GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday 30 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 THIRTY-FIVE)

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

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

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

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THE CHAIRMAN: Good afternoon everybody. In so far as three o'clock is not before two, my estimations yesterday were not entirely wrong, but I do apologise for the extra time that we have taken.

DECISION

Before the end of proceedings yesterday, you made an application to adduce evidence on

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behalf of Dr Barton from three witnesses, two of whom are patients of Dr Barton, and all of whom have had a parent treated by Dr Barton during her time at the Gosport War Memorial Hospital (GWMH). You stated that their evidence will give the Panel some insight into

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Dr Barton's general disposition and patient care practices at the time. It is your submission that their evidence is relevant to certain aspects of the fact-finding exercise that the Panel has shortly to perform.

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Mr Kark, Counsel for the GMC, opposed your application on the basis that any evidence given by these witnesses would be either character evidence, or evidence not specifically relating to the allegations in the case. Mr Kark submitted that the GMC's case relates only to

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the care received by the twelve patients that have been considered during this hearing.

The Panel has considered your application. It has had regard to your submissions and those of Mr Kark. It has also noted the advice of the Legal Assessor in relation to relevant

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evidence at the fact-finding stage. The Legal Assessor has advised that it may be helpful to consider separately the proposed evidence as to good character and general medical skills on the one hand, and Dr Barton's examination practices on the other.

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Dealing with Dr Barton's examination practices, the Panel notes that there are specific allegations as to failures in her examination and assessment of twelve patients. It appears that

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A the proposed evidence does, in part, concern the issue of patient examination by Dr Barton at GWMH during the period under consideration.

B It is not in dispute that Dr Barton assessed patients other than the twelve with whom we are directly concerned. The Panel notes that the fact that Dr Barton assessed other patients does not however, mean that she necessarily assessed these twelve.

C The Panel recognises that a large number of witnesses have already been asked general background questions by all Counsel and by members of the Panel. As you pointed out, there were questions for example, as to the safety of the wards and Dr Barton's interaction with relatives. It would appear to be inconsistent if evidence on such issues were now to be

D excluded. If adduced, the proposed evidence might or might not assist the Panel in determining the factual issues before it. The Panel will only be in a position to make such a judgement, if it permits the evidence to be adduced.

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As to evidence concerning the Doctor's good character and general medical skills, the Panel recognises that such evidence can have no relevance to the fact-finding process, and the Panel notes your concession that such evidence is not for the Panel to consider in relation to serious

F professional misconduct under Rule 27(2)(ii). However, the Panel recognises that, for the reasons given by the Legal Assessor, such evidence has already been elicited from many witnesses. The Panel takes the view that it is well able to set aside consideration of such

G evidence until the appropriate stage is reached, and that it would be wrong and unnecessary to require witnesses to return on a second occasion to give such evidence.

It is on this basis that the Panel has determined to accede to your application.

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A There is a matter that the Legal Assessor would like to raise.

THE LEGAL ASSESSOR: Thank you, Chairman. It is simply this. If one looks at the transcript of yesterday's hearing, Day 34, 29 July, there are two matters which need correcting in terms of the transcript of the legal advice I gave. I am confident that I gave advice, in fact, in the terms which I am about to correct. Could people please go to page 64 of the transcript.

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MR KARK: Sir, we do not yet have it.

THE LEGAL ASSESSOR: Perhaps a note can be made of it.

THE CHAIRMAN: We have the transcripts just coming out. (Same circulated)

C THE LEGAL ASSESSOR: If one looks at page 64 of the transcript, the bottom paragraph on that page starts with the words "In order to be relied upon by you", the third sentence in that paragraph should read as follows:

> "Although it is a matter entirely for you, you will no doubt wish to consider the position very carefully before you conclude that any character evidence or general evidence as to medical skills…".

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That is the first correction. In that paragraph if one goes to the third last sentence, starting with the word "Furthermore", that should read:

> "Furthermore, I anticipate that you will hear…".

I am confident, in fact, that those are the words I used when I gave my advice yesterday.
E Thank you.

MR KARK: Sir, certainly I accept those corrections. Can I just make a comment about your determination and it is not in any way seeking to go behind it at all.

At the beginning of the determination, it certainly sounded as if you were indicating that in your view as a Panel at this stage which you are soon to reach, in other words the fact-finding
F stage, character cannot be relevant. There are circumstances where character can be relevant if it is character evidence of a particular nature. In due course, no doubt, your Legal Assessor will give you advice about that. It is just to put down a marker now that I am sure you were not indicating that, should you receive contrary legal advice in future, the Panel was indicating in no circumstances would you be accepting character evidence as being relevant to the allegations. If, in so far as the Legal Assessor advises you that it may be, then no doubt you will review that position.

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THE CHAIRMAN: I am sure that that would be right. We were looking at the position from the point at which we are currently. I think that you had indicated to us that it was not appropriate for us to take character evidence into account at that fact-finding stage, in terms of the allegations.

MR KARK: What I was saying was, character evidence of this nature, rather than character
H evidence generally.

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THE LEGAL ASSESSOR: Perhaps I could just emphasise the fact that in the advice I gave yesterday – in fact we have just looked at it – I have already stated that I will advise the Panel formally in due course that Dr Barton's good character may be take into account, assuming that is a matter which is agreed. That part of the determination, I am sure, will be read in the light of the advice that I gave yesterday.

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MR JENKINS: I am going to ask if the determination you have just reached has been reduced to writing. I am sure it has. I would like the chance to have five minutes just to look at it, to ensure we adhere to it.

THE CHAIRMAN: It has, and there can be no reason why you should not now be given a copy. If you would like five minutes to read it, you will certainly have that five minutes.

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MR JENKINS: Thank you. I would be grateful. (After a short pause) Sir, thank you very much. Can I say, we have had to re-jig the witnesses slightly as a result of matters yesterday. I would like to call one lady who was the practice nurse at the GP practice. She did not, in fact, have a relative who was at the War Memorial Hospital. To the extent that I said yesterday she did, I had mis-recalled the information I had been provided about her, and that is my fault. However, I would like to call her. Knowing as I did this morning that I had misled you yesterday about that, it is right that I should say that before I call her. She is a practice nurse. She will have seen Dr Barton dealing with patients on a regular basis, and I raise that before calling her in case anyone wants to raise any objection, given the ruling that you have given. We have had to re-jig patients. I am going to call someone other than someone we were intending to call, but this person did have a relative who was treated at the War Memorial Hospital and I hope to call her this afternoon as well.

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THE CHAIRMAN: While we are on the subject of *mea culpa*'s, on reflection, Mr Kark, I think that we might better have drafted that paragraph in relation to good character by the simple addition of three words. Where the paragraph begins "As to evidence concerning the doctor's good character and general medical skills, the Panel recognises that such evidence *from these three witnesses* can have no relevance to the fact-finding process." I think that was the implication, albeit a silent one of what we were intending at that point.

