80mg and hyoscine 800mcgm. Dressing renewed this afternoon. Mr Farthing seen by Dr Barton this afternoon and is fully aware of Brian's condition. ... Nursed on alternate sides during night, is aware of being moved".

B Then he is said to have a peaceful nights sleep.
He was already on an increased dose of diamorphine of 60mg and 80mg. Can we look just in the middle box at page 17. "Peaceful night, position changed". Yes?
A Yes.

Q Over the page to page 18,

C "Condition appears to be deteriorating slowly. All care given ... mouth care given".

The driver is now recharged with another increase. Yes?
A Yes.

Q On the basis of the notes, can you see any justification for that?
D A Whoever was responsible for changing the syringe driver must have decided in consultation with me or whoever was on duty that day that the increase was appropriate to control his condition.

Q On the basis of the notes, can you see any justification for that increase?
A There was nothing in the notes in justification or otherwise.

E Q When we looked at the nursing notes earlier, we saw a similar failure did we not? This is not just a one off failure is it?
A No.

Q I am going to suggest to you again there was a culture here of simply not bothering to make notes. Do you accept that now or not?
A I do not. There was a culture of both myself and my nursing staff doing our very best
F to give the most appropriate treatment and care to our patients and neglecting the paperwork.

Q Giving this patient on 26 September 1998 diamorphine at a rate of 80mg and the midazolam at 100mg of which Professor Ford was very critical and described it as a very high dose indeed, those doses ran a clear risk that the drugs would bring about the end of his life.
A He was dying. He was reviewed on that day, 26 September, by my partner,
G Dr Brooke, who also obviously felt that the medication was appropriate for his condition at that time.

Q Let me remind you of the words of Mr Farthing. He spoke about telephoning the ward and was told that his stepfather had become aggressive to the staff and they had given something to calm him down. "I said I would be in the next day to have strong words with him". This now is 23 September.
H

A "I went to the ward. He was unconscious, unrousable, he was totally different. He had gone from a normal person to someone who was totally comatose".

If that reflects this patients position, that is not acceptable is it?
A What you are seeing from the clinical notes that we did make, that was not the position. This was a man who was obviously toxic when he arrived at the day hospital on the Monday afternoon. He became increasingly confused and toxic during the evening and on
B the following morning he required an appropriate dose of sedative and analgesics which would have made him much more comfortable. He was not unconscious or unrousable.

Q By the 24th, if we go back to page 16, he was on 40mg which was increased to 60mg of diamorphine and midazolam at 80mg. Yes?
A Yes.

C Q Mr Farthing said this:

"Dr Barton not come in until the next day of the 24th at around 5 pm. He had not become conscious all day. Dr Barton told me bluntly that he was dying from the poison emanating from his bed sores".

Yes?
D A Yes.

Q That is your evidence now.

"She refused to remove the syringe driver due to the pain he would experience".

Let me pause there for a moment. You have referred to him in your notes as his son. Yes?
E A In the statement I wrote for the police I referred ---

Q In your clinical notes, page 15 of the chronology,

"Remains unwell, son has visited him again today".

Yes?
F A Yes.

Q Did you know whether he was a stepson or a son?
A I cannot remember.

Q He was clearly a very caring and loving relative was he not?
A Clearly.
G

Q Why could you not reduce the dose so that he could speak to his father?
A Because his father/stepfather was in the terminal phrase of his life. My duty was totally to his father and it would have been inhumane to stop the infusion of the opiates and the anxiolytic.

Q Inhumane to this man who two days earlier said that his butt was a bit sore and he was
H requesting some chocolate.

A A Inhumane to that man in the condition that he was in on the ward that day.

Q You told the Panel, "If I had felt he was over sedated, there would be no problem in reducing his opiates". Is that still your evidence?
A Quite right.

Q Whether Mr Farthing was a next of kin or a loving relative, would you have taken
B account of his sentiments?
A No.

Q No?
A No, my duty lay to Mr Cunningham.

Q So it does not matter if he is the next of kin or anybody else does it?
C A No.

Q Going back to the initiation of the syringe driver, can I just remind you of what Ingrid Lloyd said to us on day 14 and then I am going to ask you to comment on it. She talks about 21 September. Let us go back in the chronology and remind ourselves where we are. This is on the day of his admission. She says that Nurse Hallmans entry is a retrospective one and that was in relation to the events of the night before.
D A Yes.

Q In that the events she described had already been happened.

> "They were mentioned in handover. It was with this knowledge that she and I agreed that a syringe driver should commence. This was done so that Mr Cunningham remained in a pain free and peaceful state. Although I have stated in the notes
E Mr Cunningham was peaceful at 2030 hours, it was not certain he would remain in this state. The syringe driver was not commenced until 2310 hours as it required two nurses and Fiona Walker wasn't available until this time as she had other duties to attend to as the night nurse in charge".

I will continue so that you have the full picture.

F

> "The purpose of the syringe driver was to enable a pain free and peaceful state for Mr Cunningham. With regard to who authorised the syringe driver this was a decision made by three trained nurses including myself, Shirley and Fiona. The drugs were being prescribed to be given at our discretion".

Let me just take you back.

G

> "Although I have stated in the notes that Mr Cunningham was peaceful at 20.30, it was not certain that he would remain in this state, and it was started at 10 past 11 because it required two nurses".

If a syringe driver was being administered in an anticipatory manner, on the basis of your anticipatory prescribing, that would not be a very satisfactory state of affairs, would it?
A I think in this particular circumstance it was perfectly appropriate for them to use that
H method of administering the opiate and the anxiolytic to a patient who had previously shown,

A through the latter part of the day, that his behaviour became very disturbed and difficult both for himself and other patients, as well as the staff, if he was not given adequate analgesia and sedation.

Q That rather reflects the comment I think you made yesterday. "I take this stand by what I did".
A I do.

B

Q If this patient had become conscious at Mr Farthing's request; you had reduced the dose and he had become conscious and had the ability to ask you to remove the syringe driver, would you have done so?
A It is a hypothetical question. I cannot answer it.