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MR KARK: It is always slightly difficult thinking these things through on one's feet, but having indicated that you need to hear it before you can decide whether it might have relevance, it might be better to reserve your judgment, as it were, on that amendment.

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THE CHAIRMAN: That is a further interesting point. I am grateful. I was not suggesting I would make an amendment in any event. It was merely to illustrate, I think, what was in our mind rather than the general point of evidence. It was the specific evidence that was sought to be adduced today.

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MR KARK: Just having heard from my learned friend in the spirit of abiding, as it were, with your clear wish to hear evidence and then deciding afterwards what weight you are going to give it, I am not going to raise any further argument at this stage which might delay us even more.

THE CHAIRMAN: Thank you very much.

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MR JENKINS: I will get on and call some witnesses if I may. I am going to start with Patrick Carroll, please.

PATRICK GWYLYM CARROLL, Sworn

(Following introductions by the Chairman)

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Examined by MR JENKINS

MR JENKINS: I am going to ask you to give us your full name, please.
A My full name is Patrick Gwylym Carroll.

Q What do you do, Mr Carroll?
A I am a qualified occupational therapist.

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Q When did you qualify?
A I qualified in 1989.

Q I think you are registered with the Health Professional's Council.
A Yes, that is correct.

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Q At some stage did you work in Gosport?
A Yes, I worked at Gosport War Memorial from 1994 until 2004 delivering occupational therapy to in-patient wards as well as direct referrals from general practitioners out in the community.

Q We know about several wards at the War Memorial Hospital during the 1990s, Daedalus Ward and Dryad Ward, and we have heard of Sultan Ward, which we have been told was a GP led ward. Is that right?

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A Yes, that is correct.

Q We know that Dr Barton worked there from before the time you started in 1994 and she left the War Memorial Hospital in the year 2000.
A Yes.

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Q Did you come across Dr Barton during the time you and she both worked at the Gosport War Memorial?
A Quite routinely in terms of working with patients from Dryad Ward and Daedalus Ward as well as occasionally patients on Sultan Ward. Sometimes I would also take direct referrals from Dr Barton to see patients who were out in the community still living at home.

Q How would you be seeing patients on Dryad or Daedalus Ward? How would you come to see them?

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A The role of occupational therapy is to facilitate discharge from those wards. Generally, going back to 1994 to 2000, those wards were very slow stream rehab, or what was called continuing care then, so we would only occasionally get referrals for patients who were considered to have improved or stabilised to a point where they were to be considered to go home to live independently or with support, or alternatively we might occasionally do assessments related to the level of care they might need in terms of whether they were going to go into residential care or nursing home care.

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Q How would you come to know that a patient was on those wards and that your involvement might be beneficial.
A They would generally be referred by the sister in charge of the ward and then that would mean that I would go along to either a ward round or a specific meeting with the multi-disciplinary team to discuss the referral.

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Q What would you say was the level of cover that you were able to provide patients on those two wards, Dryad and Daedalus Ward?
A For general referrals it was ad hoc cover. Traditionally the patients who were admitted to those wards were not anticipated reaching a level where they would be able to live independently in the community. So the service I worked for at the time was not funded to cover those wards but we covered the hospital anyhow, and as they were not that frequent, we would be able to cover it on an ad hoc basis. So we were able to deliver what was required, but there was not a formal agreement or formal service in order to do it.

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Q Ad hoc means just that, as required, does it?
A Yes. If they asked we would go and see the patient.

Q Does it follow from what you said that it was not part of your job description to provide cover for those wards? It was not planned that those wards would have cover.
A Not specifically, but we had capacity to be able to do it and because they were not frequent referrals it would be a case of prioritising the workload so a referral from Dryad Ward may take an extra few days to pick up, but we would be able to do it. If we were overloaded with referrals from the other wards, particularly Sultan, those would have to take priority, but it was not unmanageable.

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Q How much time were you able to allocate to the patients on Dryad or Daedalus Ward?
A As much time as was needed to discharge the patient. If they were capable of being discharged home they would get a full, comprehensive occupational therapy assessment in the hospital, usually because those patients had been so dependent we would take them out and do a home visit to see whether they could manage in their home environment as well.

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Q What, during the period that you and Dr Barton overlapped – 1994 to 2000 – was the general level of mobility and the prospects of rehabilitation for those patients on those wards that you were aware of?
A I guess we probably saw between 10 and 20 per cent of the patient population going through those wards. It tended to be that it was fairly unusual for a patient to stabilise and recover to the point where you could consider them living independently in the community with special services support.

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Q Did the mix of patients on those wards stay the same over that period of time?
A I think yes and no. Yes, they did, but what changed was the expectation of rehabilitation and getting patients home. The drive became that it was much more expected that we would not just shrug our shoulders and say, "This person has to go into care". It would be, "How can we enable them to go back and live in their own home?" So it was a general shift, I would say, within the hospital and the drive of the NHS to move away from continuing care; i.e. somebody who is admitted on an open-ended admission to the expectation that they would move through the ward and move on to some other place, either their own home ideally, but often into residential care or nursing home care.

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Q How much contact would you have had with the senior nursing staff on the two wards, Daedalus Ward and Dryad?
A I would be on there at least weekly, sometimes three times a week. What we do is we walk the wards and we would ask and see who were the new admissions; what was the likely potential for their care; what was the estimate in terms of was their medical diagnosis such that they were likely to stabilise and improve? Could we think about them going home? So it is a case of primarily building a relationship with the ward sister and keeping an eye on it, because it is a two-way process. You do not just rely on the ward telling you. You want to be seen on the ward so that you are giving advice because sometimes the opinion of the occupational therapist that somebody can go home is going to be different to the ward team's.

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Q Absolutely. Would you have had time to form a view as to the standard of care being afforded to patients on those two wards, Dryad and Daedalus Ward?
A Yes, because you are on the wards quite frequently and from my perspective there was never any concern that the standard of care was anything other than good to excellent. I think within health services you sometimes do get a feel that people will be wary about wards, but that was never anything that I picked up or felt within the War Memorial.

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Q I have asked you about two wards, Dryad and Daedalus Ward and you have just given me an observation. Does that apply to both wards?
A Yes, and Sultan as well.

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Q What would you say of the standards of nursing care for the patients, again on both of those wards?
A I think the standard of nursing care was good to excellent. I would not characterise any of the wards at the War Memorial as being anything other than having above average care generally on the wards.

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Q The Panel knows that on Daedalus Ward Sister Sheila Joines was in charge on the nursing side for much of the time that you were there.
A Yes.