Q Mr Farthing was asking you to reduce the dose so that he could speak to his father. If
C his father had then said, "I am sorry, I do not want to die in this way".
A I could not have been put in that position of being asked to do that, because I would not have agreed to reducing the amount of analgesia he was being given for very good clinical reason.

Q Let me put it another way. If a patient says to you, "I don't want that thing in me. I would rather die as conscious as possible", you would not be able to put a syringe driver
D into that patient, would you?
A That is the situation that Dr Lord was talking about, not initiating analgesia at the request, in her case, of the next of kin or, in your hypothetical case, the patient themselves. The patient has a perfect right to say, "I do not want any analgesia. I wish to die in agony".

Q The patient has the perfect right to say, "Take that thing out of me".
A Certainly.

E

MR KARK: Would that be a convenient, moment, sir.

THE CHAIRMAN: Yes, I think it would. We will return at half past three.

(Adjourned for a short time)

F THE CHAIRMAN: Welcome back everybody. Mr Kark, before you begin, I just want to say, Dr Barton, I have been reminded that this is not an endurance competition and this Panel well understand the stresses that extended cross-examination places on any witness. You have heard me say this before and Mr Kark invited you at the beginning of his cross-examination, if at any time during the course of the day you feel you have reached that point when you have had enough, then please say so and we will not subject you to further questions at that point. If you are happy to go on now we shall proceed.

G

MR KARK: Dr Barton, I was proposing to try and deal with two more patients this afternoon and then stop, but again, if you do not feel awake enough or capable, then just indicate and we will stop. I did mean, however, to ask you just one more question about the last patient, Arthur Cunningham.

You are charged with not obtaining the advice of a colleague when his condition deteriorated,
H and you have admitted that you did not. I just want to have your evidence. Do you accept

that you either could or should have sought advice, either as his condition deteriorated or when Mr Farthing asked you to stop the medication, as it were?
A I have been considering your question during the break. I have never, in 35 years of practising medicine, been asked by anybody to withdraw, or withhold analgesia so that they could die in pain. I have never been asked by a relative to withhold or withdraw analgesia. I was just completely knocked sideways by the question you asked me. I felt perfectly competent to deal with Mr Cunningham's problems and his terminal illness. It was just that your idea of withholding analgesia from somebody who was dying was just abhorrent to me.

Q Right. Did you think about obtaining the advice of one of your consultants when you had the son or stepson there saying, "Please, do not necessarily stop but perhaps reduce the dose so I can speak to him"? Did you think it would be appropriate to take the advice of a consultant?
A No.

Q This is a situation which you have just told the Panel was totally novel to you.
A Abhorrent. I did not say it was novel. I said I just could not consider anybody wanting to put a loved relative through that sort of pain that would have ensued had the analgesia been reduced.

Q Dr Barton, with respect, that is your take on it. Mr Farthing did not want his father to be in pain. He wanted to be able to speak to him. You understand that, do you not?
A Yes.

Q He was not doing it so that his father could relive any pain. That was not the purpose of his request, or did you think it was?
A No, I did not think that for one moment, but that would have been the effect.

Q The reason I said it was novel was because you have just said that in 35 years it had never happened to you, so it was, with respect, for you a novel experience.
A A first, yes.

Q Let us move on. Patient H, please. This is Mr Robert Wilson. This is the gentleman who was or had been an alcoholic, effectively.
A Yes.

Q He had alcoholic liver disease.
A Yes.

Q He had fractured his left humerus in a fall on 21 September and it seems that he did not want it to be repaired. He did not want to undergo an operation.
A Yes.

Q His wife did not return from her holiday. His sons only found out what had happened to him about a week after the event. You, I think we can safely say, have no independent recollection of him.
A No.

Q In relation to this patient, you have accepted, I think, that you knew that this man had been or was an alcoholic and had alcoholic liver disease.

A A Yes.

Q He had, during the course of his stay at the Queen Alexandra, on a number of occasions, had paracetamol. He had also had, I think, codeine. On 3 October he had had 2.5 mg of morphine because his arm was hurting him.
A Yes.

B Q That was by way of injection.
A Yes.

Q Again this is a patient who, when he got to you, we should properly regard as opiate naïve.
A Yes.

C Q Codeine is not going to affect his future resistance to morphine realistically, is it?
A No.

Q You knew, and I understand what you say about it, that those with liver problems such as this, needed to be treated particularly carefully.
A I knew that and I also knew that opiates were not contra-indicated if they were necessary for the patient.

D Q I have understated the morphine position so let me correct it. I think he was given 2.5 mg on 3, 4 and 5 October, which were described as being, "of good effect" for his painful arm. Then if we go to page 17 of the chronology,

> "No problems. Eating well. Elbow and cuff in situ arm remaining swollen".

E He is described as "chatty and funny".

> "Hand remains very red and oedematous. Sacral cleft quite red with penile discharge. Ankles very oedematous and tender. Appetite variable. Paracetamol given as prescribed.
> PM Sat out for most of afternoon, but was very tired and needed to rest in bed by the end of the afternoon. Communicating quite well although varies according to mood.
> F Asked doctor to consider stronger analgesia, now prescribed codeine phosphate".

So the doctors were not ignoring any requests for analgesia, and they were prepared to prescribe him codeine and paracetamol, even though he had liver problems.
A Yes.

G Q If we can go, please, to page 22 of the chronology, 13 October. He is reviewed y the medical team. He has oedematous limbs at high risk of breakdown. His right foot already about to break down. This is due to oedema secondary to cardiac failure and low protein. His weight is up to 114.4 kg. For those who like old-fashioned language I think that is about 17.5 stone. He is described as being in a good mood this morning, "no complaints of any pain". He was passing urine independently using a bottle. Peaceful night. Slept well again. No complaints of pain. Then we have the referral letter, again revealing to you that he had alcohol problems. He was being transferred for continuing nursing care needs.
H A Yes.

A

Q His Barthel was 7, which again in your terms at your hospital would be relatively high. Somebody needing a lot of help but very much better than many of your patients.
A But not giving you a measure of the co-morbidities present in this patient.