Q Then the ward manager was Code A
A Yes.

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Q On Dryad Ward, throughout the time with which we are concerned, certainly from the time you were there, it was Sister Code A
A That is correct.

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Q Again, what would you say about those three individuals as nurses, sisters in two cases and ward manager in the other?
A I think if I had to list them in order of people I had the best rapport with, I would probably say Code A and Sister Joines were what I suppose we would now describe as classic, old school ward sisters where basic nursing care was paramount and they did rule the ward. They were the authoritative figure on the ward. I had no difficulty working with either of them. I would say the level of patient dependency was often higher on Dryad ward than Daedalus Ward and so we did not necessarily, as an occupational therapist, anticipate a high number of referrals from that ward. We tended to get a few more from Daedalus Ward.

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Q What would you say from your perspective about the success that was being had with patients being treated, both by the nursing and medical staff but also yourself?
A I think if you consider what the wards were there for, it was a balance between sometimes the frustration that they had a tendency to get patients better when maybe it was less expected. They get patients to a level of independence where you really could consider discharge home and that would create more work for my service and myself because domiciliary visits would be required for those patients because they had been so dependent. You could not trust what you saw in the hospital. You had to see it within the patient's own environment, so if anything I think they tended to get rather more patients than I would have expected to the level where they could live independently.

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Q What would you put that success down to?
A I could only put it down to the care that they received because sometimes patients would be transferred in pretty poor states and it would takes sometimes several weeks to stabilise them. On Dryad Ward I would often say to **Code A** "Let us see what the patient is like in a couple of weeks or three weeks", just to be sure that they had stabilised and part of that was me protecting myself so I could actually plan my diary in enough time. So my impression was that they provided very high levels of care.

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Q What about Dr Barton, what would you say about her?
A From my perspective I think sometimes it is difficult to build a rapport with general practitioners because sometimes they hold themselves aloof, often for very understandable reasons, or there is a tendency to prescribe other professional's practice. They would say, "I want Patient X to have occupational therapy" and then do not define that; they do not define the problem, whereas referrals from Dr Barton would be much more of an open discussion about, "Do you think you could see this person? Do you think they would benefit? Could you get them out on a home visit/" It was much more of a professional dialogue rather than a fire and forget type of referral, which I think generally my experience of general practitioners is that they like to fire and forget.

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Q What would you say, from what you saw, of Dr Barton's commitment to patient care?
A I think the level of involvement she had with the patients was extremely high. It was certainly different to other GPs I have worked with. She was very concerned that patients received a good level of care within the context of what is quite a difficult thing; it was quite difficult to provide in those days good medical care within a community hospital. It tended to have been developed, I felt, from an informal agreement and Dr Barton, if you were going to see a GP, you would see Dr Barton. Generally I would say I would have expected or been aware that she would have popped into the hospital almost daily, and that is really quite unusual in comparison to some of the patients who were admitted on to Sultan under the care of their GP. Dr Barton would be somebody who is around that you could have a dialogue with and you felt your point of view was being heard and very much felt like you were part of a team being led to provide the best outcome for the patients concerned.

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Q You would have been on those wards doing a walk through, you have told us.
A Yes. That is how I would pick up the referrals. In terms of working with the patients, if we were carrying out assessments to see whether somebody could wash and dress, we might be on the ward for an hour, an hour and a half, in the morning

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A where we would take over that process with the patient from the nursing staff in order to see how much the patient can actually do for themselves so we can make a clinical judgment about how they might cope at home where carers might not be completely reliable and they might have to get themselves washed and dressed.

Q You told us you might be dealing with 10% or 20% of the patients on the wards.

B A Yes.

Q Why were you not dealing with the other 80 or 90?

A Sometimes because they were simply too medically unwell. Sometimes it was - I do not know whether now it would be, but then it would be obvious that the patient was not going to be able to go home. Some of the patients were, effectively, receiving palliative care. They were not going to improve to the point

C where perhaps they could even be discharged from the hospital. A lot of transfers into that ward would come from the acute hospitals and there is great pressure on the acute hospitals to clear their beds, they need to get their beds clear, and if they have a patient who is clearly not going to be able to go home they would want to transfer them into a continuing care bed or a very slow stream rehab bed in order to relieve the pressure on the acute side, and sometimes there would be a tendency for those hospitals to perhaps - I think the kindest way would be to enhance the patient's capabilities and potential in order to facilitate the transfer, so we might be

D told somebody is mobile with one and then when they are on the ward and we carry out an assessment they either are not mobile or they are mobile with three physiotherapists and a walking frame. I suppose it is playing within the system in order to move patients through.

Q Are you able to help us with the practice of transferring patients from one facility to another and whether that may have any consequences for the patient?

E A I think it is sometimes underestimated that a patient in the acute trust might have transferred through three wards and then, sometimes very late at night, would have been transferred by ambulance to the War Memorial. So somebody who could be described as stable after 24/48 hours in an acute hospital, the stress of the ambulance journey, the stress of the transfer, could set them back quite considerably and have a marked impact on their medical state. So often we would want to delay even thinking about an assessment or a referral for several days after

F somebody had been transferred.

MR JENKINS: Thank you very much, Mr Carroll. Would you wait there because you may be asked a few questions by others.

Cross-examined by MR KARK

G Q I have very little to ask you. Can I just deal with the comment you just made about, effectively, playing the system to get the patients transferred out of hospital? Are you saying that in relation to both the QAH and the Royal Haslar?

A They were the primary transferring hospitals so, yes, it was certainly known that it would happen.

Q So far as the patients that you saw on Dryad and Daedalus wards, do we take

H it you saw those patients who were referred to you by the medical staff?

A Yes, and we would also discuss potential referrals in the ward rounds, so we

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would discuss other patients in terms of what their likely potential was because I would be trying to establish what my workload might become in the next couple of weeks or so.

Q I understand, but if Code A or one of the nursing staff or, indeed, Dr Barton says of a particular patient, "Well, this one is for palliative care", or end of life care, would you make your own individual assessment of that patient?

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A Not generally. Occasionally we would because if somebody was for palliative or end of life care and they wished not to die in the hospital, they wished to go home, then the Occupational Therapy Service would be involved in terms of identifying providing equipment and assessing that the equipment was appropriate to that person's needs.

Q If that was an option for that particular patient?

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A Yes.

Q I understand. Forgive me, but you have been speaking about occupational therapy. How close is that to physiotherapy?

A The two professions overlap quite a lot. Occupational therapy is centred around functional activity. So a physiotherapist would work with somebody to retrain them to gain range of movement and particularly around gait and transfers. An occupational therapist is concerned with how you might use that ability. So,

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for instance, a patient might regain fully after a stroke their ability to move their arm but if they have cognitive deficits it will be the occupational therapist who identifies that through their inability to make a discrimination between their shirt and their underpants when you are doing washing and dressing practice. So occupational therapy is what can you do with the ability; physiotherapy is much more focused around regaining an ability.

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Q Can we take it you work quite closely with the physiotherapists at the same time?

A Yes. Often we would do joint visits to somebody's home in order to ensure, for instance, that if we were looking at them being able to ascend and descend a staircase you might take a physiotherapist with you because that is their area of expertise and I would be concerned with looking at whether the patient needed, for instance, an extra rail.

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Q For those patients who were referred to you, no doubt there were times that you were busier than others but you did not find you were unable to fulfil your commitments?

A No. If the patients needed to be seen we were able to see them. Occasionally they might wait maybe a week maximum before we could pick up the referral but that was understood on the ward as well.

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Q Was that the same, as far as you were concerned, with the physiotherapist?

A I believe the physiotherapists were contracted to provide a service to the wards so they would tend to have more capacity to be able to do it.

Q They had greater capacity than you did?

A Yes.

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MR KARK: That is all that I ask you. Thank you very much.

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MR JENKINS: I do not have any re-examination. Thank you.

THE CHAIRMAN: Thank you. We have reached the stage, Mr Carroll, when it is open to members of the Panel to ask any questions of you if they have any and I am going to look now to see if they do.

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Questioned by THE PANEL

MRS MANSELL: It is just a point of clarification really about the multidisciplinary teams that you talked about. Who would form the multidisciplinary teams?
A The core of the multidisciplinary team would be the doctor, whoever was responsible for that particular patient, it would be the nursing team on the wards, it would be the physiotherapist, the occupational therapist, occasionally speech and language therapy might be involved, often a social worker or somebody from adult services would be along for planning meetings if patients needed support in the community post-discharge. Also I would argue the patient and their relatives were part of the multidisciplinary team as well.

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Q Thank you. So on Dryad and Daedalus it could be either Dr Barton, could it, who would be the doctor or would it be the patient's GP because it was always about patients going home?
A On those wards it was Dr Barton. On Sultan Ward it would be other doctors because a patient would be under the care of their GP then.

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Q How easy did you find it to get a multidisciplinary team pulled together?
A I think sometimes you would struggle getting somebody from adult services, but, generally, the rest I would say nine times out of ten we were able to get everybody together for the planning meetings and to deliver the care.

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Q Without a tremendous amount of planning or forward thinking?
A I would say providing you had around about five days to seven working days you could pretty much guarantee to get everyone together.

Q Some of those patients, because it was a slow stream stroke patient that you may be rehabilitating, was a lot of that not just about getting patients home but to increase their capacity on the wards?
A I think expectations have changed in the last ten years in terms of the standards that we set ourselves as clinicians. Going back ten years, I think we were only just learning the necessity to keep working with everybody all the time. That is not to say that we would write patients off, but if a decision was made that somebody was going into nursing home care I had a limited resource so I would make the decision that there was little or no point in carrying out washing and dressing training with somebody because after discharge that was pretty much going to be done for them by the care staff in whatever residential home they went to.

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Q So your focus was primarily for the patients who were going to go home?
A Yes.

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THE CHAIRMAN: That concludes the questions from the Panel members. There is one final hurdle. I now have to ask the barristers whether they have any questions arising out of the Panel questions.

MR KARK: No, thank you very much.

MR JENKINS: Nor I, sir. Thank you very much.

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THE CHAIRMAN: Very well. That concludes your testimony. Thank you very much for coming to assist us today. I do apologise if you have had to wait a bit but you are now free to go. Thank you.

(The witness withdrew)

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MR JENKINS: Sir, I am going to call Susan McConnell, please.

SUSAN LESLEY MCCONNELL, Sworn

(Following introductions by the Chairman)

Examined by MR JENKINS

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Q I am going to ask you to give us your full name, please?
A Susan Lesley McConnell.

Q Ms McConnell, I wonder if you would give us your professional qualifications?
A I am a State Registered Nurse and a Registered Midwife.

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Q When did you register as a nurse?
A 1969.

Q As a midwife, I think about four years later?
A 1973.

Q Have you worked as a nurse alongside Dr Barton?
A As a midwife.

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Q And when and where was that?
A I first met Dr Barton in 1985 when I went to work at the maternity unit in Gosport as the senior midwife.

Q You say "Gosport"'; is that the War Memorial Hospital?
A No, it was not that. It was Blake Maternity, which was a GP unit.

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Q And did that subsequently close, and was it transferred to the War Memorial Hospital?
A It transferred to the War Memorial Hospital in 1992, I think.

Q You would have worked with Dr Barton from 1985?
A Yes.

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Q And how did she come to be working with you at the Blake unit?
A Blake maternity unit was a GP-led maternity unit at the time and Dr Barton together with all the other GPs in Gosport were responsible for the care of their patients whilst they were in Blake.

Q And did that system follow, once the unit was moved to the War Memorial Hospital?
A Not precisely. A lot of GPs opted out of maternity care or obstetric care, but they did continue to see their patients in the War Memorial.

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Q So you would have seen Dr Barton in the Blake maternity unit?
A Yes.

Q When it was running. And would you have worked with her after the Blake unit closed?
A Yes, into the War Memorial.

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Q In the War Memorial Hospital?
A Yes.

Q So how many years in total would you say you had worked with Dr Barton?
A About eighteen.

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Q Did you have the opportunity during that time to form a view as a fellow professional of Dr Barton's skills and abilities as a doctor?
A Yes, I think so. I think Dr Barton was an excellent GP.

Q Tell us why you say that?
A Because her care was always for the benefit of the patients. She was careful and considerate to the patients. She valued the opinion of colleagues, like myself, and always acted in the best interests of her patients.

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Q Do not all doctors value the opinion of colleagues?
A No, I am afraid they do not, at least not nursing colleagues or midwifery colleagues. Whenever we called Dr Barton or asked her to come in, she always came in immediately and would always say, "Why are you calling me? What is the problem? What do you think?" And would listen to the staff, the midwifery staff, and not just come in and do what she thought.

F

Q Right?
A She would discuss it with us and was delightful to work with.

Q You would have seen her dealing one to one with patients?
A Oh yes, yes.

G

Q How was she in dealing with patients?
A She was always extremely kind and caring towards her patients, and they were always delighted to see her because when we went to the War Memorial the patients used to come in from either St Mary's, the main maternity unit, or they would deliver in Blake, and we would always ring the GPs to say, "Your patient has arrived." When we told the patients, "Your GP

H

A is coming in to see you", Dr Barton's patients were always very excited that she was coming in to see their new baby, or to see them.