Q I entirely understand that. It is simply the assistance that he needed with his activities of daily living.
B A Yes.

Q He is still in a lot of pain with his arm and difficulty on moving. On a high protein diet, legs very oedematous and at high risk of breakdown secondary to cardiac failure and low protein. He needs 24 hour nursing care. Medication paracetamol four times a day. Over the page, refused to mobilise. Remains oedematous. Transfer summary,

C "Ensure left arm supported. Sit to stand practise with two. Transfer practise with 2…Plan: Continue with active movements mobility and transfer practice".

Would you agree that just as with the patients who have had to have these hip operations, getting a patient like this moving, is pretty critical to their rehabilitation.
A And, by the same token without adequate analgesia it would be impossible to get him mobilising, hence the entry, "refused to mobilise", because it hurt.
D

Q I understand that. But shall we deal with one issue at a time. Do you agree that with a patient like this, and those who have had those hip operations, if they are going to have any chance of recovery, you have got to try to get them moving.
A Yes.

Q He is given codeine, paracetamol that day, and then he is transferred to you, and you
E make a note yourself of his past medical history, his alcohol problems, recurring oedema, congestive cardiac failure. You note that his Barthel is 7, "Plan: gentle mobilisation". On the same day we can see there is a nursing entry, if we go to page 24, he is described as, "fully comprehending".
A Yes.

Q "Restless at times. Used urinal with assistance as he wanted to stand".
F

So it is a reflection that he is able, at least, to stand and move about, albeit with assistance.
A Yes.

Q The last time that this patient had had morphine, I think, had been about nine days before on 5 October after he had knocked his arm.
A Yes.
G

Q Let us see what you prescribed for him, please. If we go over the page to page 25, Oramorph, up to 10 mg four-hourly.
A Yes.

Q That was actually given to him on the day of his arrival on the ward, and you prescribed diamorphine – again I will not go through it – and midazolam and the lowest dose
H

A equivalent to diamorphine would be 60 mg orally. The most he had had until that time was 5 mg.
A Yes.

Q After he knocked his arm.
A Yes.

B Q A massive increase, would you agree?
A Yes.

Q Do you accept that your prescription appears, at least on the face of it, to be flying in the face of his management by other doctors up to that date?
A I think that my management reflected my feeling that although he had come to me for gentle rehabilitation, that his overall prognosis was poor. He was in incipient cardiac failure
C when he arrived with me and that his condition could well deteriorate at any time.

Q Yes. I will put the question again. Do you accept that the prescriptions that you wrote out on the day of his admission appeared, on the face of it, to be flying in the face of his management by other doctors at that stage?
A They appeared to be flying in the face because they are more realistic than the previous prescriptions that were written.
D

Q So none of the other doctors, in your view, who had been dealing with this patient up until this stage at the Alexandra Hospital had been realistic.
A About the long-term future for this man, no.

Q In your view, was this patient for terminal care?
A No. He was for palliative care because none of the conditions from which he suffered
E were curable. He had irreversible liver disease. He had congestive cardiac failure. He probably had a degree of renal impairment. None of these were curable, so any treatment that we gave him was palliative.

Q Are you saying that your view that he was never going to leave your hospital?
A I thought that it was unlikely that he would ever leave the hospital.

F Q But he came to you for rehabilitation, did he not?
A Yes.

Q And rehabilitation was not an impossibility?
A No.

Q Or was it?
G A No.

Q No. When you wrote out what I hope you will forgive me describing as your usual prescription of diamorphine 20 to 200 and midazolam 20 to 80, what account, if any, did you take of his alcohol liver-related disease?
A I did not reduce the doses because I knew that he had previous acute alcoholism and had liver damage. I kept the doses exactly the same.
H

A Q You took no account of it, did you?
A No.

Q It would have been important, would it not, for the nurses to be aware that he had had alcoholic liver disease and the effect that that would have on the administration of any opiates?
A Yes.

B Q Why did you not reduce your usually wide range to take account of that fact?
A Because I still felt that, should the need arise, that it was appropriate that he had an effective amount of diamorphine and midazolam should he need it.

Q The potency of the drugs that the nurses would administer would be made more potent by reason or stronger by reason of his liver disease, would they not?
C A Yes.

Q Did you give the nurses any special warnings about that?
A The nurses were well aware of the special conditions, as evinced by Shirley Hallmann's long history of heavy drinking. The nursing staff would have been aware that he had a chronic alcohol problem.

D Q Yes. Shall we look at what happened to him from the day of his admission when he was able to use a urinal with assistance because he wanted to stand. He was given, on the day of his admission, I think it is, 20 mg of oral morphine. Yes?
A The ---

Q I am looking at page 25 – 10 mg administered at 14.45 and 23.45?
A Yes.

E Q Did you consider whether codeine might do it – whether codeine might control his pain?
A I knew that codeine had not controlled his pain because he had been prescribed it on the acute ward in addition to paracetamol.

Q But did you consider an intramuscular dose into his arm? If his arm was particularly
F painful, it might help control his pain?
A Intramuscular injection of what?

Q Of morphine?
A No. It was very swollen and oedematous. It would have been quite inappropriate to inject morphine into the arm.

G Q On the following day, 15 October, the day after his admission, he was commenced on Oramorph four times daily, 10 mg, and a double dose at night.
A Yes.

Q And so if we look at the bottom entry on page 26 we can see that Oramorph was administered, 10 mg at 10 o'clock, 2 o'clock and 6 o'clock in the evening, and then the 20 mg dose was given on that one occasion, giving him 50 mg on his second day at your hospital?
H A Yes.

A

Q Yes?
A Yes.

Q Did you consider at any stage that this man's deterioration appears to have broadly followed the potency of the opiate medication you were giving him?
A No. I felt that his deterioration mirrored the increase in chestiness and emergence of
B his cardiac failure, following the move to my hospital and the first night.

Q You see, if we look at the entry in the middle of page 26 when he has been started on these doses of Oramorph, he is given 20 mg at midnight with good effect, then 10 mg at 6 o'clock in the morning.