Q Could you say the same for all the other patients, about their GPs?
A Not always, no. Some of the patients would say, "Why? Why is my doctor coming in? We do not need to see them."

B Q Tell us a bit more about the War Memorial Hospital. I think a relative of yours was a patient there for a period?
A My mother was in the War Memorial Hospital for a number of years. She was often admitted. She was chronically ill for about 15 years before she died and she was admitted to all the local hospitals, including the War Memorial, and whichever hospital she was admitted to she always wanted to go to the War Memorial Hospital, because she loved it there. The care that she received was excellent and she was very happy there. She was in all the wards
C in the War Memorial Hospital at one stage.

Q We know of Sultan Ward as a GP-bedded ward.
A She was in Daedalus.

Q There was Dryad and Daedalus Wards as well?
A She was in both of them.

D

Q Was she in Dryad too?
A Yes.

Q And we know that Dr Barton was there as the clinical assistant from when Daedalus and Dryad opened in 1993 to when she resigned in 2000. Would your mother have been on Dryad or Daedalus within that period, between 1993 and 2000?
E A I would think she was because she was in and out of hospital so much, and she must have been in at one stage because she was MRSA positive. It was Dr Barton who came to tell me she was MRSA positive. She came to tell me because she felt I should know, to get myself tested, because obviously I was working with newborn babies.

Q Again, what was the standard of care that your mother got when she was at the War Memorial Hospital?
F A It was very, very good. She was very well cared for.

Q The Panel has heard evidence from various sources about the War Memorial Hospital. They have heard observations from different people: many people who worked there and some others who had relatives who were treated there. But as someone who worked there, and someone who had a relative treated there, what would you say of the general standards that were applied on Dryad and Daedalus Wards, as examples?
G A I think the standards of care were very good. As a nurse you notice the way people are treated and the way people look when you walk into a hospital ward. You can see if they have been cared for, if they have been bathed and their bed has been made and if they are comfortable. I always felt whenever I went into any of the wards in the War Memorial Hospital that that was a good, high standard of care that the patients were receiving.

MR JENKINS: Thank you, Ms McConnell. Would you wait there, because you may be
H asked a question or two by others.

A

MR KARK: No thank you, no questions.

THE CHAIRMAN: Clearly no re-examination.

MR JENKINS: No.

B

THE CHAIRMAN: And no cross-examination. We have reached the point now where members of the Panel can ask questions of you if they have any. I am going to look to see if there are any questions. (The Chairman conferred with Panel members) There are no questions from members of the Panel so you have completed your testimony.

Thank you very much indeed for coming to assist us today. It is most helpful when we have witnesses who are able to come and tell us from their own experience what happened and how things were, often many years before. It assists us in the task that we ultimately have to address. Thank you for coming. Thank you for your assistance, and you are free to leave.

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THE WITNESS: Thank you.

(The witness withdrew)

D

MR JENKINS: I am going to call Gillian Hughes, please, as the next witness.

GILLIAN TINA CAROL HUGHES, Affirmed

(Following introductions by the Chairman)

Examined by MR JENKINS

E

Q Can you give us your full name, please?
A Yes. It is Mrs Gillian Tina Carol Hughes.

Q Mrs Hughes, I think you know Dr Barton?
A I do.

F

Q How long have you known her?
A About 25 years.

Q I think you are a patient of her general practice?
A Yes. She is my GP, to myself and my two children, who are 23 and 13.

G

Q And did she also look after your father at some period of time?
A Yes. She looked after my father. My father was transferred from Haslar Hospital to Gosport War Memorial Hospital in the very beginning of 2000. When he was transferred, Dr Barton met us on his arrival.

Q Right?
A And introduced herself, and told us that she would be looking after my dad's welfare while he was in hospital there.

H

A

Q Was she his GP? Is that right?
A No, no.

Q So she had not met him before?
A No, never.

Q So it was the beginning of 2000 he was transferred from the Haslar. Was it Dryad Ward, did you say?

B

A Yes, yes. He went to Dryad Ward, yes.

Q And I think sadly he died at the War Memorial Hospital?
A Yes. He died on January 24, 2000.

Q Dr Barton was the clinical assistant, the doctor looking after him, whilst he was there?

C

A Dr Barton was the doctor who met us on the arrival of my dad and explained to us the situation of what was going to happen, carrying on and everything. We said to her, we knew that my dad was dying. He had cancer and we did not want him to be in any pain whatsoever. We wanted to make sure that he was well looked after while he was in there.

Q How old was your dad when he was transferred there?
A 86.

D

Q What would you say about the standard of care that he got when he was at the War Memorial Hospital?
A We were always kept up to date what was going on. After about a week, my father was in there, he was put onto a syringe driver and I cannot remember the nurse's surname – Gillian somebody. I do not know her surname. She told us and explained to us what had happened and everything, and that my dad was on the syringe driver. Dr Barton also told us

E

that the reason was, it was because he was… You know. We knew what was going to happen. We knew he was gradually dying, but we would go in there a couple of days after. He would be there chatting away to us. He was aware of what was going on. I could not have asked for better care that was given to my dad at the time when he was in there.

Q But you have your own experience of Dr Barton?
A Yes.

F

Q That is your doctor, and that of your two children?
A Yes, especially my little girl. Mind you, she is not little any more. She is thirteen.

Q I do not want to ask about any particular medical conditions that anyone may have for either you or your children.
A Oh, no, no.

G

Q But you have needed to see the doctor a few times over the years?
A Oh yes. Many, many times. Yes, especially with my little girl. She suffers from epilepsy. I was a nervous wreck when she got taken into hospital, but Dr Barton reassured me that under proper medication everything would be controlled and she would be all right. Nothing would happen to her. Of course, as a parent you always think the worst. I used to say… She would say, "Look, she is going to be fine." She gave her nickname, and she

H

called her "Baggage". After a period of time when she got on with the medication, my little

A girl sent her a picture of "Thank you" for looking after her, and she put on there, "Thank you, Dr Barton. Love from Baggage."

Q What would you say about Dr Barton from our perspective as a patient?
A As a patient?

Q Yes.
B A I have never had any qualms or anything wrong. She has always been there. She always reassures me, whatever the matter is. After my father sadly passed away, she constantly contacted me to make sure that I was okay, and if I needed any help she was there for me, and especially a period of time when my son – I had a bit of trouble with my son. She just guided me through and said he was 18, and he had a life. "He'll still be there. You'll still be there for him." A couple of times I wanted to go on depressants, and I thought "No." But the reassurance I got from her was that I did not need it. She was just
C there to tell me that everything would be all right, and it was, and it always has been.

Q It sounds as though she was going beyond the medical problems.
A Yes. I mean, if I had a problem, I knew I could go and talk to her and come out of there feeling on Cloud 9, and I knew that whatever advice she gave me, I knew would be correct and I would be all right, even with my children as well.