"Condition deteriorated overnight. Very chesty +. "

C

I think that means very, very chesty.

"difficulty swallowing medication. Incontinent urine ++"

Now the day before he had been able to stand at a urinal?
A I think that the "very chesty ++" and the "difficulty swallowing medication" and the
D incontinence mirrored the appearance of his cardiac failure, which would have been ameliorated, if anything, by doses of Oramorph during the night, not made worse.

Q Page 27, please. He is reviewed by Dr Knapman. There is a note that he had declined overnight with shortness of breath.

"… bubbling. Weak pulse. Unresponsive to spoken orders."

E

Did you consider that what happened to this man, who three days earlier had been described as being in a good mood with no complaints of any pain, may have been the result of your opiate medication that was causing that man to be like that?
A Dr Knapman obviously did not consider that it was a result of the opiate administration. He felt that he was in cardiac failure and he gave an increased dose of diuretic to try and reverse the increasing cardiac failure that he was demonstrating.

F

Q When you gave evidence, you seemed to suggest – and I just want to have this clear from you – that it was Dr Knapman who had instituted or directed the institution of the syringe driver. Is that your evidence?
A It is difficult to say because obviously I did not make a note, but I was not in the hospital that Friday morning, 16 October. It is quite possible that I was not available at the hospital for the rest of the day, in which case Dr Knapman, as the duty doctor, would have
G been asked to agree to the syringe driver.

Q Except that he would not need to, would he?
A They would have asked him if it had been appropriate, but no, it was written up anticipatorily for them to use should it become necessary.

H

A Q I am going to ask you, I am afraid, to look at some nursing notes. Could you take up the file for Patient H, could you go to page 266B. That is 16 October 1998. That is the day we are looking at, is it not?

"Seen by Dr Knapman am as deteriorated over night. Increased Frusemide to 80 mgs daily. For A.N.C"

B A All Nursing Care.

Q

"Wife informed will visit this morning."

And that note is signed off – I am not sure who that is, I am afraid.
A No, I am not sure who that is.

C

Q The next entry is p.m., is it not?
A Yes.

Q 16 October 1998, p.m.

"Patient very bubbly chest this pm. Syringe driver commenced 20 mg diamorphine
D 40-0 mcgs Hyoscine. Explained to family reason for driver. Wife informed of patients continued deterioration. Has been to visit."

And that is signed by Nurse Hallmann.
A Yes.

Q There is no indication from that that Dr Knapman authorised that syringe driver, is
E there?
A And there is no information as to whether I authorised the syringe driver either there.

Q I understand that.
A No.

Q On any basis, the syringe driver was available to be authorised because you had
F written it up?
A Yes.

Q If we go to page 28, we can see at the top that Oramorph had been given to this patient that day, 30 mg, and then diamorphine was started through the syringe driver at 20 mg at ten past four in the afternoon. I am not going to go back again through the conversion rates but, again, do you accept that that is a fairly significant increase?
G A Yes.

Q It is from 30 mg up to the equivalent of 60 mg orally, is it not?
A Yes.

MR LANGDALE: I am sorry – I would just like to clear this point up. I think in fact in the previous 24 hours, he had been on a total of 50 mg of Oramorph. If I have got that wrong,
H

A I apologise, but I think in the previous 24 hours, the administration of diamorphine has been 50.

MR KARK: I think Mr Langdale is right. If we go back to page 26 – I am grateful. I have certainly made a note – 50 mg for 24 hour period. Then, on the 16th… Yes, Mr Langdale is right. He is given Oramorph in the morning, and then he is started on the syringe driver. It is still an increase but it is certainly not such a significant increase. Yes?

B A Yes.

Q All right. Then at page 28 we can see that he was reviewed. Professor Ford described this patient. "By this stage he has deteriorated and is very ill." It is described as a rapid deterioration. Professor Ford said this, and I want to ask you to comment on it: "No one appears to have considered the effects of the opiates and the response" – and this is looking at the entry at the bottom of page 28 – "is to add another sedative in. There was a failure to

C monitor carefully the effects of the opiates." First of all, are you saying that you were considering the effects of these opiates?

A Yes, and if he was suffering from congestive cardiac failure the opiates were entirely appropriate to manage his symptoms.

Q When he came to your hospital ---

A He had already put on 11 kg in weight, which was made up of fluid. His arms, his

D legs were oedematous. He was already on the point of developing congestive cardiac failure. It would have been that journey in the minibus and the transfer that would have tipped him into congestive cardiac failure.

Q That is your view?

A Yes.

E Q And I understand. You appreciate that on the day after his arrival on 15 October he was given, as Mr Langdale has just properly pointed out, 50 mg of morphine orally, which is more morphine than he had received in his entire stay in the Queen Alexandra Hospital.

A And it was entirely appropriate to give him that for the condition that he was in.

Q You spoke about his transfer. Let us look at what Gillian Kimbley said about it, because she actually travelled with him. She told us: "I travelled with him on his transfer to

F the Gosport War Memorial Hospital. He was not too bad. He was in a wheelchair. It took about an hour and a half. I could hold a conversation with him. He was exhausted. We spoke to Dr Barton and she said to him, 'Get straight into bed and I will give you something to calm you down'." You appeared to be rather appalled at that. I have to say, of all the criticisms in the case, that is not one that I would level at you. You were simply telling, on her account, the patient to get into bed because he had had a long journey.

A Yes.

G

Q All right.

A That is normally a nursing procedure, however, not for the medical staff to undertake.

Q But if he had had a long journey, there would be no problem about saying to a patient, "Hop into bed", would there?

A He was probably not capable of hopping by that time. He would have been helped

H into bed, yes.

Q She said this: "He had his sedation. He seemed okay. He had his lunch. He was fine. I visited him the next day. In less than 24 hours there was a big difference. He had food hanging out of his mouth. He was mumbling, not making sense. He was semi-conscious. I spoke to a sister and she said, 'Your husband is dying. He will be dead within a week.' I could not believe it. By 16 October he could not even speak. I had no further conversation with him from that time." From the drugs that he was given you would have no reason to disagree with that report of his condition, would you?
A I would ---

Q That is quite likely to be the effect of the drugs.
A From the condition that he was suffering from, I could understand that she had noticed a very marked deterioration in his overall ability to hold a conversation and hold his food in his mouth. I would be blaming it on the effect on his brain function, caused by the congestive cardiac failure rather than the opiates necessarily.

Q Again in relation to the transfer, she said, "He was buffeted a little bit on transfer, but it was not too bad. He was a bit tired afterwards. It did not take four hours. The plan was for him gently to get mobilised. The sister discussed with me his cardiac failure and the fluid on his body. From the 16th he was unconscious." Now, this is a patient who undoubtedly had a long journey, but it was a long journey from which he might have recovered. Do you agree with that?
A He might have recovered, but the treatment that he was given was perfectly appropriate on his arrival at the ward and the next day when his congestive cardiac failure became apparent.

Q Mr Ian Wilson gave evidence about this patient as well. I just remind you. He said: "I saw him the evening before his transfer to GWMH. He had eaten. He had been drinking. Sat up alongside his bed. Someone had the *Daily Sport* and there was a jovial atmosphere. On the 15th" – so this is the day after his admission and the day after he has been started not on the syringe driver but on his Oramorph – "he was in a comatose state. He did not appear able to move himself. I leant over. He spoke his last words, 'Help me, son, they are killing me,' and I thought he was dying. He was comatose." Does your answer apply to that as well, that it would have been his illness that was causing him to be in that state?
A Yes.

Q Mr Wilson went on: "I could not rouse him," and he never saw you. You have no recollection of this patient, have you?
A I have not.

Q So far as this patient is concerned, going to the heads of charge if you would please, in particular to head of charge 9(b), which I think you find on page 9 if you have the green copy.

"b.
to give **Code A**

- which we have looked at already. The prescription was 14 October –

"… was,

A

i inappropriate,

ii. potentially hazardous,

iii. likely to lead to serious and harmful consequences for Patient H,

B

iv. not in the best interests of Patient H."

Do you agree that in light of his alcoholism and liver disease your prescriptions should have been lower?
A No.

C Q I will not take up time going through the rest of those charges, and I was going to turn to Patient I. Dr Barton, are you alert enough to deal with another patient, or would you like to break now?
A Could I have a brief break, please.

MR KARK: I am sure you can.

D THE CHAIRMAN: I do not think it was the doctor's alertness that we were concerned about, but merely the fact that it is a very gruelling experience. You can certainly have that break, Doctor.

THE WITNESS: Thank you. Shall I just go and come back?

THE CHAIRMAN: Please do, and anybody else who would like a short break, now is the
E time.

(After a short pause)

Q Dr Barton, Patient I, was the 92-year old patient who on 19 March 1999 was pulled over by her dog causing her to break her right hip. She was operated on on 20 March and you may or may not remember that morphine caused her to have hallucinations.
F A Yes.

Q Nevertheless, she did in fact continue to receive some opiates during her stay at the hospital. Unfortunately, she continued to have pain in her hip for quite a while after her operation. If we go to 24 March, the day before, at the bottom of page 6, there is reference to her skin being very thin and fragile lower legs. "Has proved difficult to get mobilised and her post-op rehabilitation may prove some what difficult". Her main problem is described by
G Dr Reid as,

"Pain in her right hip and swelling of her right thigh. Even a limited range of passive movement in right hip still very painful".

Yes?
A Yes.

H

A Q At the top of page 8,

"Still in a lot of pain which is the main barrier to mobilisation at present - could her analgesia be reviewed?" She is still been given paracetamol. At the bottom of page 8 we see that the swelling on her right leg has increased; that her skin is paper thin and very fragile. Haematoma is said to have developed and broken down. "Dress with gelonet. Elevate. Ready for GWMH when bed available. Needs great care of skin + B warn GWMH of skin state".

At the bottom of page 9, we can see that she transfers to Dryad ward. That is on 26 March. Her last dose of morphine, by my reckoning, had been some five days earlier, 5mg on 21 March. Again this is a patient who we must regard as opiate naive.
A Yes.

C Q On the first day of her arrival at your hospital upon your prescription, she was given I think 25 mg of Oramorph if you go to page 11. Yes?
A Yes.

Q Again, can we take it that the palliative care hand book has figuratively gone out of the window, as has the BNF? You are starting this lady on 25mg of opiates.
A She had had major surgery. She had a very early transfer to us. She had a journey. D She had a lot of pain in that hip. This is not the palliative care pathway I am throwing out of the window. This is a lady in need of realistic levels of analgesia while we get to know her and assess her rehab potential. "Plan, sort out analgesia". It would not have been appropriate to continue giving her paracetamol and that level of dosage of Oramorph was equivalent in strength to one daily and considerably more pleasant for most patients to take than the codeine-based analgesics.

E Q She had not been on eight dihydrocodeine had she?
A No, and that would have been the alternative. I was going to move up from the first rung of the analgesic ladder. I was not going to continue to give her paracetamol. I went to the bottom of level three rather than the top end of level two.

Q Let us examine that for a moment. She had on 23 March, if you go back to page 6, a gram of paracetamol.
F A Yes.

Q That is not the maximum is it?
A Yes.

Q It is the maximum?
A No, 1 gram four times a day would have been the maximum. We would accept that G her analgesia was not adequate during her time at Haslar.

Q I understand that. Let us look at what she had been on. Page 6, on 23 March 1 gram of paracetamol. The next day another gram, page 8.
A Yes.

Q The next day another gram of paracetamol. Did you think about increasing her H paracetamol?

A A No, I did not think that that would be appropriate analgesia.

Q Did you think about going to level two on the analgesic scale?
A Yes, and I have explained that the equivalent to a reasonable dose of level two analgesia would have been a small dose of Oramorph which is what I gave her.

Q Why could you not start on the next level up from paracetamol?
B A I could have.

Q You could have done?
A I could have done.

Q If we go on to page 11, this patient, as we see at the top, is said to be experiencing a lot of pain on movement. Yes?
C A Yes.