D Q Can I come back to your father?
A Yes, of course you can.

Q He was put on a syringe driver after a period of time when he was in hospital.
A Yes.

Q Can you just remind us, after he was put on the syringe driver, you obviously went in
E to see him.
A I used to go in and see my dad every day. I took my little one in with me.

Q How was he coping on the syringe driver?
A He was fine. One day he would be asleep when you went in. It depended on what time of day you went in and most of the time it used to be about dinner time I would go in. He would be awake and start gobbing off at us, "What you doing here? Get out of here. I
F don't want you here", sort of thing.

Q So he would be his usual self?
A Yes, typical, and I thought, "Here we go again". Then like one time you could go and he would just be asleep and he would be quite happily laying there asleep, and we knew that he was not in no pain. He was quite comfortable and looked after by all the staff that were in the hospital. Unfortunately the day he died is the hardest thing that I have really got to try and
G get over, because the hospital phoned us the night my dad died. They said they phoned me and I never ever received a phone call. They assured me they did, but I was there and it is something that I have had to live with since.

Q I understand.
A As I say, when we finally did get the message it was via the police, because they were trying to get hold of my brother as well. We went in on the following day and that day, later
H on, I received a phone call from Dr Barton to say to me, "I am here if you need me", which I

A

thought was marvellous. I did not expect a response like that and if I needed help with any arrangements whatsoever, she was there to help me.

Q Did you need to call her in fact after that?
A No. But if I needed her she was there. She phoned a couple of times even after my dad's funeral. She phoned a couple of times just to make sure that we were still all right. As I say, I never expected that sort of thing and to me that shows that she really cared what she was doing. She was caring about people.

B

MR JENKINS: Please wait there because you may be asked one or two questions.

MR KARK: I have no questions, thank you very much.

THE CHAIRMAN: It seems that members of the Panel do not have any questions, so thank you very much. You have completed your testimony. Thank you very much for coming to assist us today. It is very much appreciated. You are free to go.

C

(The witness withdrew)

ANN DEAN, Sworn

D

(Following introductions by the Chairman)

Examined by MR JENKINS

Q I am going to ask you to give us your full name, please.
A It is Ann Dean.

E

Q Would you give us your professional qualifications?
A Registered General Nurse and Registered Midwife.

Q I do not think you qualified on the south coast.
A No. I qualified in Glasgow.

Q What was your nursing career after you qualified?
A I think I was a staff nurse for about 18 months perhaps and then became a ward sister. I was a ward sister then for about 10 and a half years before getting married.

F

Q That was in Glasgow where you were a ward sister, was it?
A Yes.

Q What kind of ward?
A Surgical ward. I then became a practice nurse thereafter. I worked initially for my husband who was a single-handed general practitioner. I worked for him for a very short time.

G

Q Was that in Birmingham?
A That was in Birmingham. Then he joined the Navy and we moved to Gosport, and that is where I encountered Dr Barton.

H

A

Q I think you worked at the practice where she was a general practitioner.
A I worked at Forton Road Surgery, yes.

Q Did you work there for two periods of time?
A I did. I am a bit hazy about the dates.

Q I do not think the precise dates matter.

B

A I think it was 1994 until the end of 1995, so maybe for 18 months. I was then gone for about 18 months and then came back and worked for about five years, approximately.

Q So six or seven years in total that you have been practice nurse at the practice where Dr Barton and other doctors worked.
A Yes.

C

Q We know that there were a number of doctors in the practice.
A Yes, six I think.

Q How did you find Dr Barton whilst you were working with her there?
A I found her to be an excellent colleague. She was very approachable, very supportive of the nursing staff and by my observation all the other staff in the practice. I found her to be very caring and considerate of patients.

D

Q Would you have seen her with patients?
A Not a lot but on occasions. I did work with her when we were doing childhood immunisations and also perhaps when I would call her to the treatment room to have a look at a leg wound or whatever, or maybe to examine a patient that I did not feel should wait to be seen really.

E

Q If there were discussions about patients, or if you were seeing patients together with Dr Barton or in meetings at the practice, would you have been able to form an impression of Dr Barton's commitment towards her patients?
A Absolutely.

Q Tell us what that impression was?

F

A She was totally committed to them. She was very caring. She always put them before herself on many occasions. She would be ready to leave the practice, ready to go out of the door and I certainly have asked, could she possibly see another patient and she would just turn about and go back and see the patient. She had a lovely manner with the patients and always came over as very caring, and as for her clinical expertise, I was very impressed. I never had any occasion to doubt that at all.

G

Q I am not asking for names, but could you say the same of her colleagues, the other doctors in the practice?
A She stood out as being particularly caring and attentive.

Q What about her clinical judgment, so far as you were able to see that being exercised?
A I never had any worries. She always concurred with my own judgment. As an experienced nurse I never had any doubts about that.

H

Q Would you have had feedback from patients?

A

A Yes.

Q As the nurse did you find yourself talking to patients about which doctor they might want to see?
A I do not think it was every necessary for me to talk to them about which doctor they would want to see. The vast majority of patients wanted to see Dr Barton.

B

Q That is in a practice of six doctors.
A Yes.

Q Was that always possible?
A Not always possible at all. They would come to see us specifically because they wanted a back door in to see Dr Barton, because she was so caring and just so wonderful with them. Lovely manner with every patient, no matter who they were; patients with all sorts of difficulties, she was so nice and so good to them.

C

MR JENKINS: Thank you very much. Will you wait there because you may be asked questions by others.

MR KARK: I have no questions. Thank you.

D

THE CHAIRMAN: There are no questions from the members of the Panel so it follows that that completes your testimony. Thank you very much indeed for coming to assist us today. It is very much appreciated and you are free to leave.

(The witness withdrew)

E

MR JENKINS: Sir, that is all the live witnesses I have this afternoon. What I can do, though, if it is convenient, is read some statements to you. These are statements that are agreed, as I understand it, and there is no objection to them being read from across the room. I am going to start – I have a copy for the shorthandwriter (document handed) – with Angela Southam. Her statement is dated 19 July 2009. It is signed by Angela Southam and it has this endorsement:

F

> "This statement consisting of two pages signed by me, is true to the best of my knowledge and belief and I make it knowing that if it is tendered in evidence I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true".

MR KARK: I am sorry to interrupt. Is there a spare copy of this statement?

G

MR JENKINS: Yes of course. Can I say, I am going to be reading a statement from Fiona Smart and two statements from Dr Grunstein.