Q We heard from both Professor Ford and Mr Redfern about this patient. Yes?
A Yes.

Q Mr Redfern considered it very unusual to continue requiring morphine so late on.
A Yes.
D

Q Professor Ford said you would not have expected such pain so long after the operation. Yes?
A Yes.

Q Did you ask yourself "What on earth is going on with this hip?"
A Yes, but I did accept that there are enormous variations in the rate at which people get
E over major surgery. I was also aware that she had had a haematoma develop and break down before she was transferred over to us and that might have indicated that the prosthesis was still very uncomfortable.

Q What was your continuing plan, therefore, for this patient?
A To sort out her analgesia to make her comfortable?

F Q Did that plan change at any stage?
A No.

Q I suggest you never went back to the root course of this patient's pain did you?
A No.

Q Mr Redfern told us that in orthopaedics they had a very low threshold for re-
G operating. You smile, so we had better record it. Why are you smiling about that?
A Because orthopaedic surgeons are well known to have a very threshold for re-operating. If it moves, operate on it. This lady had barely survived her first major surgery. She would certainly not have survived another operation.

Q That is your view apparently of Mr Redfern.
A Yes.
H

Q Let me just remind you of some of his evidence. This is Day 16/21.

"Q What would have happened if this lady had been sent back to the Haslar Hospital? Would it have required a re-exploration of her hip?
A On the assumption that there was a failure of fixation, then there would have been an evaluation of her general fitness to [under]go revision surgery".

A Yes.

"A And had she passed that assessment, which is usually done by the anaesthetist who is scheduled to do the surgery, then she would have undergone revision surgery.

Q That evaluation is very important?
A Yes.

Q Because decisions have to be made about what is in the patient's best interest?
A That is correct".

Q Then he was asked this:

"Q If a patient is elderly, in poor physical shape, it may well be thought this is not in the patient's best interests to undertake surgery under general anaesthetic?
A Yes. There would have to be considerable co-morbidity though. We have a very low threshold for operating on people with fractured neck of femur, because they commonly carry considerable co-morbidity. The bar is set fairly low".

A Yes.

Q Is that your understanding as well?
A Yes.

Q Then,

"Q And one would want to evaluate whether it is generally in the patient's interests and that they will survive the insult that general anaesthetic involves?
A Death under anaesthesia is extraordinarily uncommon, even in very frail patients".

Is Mr Redfern one of those surgeons who you would ---
A I think that is a very balanced account of the risks, but the risks of re-operating on an elderly frail lady at her age, even without a large number of co-morbidities, are exponentially higher. She has been through it once and you are asking her to go back to theatre and have it re-explored. I did not feel at that time it would be appropriate for her.

Q What is the realistic alternative for this patient?
A Sort out her analgesia.

Q And then?
A Keep her comfortable.

Q Does that mean this patient is on a terminal pathway again?
A She is on a palliative care pathway because it is perfectly possible that without having further surgery, particularly if there had been an infection there which we were beginning to suspect, that she would regain a certain amount of function, an adequate amount of function.

Q Would you have discussed the possibility of surgery or going back to the hospital with the patient?
A Not at that stage. It was too soon at that stage.

Q On 28 March she was given two doses of Oramorph which apparently she vomits up, if we can go to page 13. You advised to stop Oramorph. Yes?
A Yes, go back down to level two.

Q She is now on to co-dydramol.
A Yes.

Q On Monday 29 March, she is given two tablets four times days list. Is that the maximum?
A Yes.

Q There is no mention of any pain in the nursing notes is there?
A There is not.

Q Over the page at page 14, on 30 March, again the same dose of co-dydramol, "Both wounds redressed with paranet". What is that?
A A dressing.

Q Then,

"Steri-strips from surgery removed. One small area near top oozing slightly - mepore dressing in situ. Check in a couple days. Sat out in chair for assisted wash/dressed. Zinc and castor oil applied to bottom, liquid paraffin ...applied to legs".

A On that day it appeared as if her condition was possibly beginning to improve apart from this slightly worrying thing about the oozing on the top of her dressing beginning.

Q On the Wednesday, we come back to Oramorph. Yes?
A Yes.

Q Which Professor Ford described as being appropriate if the co-dydramol had not worked.
A Yes.

Q If we go to the top of page 15, she is described as walking with a physiotherapist this morning but in a lot of pain.
A Yes.

Q This is now five days after admission.
A So it is two weeks after surgery.

A Q By this stage, surely you must have been beginning to worry about what was causing this patient's pain.
A I was beginning to wonder why she was still in a lot of pain. The physio I feel would have noted had the prosthesis been dislocated or had collapsed at that point because it would have been apparent when she walked.

Q The physio might have done.
B A No, would have done.

Q But this was your patient.
A Yes, but they are very expert professionals when assessing post-operative hip surgery patients.

Q Dr Barton, this is your patient; she is several weeks after surgery; you would have
C been seeing her according to your evidence daily would you?
A During the weekdays, yes.

Q Would it not have concerned you, whatever the physiotherapist was doing, because he might be making it worse, would it not have concerned you to re-examine the leg and the hip?
A What by X-raying it you mean?
D
Q No, first of all re-examine it.
A There was nothing to see. It had a dressing on it which was just oozing.

Q It was oozing; why could you not swab that?
A We then did swab it.

E Q I know you did then swab it.
A When there was enough to swab, when it became apparent that it was likely to be an infection, then we took a swab and instituted antibiotics.

Q Can we just pause, please, page 15, 1 April, Thursday so you would have been on duty.
A Yes.
F
Q The wound is described in the following way:

"Wound in right hip oozing large amounts of serous fluid and some blood. Hole noted in wound".

Does that give fairly obvious indicators of a possible infection?
G A It is a possible infection. It is also possible that that haematoma that she had at the time shortly after the surgery was now resolving and discharging through the suture line. That would give you serous fluid and a bit of blood. It was not necessarily infected at that point.

Q Would you not want to swab it to find out?
A I was going to swab it the following week.
H

A Q I am not sure where you have gone; I am still on Thursday 1 April when this patient's wound is oozing a lot of serous fluid and blood. Would you not have wanted to swab it?
A It would have been possible to swab it, yes.