MR KARK: We have the Grunstein statement and the one from Fiona Smart. (Document handed)

MR JENKINS: The statement reads as follows:

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STATEMENT OF ANGELA SOUTHAM, Read

"I am Angela Southam of Jubilee House, Medina Road, Cosham, Portsmouth. I am a Clinical Nurse Manager at Jubilee House, which is a continuing care assessment/end of life unit based in the community. I have held this position since 2005. Prior to this I was a senior nurse from 2002 – 2005 at Jubilee House, and a staff nurse there from 1998 – 2002".

B

Forgive me, I break off from the reading. This is relevant in relation to the evidence the Panel heard from Shirley Hallman. She gave some evidence about Jubilee House and this is Jubilee House. I go back to reading the statement,

"The unit is essentially nurse led, with local GPs carrying out the day to day medical care of the patients under the authority of Consultants. Consultants will carry out ward rounds every two weeks.

C

The Unit has 25 beds, most of which are occupied at any one time.

"The GP on duty will attend to see patients for about three hours each day, usually between 12.00 pm – 3.00 pm. These hours do vary slightly depending on the needs of the patients. On occasions they may be a little less or a little more. The only variation on this is when the consultant attends to carry out a ward round, usually each Thursday, when a GP will then be in attendance for that ward round which takes place in the morning.

D

On occasion, when patients are admitted to the Unit in the afternoon or when a patient deteriorates, the GP may return to the Unit following afternoon surgery, in order to attend to the patients. If it is necessary for there to be clinical input out of hours, an out of hours service is available to the Unit.

E

These arrangements, in terms of the nature of the medical input at the Unit, the periods and amount of time spent each day by the GP and the number of beds have not altered since 2000".

The next statement I read is that of Fiona Smart. Her statement is dated 15 July 2009. It is signed by Fiona Smart and it carries the same endorsement as the statement that I have just read to you, namely that it is true to the best knowledge and belief of the maker. I will not re-read that. The statement reads as follows:

F

STATEMENT OF FIONA SMART, Read

"I am Fiona Smart of Omega House, 112 Southampton Road, Eastleigh, Hampshire. I am Associate Director for Clinical Standards at NHS Hampshire at the above address.

G

Having worked as Services Manager for Community Hospitals in East Hampshire, I was appointed as Interim Divisional General Manager for Fareham and Gosport Division of Portsmouth Healthcare NHS Trust in January 2000. As such, I was responsible for two community hospitals in the area, Gosport War Memorial Hospital and St Christopher's Hospital, District Nursing and health visiting and physiotherapy,

H

A

dentistry and occupational therapy Trust wide. My appointment was initially on an acting basis and I was then appointed to the substantive post.

In my capacity as Divisional General Manager, I met Dr Jane Barton on a number of occasions. I believe that she was involved with the Primary Care Group at this time.

B

I recall that Dr Barton came to see me on one occasion, when we had a conversation about the pressures associated with her work at the Gosport War Memorial Hospital (the Hospital) where she was a Clinical Assistant in Geriatrics. I recall that I was told Dr Barton would come to the Hospital at 7:30 in the morning in order to do a Ward Round, and would also have to undertake weekly Ward Rounds. I was told that her partners were not sufficiently supportive of her to enable her to get back to the Hospital to carry out further work as she would wish. Our discussion was about the

C

need for her to be available in the hospital later than had been her practice. Whilst I recall that the level of dependency of patients had increased over time and they were generally less well on admission, I cannot now recall if this was specifically discussed by us.

The demands on Dr Barton were such that she felt obliged to resign at the end of April 2000. A copy of her resignation letter was passed to me",

D

Sir, I break off. The Panel have it.

"and in consequence of that I felt it appropriate to write to her, which I did by way of a letter dated 19th May 2000."

Again, the Panel have it.

E

"A copy of that letter is attached to this statement and marked 'FS1' [an exhibit], the letter being written in my previous married name of Fiona Cameron. In that letter I made the point that over the period Dr Barton had been at the hospital (which I stated in error as 7 years) there was little doubt that both the Client Group and the workload had changed. I was aware of and acknowledged that Dr Barton's contribution, commitment and support

F

to Gosport War Memorial Hospital. I fully acknowledged her 'contribution to the service whilst working under considerable pressure'. I would not have complimented Dr Barton in my letter unless I had felt that this was clearly appropriate and deserved.

Although I did not know Dr Barton well, I felt she was a person of integrity. She had a reputation for being very straight talking, and her level

G

of forthrightness may have meant that some would feel that she was brusque. I considered her very easy to deal with.

In my letter to Dr Barton I stated 'acceptance of the above pressures, coupled with your resignation, has led to a review paper being produced which outlines the current service at Gosport War Memorial Hospital for Elderly Medicine patients, the medical support to this and the issues and

H

pressures arising'. The review proposed enhanced medical input. In due

A

> course a number of changes were made to the service at the War Memorial Hospital. A full-time staff grade doctor was appointed in September 2000, providing greater medical input. There was also an additional consultant session to provide greater consultant support."

That statement is signed "Fiona Smart".

B

STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read

Sir, I am going to read three statements from a Dr John Grunstein. The first is a police statement. It is dated 4 November 2005. He gives his age as over 18 and his occupation as a retired medical consultant. The statement carries the same endorsement in the same terms that I have read before. He says:

C

> "I am Doctor John Albert Henry GRUNSTEIN and I am a retired medical Consultant previously employed by Portsmouth Health District and successor organizations. I retired in 2000."

He sets out his qualifications and CV. I will read them all, if I am asked to, but he gives his date of birth in 1935, the medical school was the London Hospital, Whitechapel, between 1968-1963. That is what it says. His medical qualifications, 1963 MRCS, LRCP, 1963 MB, BS Lond. Higher registrable medical qualifications, 1968 MRCP Lond, FRCP Lond. Relevant appointments, 1969-70 Senior Registrar Geriatric Medicine Guy's Hospital. 1971, appointed Consultant Senior Physician in Geriatric Medicine to the Portsmouth Health District and successor organisations. 2000 retired.

D

> "Since retirement I have continued to work as a part-time locum in various capacities.

E

> *Responsibilities in Gosport:*
>
> *a. Shortly after I was appointed I initiated an outpatient service in Gosport.*
> *b. I shared responsibility for the continuing care wards in Gosport. Initially these were in the Northcote and Redcliffe annexes of Gosport War Memorial Hospital.*
> *c. In 1992, I believe, I gave up all responsibilities in Gosport.*

F

> Dr Jane Barton applied for the post of Clinical Assistant in Geriatrics at the Gosport War Memorial Hospital, Hants. On 17th March 1988. I also believe that she was the only applicant for the post. I have seen her application sent to me recently from the Queen Alexandra Hospital, Cosham, Hants."

G

Sir, the Panel have it and have seen it in bundle 1.