Q Would you not have wanted to find out what was going on?
A Yes.

B Q Over the weekend, she is then on the Thursday to deal with her pain started on slow release morphine. Yes?
A Yes.

Q On the Sunday, her wound is still losing serous fluid and blood.
A Yes.

C Q So that is not getting any better?
A No.

Q We see that you actually get to her, at least you are noted as seeing her on Tuesday 6 April.
A Yes.

D Q "Seen by Dr Barton. MST increased to 20mg. Nephew has visited, if necessary once Enid is discharged home (she is adamant about not going to a nursing home) he will employ someone to live in. Enid has been incontinent of urine a few times over the weekend. I have spoken to her about a catheter".

Then a swab is taken, and that was at your direction, was it?
A Yes.

E Q So it took from Thursday to Tuesday to take a swab from this oozing wound.
A Yes.

Q Can you explain why?
A No. I cannot explain why we waited from Thursday to Tuesday to do the swab. I have no intelligent explanation of it.

F Q In terms of a wound infection, that is actually quite a significant period of time potentially, is it not?
A Yes.

Q You want to get antibiotics started if you need to, as quickly as possible.
A Yes.

G Q Can we go please to page 18? You apparently see the patient in the morning and it looks as if, at that time, the fracture site is described as, "red and inflamed". That would be the wound site, would it?
A Yes.

Q "Seen by Dr Barton", and you start her off on antibiotics.
H A Yes.

A

Q Those are general antibiotics. You do not know what is going on in there, but you understandably --
A I am awaiting the results of the swab but I am going blind to suitable broad spectrum antibiotics to treat infection.

Q This patient is then seen by Dr Reid, and he obviously performs a full examination,
B does he not?
A Yes.

Q "Still in a lot of pain and very apprehensive. MST up to 40 mg a day. Try adding flupenthixol".
A An anxiolytic.

C Q "For x-ray right hip as movement still quite painful – also, about 2" shortening right leg".

Can you explain why that is something that you had not noticed?
A Because it had not been apparent until that day. I had not seen any shortening the last time I had examined the hip, which would have been the previous Thursday when I did not take the swab.

D

Q Did you review her on that day with Dr Reid?
A I do not think I was there.

Q You see your note that we have just looked at, "Seen by Dr Barton", would have been made in the morning, would it not?
A But I would have looked at the patient in the bed and looked at the wound – they
E would have shown me the wound oozing, but I would not have attempted to walk her or examine the hip.

Q No, but you plainly did not undertake the same sort of examination that Dr Reid conducted.
A No, I did not, not that morning.

F Q Because we can take it, I think, that the leg probably did not shorten itself two inches --
A During the morning.

Q During the morning.
A No.

G Q And Dr Reid on the Wednesday has asked for an x-ray.
A Yes.

Q This presumably is something that would have been relayed to you, "Dr Reid examined one of your patients and found that one leg was two inches shorter than the other leg and asked for an x-ray".
A Yes.

H

A Q That would be relayed to you, or you would see it in the notes.
A Yes.

Q The following day, you would want to know what had happened about that x-ray or what was happening about the x-ray, would you not?
A I knew that it had been booked. I did not pursue the x-ray any further than that. I knew that Dr Reid was going to review it when he saw her on the next ward round.

B Q Which would be when?
A The following Monday, by which time she would have finished her course of antibiotics.

Q But her antibiotics, of course, are not going to deal with her shortened leg.
A It is going to deal with her wound infection.

C Q If she has got a shortened leg, certainly as a lay person it is very much like the repair has collapsed in some way, is it not?
A Something has happened to the repair, but that is not as urgent a problem as dealing with the wound infection.

Q So your comment, that I have recorded, is that nothing about the x-ray would have
D altered your management.
A That is correct.

Q You also said, "I would not have looked at the x-ray".
A No.

Q Why not?
E A Because looking at the x-ray would not have altered my management of her patent wound infection, leaving aside whether the prosthesis had or had not collapsed, or the head had dislocated. That would not alter my management of the wound infection and you could not transfer her back to the orthopaedic unit with a raging wound infection.

Q Did you think of consulting the orthopaedic department to see what they would do?
A No.

F Q Can we go over please to page 21 of the chronology? Sorry, I have missed something important. Can we go back to page 20? On the Saturday there is a nursing note that she had a very poor night and the patient appeared to be leaning to the left.

"Does not appear to be as well and experiencing difficulty in swallowing".

G A Yes.

Q You say, I think, "I would take this to be a stroke".
A Yes, or a transient ischemic episode.

Q Did you have any other possible diagnosis for that?
A No.

H

A Q Bearing in mind that her right hip is painful and inflamed, apparently, that something has gone wrong with her operation. Did you think it could be connected to that?
A If she had a wound infection and she had become septicaemic, I suppose a bolus of infection to the brain. That is a possibility.

Q Come Sunday, page 21, she is described as,

B "Condition ill. Tolerating sips of oral fluids. Not anxious to be moved in any way",

and there is pain on movement.
A Yes.

Q If we look at the review by yourself, and you think this is on the next day I think, 12 April.
C A I do.

Q "Enid's condition has deteriorated during this afternoon. She is very drowsy, unrousable at times. Refusing food and drink. She denies pain when left alone but complaining when moved at all".

"Unrousable at times", would you need to reflect upon that when you administer any
D morphine to her?
A No. I would be keen to give her adequate analgesia. I would be aware that she was unrousable at times because she had entered the terminal phase of her life on the Saturday.

Q So at this stage all hope is lost for this patient. Is that right?
A Yes.

E Q No point in looking at any x-ray.
A This is Saturday we are talking about?

Q No, Monday 12 April. Just pause for a moment.
A Yes, they come in on Monday morning. I am not expecting to look at the x-ray one way or the other. I come in to find that Enid has deteriorated markedly over the weekend and has entered the terminal phase of her life.
F
Q That is your view.
A That is my view.

Q At the bottom of page 21 we can see that on the Sunday she is given Oramorph at 7.15 in the morning, 5 mg and then 20 mg of MST.
A Twice.
G
Q So a total of 45 mg.
A Yes.

Q Which would be, MST is oral, so 45 mg, an equivalent dose would be around 20mg.
A Yes.

H

A Q Of diamorphine. Over the page please to page 22 and 23. You wrote out your usual prescription for diamorphine and midazolam, did you not?
A Yes.

Q You decided that this patient should start on 80 mg of diamorphine.
A Yes.

B Q Which would be the equivalent oral dose of 240 mg orally.
A Yes.

Q Now reflecting upon that, do you accept that that was far too high?
A I prescribed what I considered to be an appropriate dose to control her pain and her symptoms on that Monday morning when I saw her on the ward. I did not consult with the Palliative Care Guidelines. I gave Enid what I thought was appropriate for her condition.

C Q She was, the day before, described as "very drowsy and unrousable".
A Yes.

Q You then give her a dose which was four times as high as the one she had been on.
A Yes.

D Q Even now you do not think there was anything wrong with that, do you?
A I gave her what I felt on that morning, seeing her, was the appropriate dose.

Q So the answer, Dr Burton, with respect, is no.
A No.

Q You do not think there was anything wrong with that.
E A No.

Q You must have been surprised when Dr Reid reduced it by a half.
A If he felt it was appropriate to reduce it, that is absolutely fine.

Q It is absolutely fine, all things might have been fine, but did you not say to Dr Reid, "What are you doing with this patient?"?
F A I was not there.

Q No, but did you become aware that that is what had happened, that he had reduced the dose that you thought was necessary by a half?
A Yes.

Q Did you take it up with him?
G A No.

Q Why not?
A Because I did not think it was necessary to take it up. I had had my opinion of how she should be treated that morning. He had a different opinion that afternoon. He had changed the dose of the analgesia. That was absolutely fine.

H Q But did you say to yourself, "Well, one of us must be wrong"?

A No, neither of us were wrong. It was a clinical judgment on both occasions as to what dose you give that patient in front of you.

Q What then happens is that, having reduced the dose, it appears that a nurse, either by mistake or deliberately, doubled the dose of midazolam.
A Yes, that is apparent.

B Q Dr Reid himself described that as "astonishing". This was a doubling up – I was going to say it was Nurse Hamblin but I am not sure that that is right. Do you find it surprising that a nurse would think it appropriate, if that is what happened?
A I can only think that that was the instruction that she thought she had gotten from him. I was not there. I cannot make any further judgment other than that, but she may have understood him to say, "Put them both to 40", or something like that. I can honestly give you no more intelligent answer than that.

C Q The ability to increase that dose by doubling it was allowed for by our prescription, was it not?
A Yes, it was.

Q Professor Ford described your starter dose as definitely excessive. You do not accept that, do you?
D A I do not accept that.

Q And he also commented that even reducing it by as much as a half, with the midazolam, you could not now assess how the patient was. You agree with that, presumably, because she would be unrousable.
A I did not assess her. I did not see her that night.

E Q And the patient died at 1.15 the following morning.
A Yes.

Q Do you accept that it seems very likely that this patient died as a result of the sedation that she was on?
A No.

F Q You put down her cause of death as CVA.
A Yes.

Q What was that based on?
A The evidence of my nurses when they saw her on that Saturday morning, and the evidence of what I saw when I saw her on the Monday morning. Again, I did not record anything.

G Q If you had recorded her cause of death as being a direct result of over-sedation, would that have initiated an inquiry?
A I have no idea.

Q Did you consider that she might have been over-sedated?
A Not at all.
H

A Q Even after you knew that Dr Reid had reduced the dose by a half?
A Not at all. I felt that on that Monday she was dying, and the initial dose that I gave her was appropriate for her condition.

MR KARK: That is all I ask you about Mrs Spurgin. Sir, I wonder if in the circumstances that would be a convenient moment.

B THE CHAIRMAN: I think it would be a very convenient time, thank you. Mr Langdale?

MR LANGDALE: May I just mention a matter which may arise in connection with all witnesses. I know from what my learned friend has indicated to me, he anticipates his cross-examination will go some way into tomorrow morning but will conclude before lunch time. I would have thought such re-examination as I have for Dr Barton will not take any great length of time.

C There is a witness whom the defence are anxious to call. It is a nurse. She is in real difficulties in terms of holiday arrangements, as I understand it, if she is not called tomorrow afternoon. The Panel are not sitting on Thursday. I understand it would or might be just about possible for her to give evidence on Friday, but that would be causing her some difficulties. I just wonder whether the Panel would be kind enough to consider whether it would be appropriate for her to be called tomorrow afternoon. I do not think she is going to
D take anything like all afternoon. Those besides me think not.

THE CHAIRMAN: If there would be no objection to the Panel delaying their questions, then I think we could accommodate you. I think in any event, the Panel at this time are feeling very much again that we have been moving very fast, and they would wish to have an opportunity to look at transcripts beforehand, so it may be in fact that that would work well and I could say now, yes, by all means arrange the witness for such time after Mr Kark has
E finished, and hopefully after you have completed your re-examination. Do you have any sense of how long that witness is likely to need?

MR LANGDALE: Mr Jenkins says maybe up to an hour. He will be taking the witness. She is not dealing with lots of patients. There is only one patient she deals with. I doubt if Mr Kark's questions will be particularly lengthy with her. Something of that order.

F THE CHAIRMAN: I think we have no difficulty in doing that and I have to say now that we would rise then at the end of that period, whenever it was. Given that the following day is a non-sitting day, it will not be possible for the Panel to be using that day for its review, so we would probably be trespassing into Friday. I think what I will say is, when we rise tomorrow – at whatever time it is – we will then give an indication of a "not before" time for the Friday morning. We would do our independent study, and you would not need to be here waiting on us, in effect.

G MR LANGDALE: Thank you very much

THE CHAIRMAN: Very well. Thank you very much, ladies and gentlemen. Tomorrow morning please at 9.30.

(The Panel adjourned until Wednesday 22 July 2009 at 9.30 a.m.)

H