> "This occurred following a request to the Elderly Medicine Department to ascertain if they could unearth any relevant documentation. I cannot recall whether Dr BARTON was formally interviewed for the post, to which she was appointed. At the time of her application and subsequent appointment,

H

A

I was a Consultant with a clinic and shared responsibility for long stay (as they were then termed) beds in the Gosport area.

Dr BARTON was an experienced doctor with her own general practice in Gosport. I remember her being very good. She enjoyed the work and her heart seemed to be in it. (Not always true of those employed with similar capacities). She had a liking for these very frail elderly patients.

B

Documentation is available showing that there was initial training consisting of ten half day sessions. She probably attends ward rounds, outpatients and day hospital sessions in order to get 'hands on' training, during which we would discuss the management of patients. This training period covered most aspects of elderly care but I would not describe it as 'in depth'.

C

Dr BARTON was an experienced doctor and a Principal in General Practice. I would not treat her in the same way as a very junior colleague. I remember her as attending these sessions assiduously and showing interest in her duties.

She also attended the Clinical Assistant Training Programme - Elderly (CATPE). This was a series of lectures given in the training of most

D

aspects of Elderly Medicine, including lectures in palliative care, causes of confusion (dementia), strokes, falls, incontinence, heart and lungs disease all from the point of view of elderly medical care. These covered relevant topics appertaining to the elderly who often have different diagnostic presentations and requirements compared to younger patients. She probably would have also heard about the 'analgesic ladder' which describes the incremental use of drugs to control pain and distress. The

E

analgesics would usually (though by no means always) start with paracetamol and progress through to the opiates including diamorphine.

CATPE was given in a lecture theatre environment. Doctors also gave case presentations which were open to discussion. I am reasonably certain that in addition to attending CATPE, Dr BARTON gave presentations.

F

Routine business ward rounds with Dr BARTON would have taken the form of reviewing new patients, assessing those with problems and some cyclical patient reviews. It would be my responsibility to offer advice on the best management of patients including investigation, diagnosis and treatment. This would include advice on drug dosages. I might also suggest the administration of alternative drugs and dosages to patients. I would expect my advice to be followed as ultimate responsibility for

G

patient care was the consultant's. The nature of Dr BARTON's post required that she exercise a considerable degree of autonomy.

Dr BARTON made arrangements within her own practice for cover whilst she was unavailable or off duty, though I thought it notable how assiduous she was in making herself available. I think it is fair to say that the nurses were unusually reliant on Dr BARTON",

H

A - he then names a doctor that we have heard named as "Dr X" -

"and others from other practice worked on the wards while she was unavailable."

"She" obviously meaning Dr Barton.

B "My department did not vet the skills of these doctors. Cover was twenty four hours a day, seven days a week.

Admissions to all elderly medicine continuing care wards (long stay wards) were authorised by a consultant in elderly medicine and occasionally by a registrar acting up as a consultant locum.

C During their time in hospital the patients own General Practitioner had no responsibility for supervisory rights.

During the time that I had specific responsibilities in Gosport (1971-1992). Patients transferred to Gosport had varying combinations of illness, frailty and severe disability. They were thought to be unlikely to benefit from rehabilitation, which was not specifically available for elderly medicine in

D Gosport.

Occasional patients were transferred to await discharge to non NHS accommodation (Residential or Nursing Home) or home. Some patients improved and were also discharged.

The bulk of patients transferred to Gosport were considered too

E incapacitated to be cared for in registered nursing homes (i.e. the frailest of the frail), though over the years the political, financial and logistical reasons governing the balance between NHS and private care has shifted towards the latter. Palliative care (care of the dying) was a significant part of our work.

The survival time of new admissions was short (on average less than a

F month), but the average length of stay was long. (perhaps a year). I cannot recall precise figures, which anyway would depend on the definitions adopted and would fluctuate wildly.

I considered Dr BARTON to be an outstanding, caring and compassionate Physician."

G <u>SECOND STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read</u>

Dr Grunstein wrote a second statement for the police. That one bears the date of 19 January 2006. It carries the same endorsement which I do not read. It says:

"I am Dr John Albert Henry GRUNSTEIN, a retired Medical Consultant and previously worked at the Queen Alexandra and Gosport War Memorial

H Hospitals, Hants.

A

I worked for a time with Dr Jane BARTON.

I produce as exhibit ...",

- he gives the exhibit number -

B

"... Dr BARTON's application for the post of Clinical Assistant in Geriatric Medicine dated 17/3/88, a letter from Miss K SOUTHWELL, Portsmouth and South East Hampshire Health Authority of 18th March 1988 to me and my correspondence of 19th April 1991 confirming that Dr BARTON received ten half day sessions from 27th - 31st November 1989.

I cannot recall why she was trained a year and a half after her appointment. The letter is addressed 'To whom it may concern' so I think there may have been something in the GP contract which required additional formal training.

C

I do not believe I ever interviewed Dr BARTON formally."

That, like the previous statement, is signed by Dr Grunstein.

D

FURTHER STATEMENT OF JOHN ALBERT HENRY GRUNSTEIN, Read

There is a further statement from Dr Grunstein. That carries the same endorsement as the others before it. This one is dated 2 June 2009. Again, signed by Dr Grunstein. He says:

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"I am Dr John Albert Henry GRUNSTEIN",

- and he gives his address in Soberton, Hampshire. He says:

"I was ... a Registered Medical Practitioner, and was formerly a Consultant Physician specialising in elderly medicine, employed by the Portsmouth and District Health Authority and successor Trust organisations. I retired from full-time practice in 2000.

F

As indicated in my statement to the police of 4th November 2005 I qualified at the London Hospital, Whitechapel, in 1963."

He gives his qualifications that I have already given. He says:

G

"Although I retired from full-time practice in 2000 I continued to work for a time as a part-time locum in various capacities until 2006.

Again, as I indicated in my police statement, shortly after I was appointed, I initiated an outpatient service at the Gosport War Memorial Hospital. In addition, I shared responsibility for the continuing care wards in Gosport which were initially sited in the Northcote and Redcliffe annexes of the Hospital. I believe I shared Consultant responsibilities for these Annexes with Consultant, Dr Bob Logan.

H

A

Initially my responsibilities in Gosport included carrying out outpatient clinics, and visiting the GP Wards, when asked to see patients admitted by local General Practitioners. As I have indicated, I shared responsibility for the medical care of the patients on Northcote and Redcliffe Annexes.

B

GP clinical assistants provided day today clinical care and dealt with emergencies. Elderly medicine consultants and registrars were available for telephone advice and occasional emergency visits. It was more usual to transfer patients with difficult problems back to the DGH.

C

From my appointment in 1971 I saw a number of clinical assistants come and go at the hospital. In due course, when the post became vacant, Dr Jane Barton applied for the post of Clinical Assistant in Geriatrics at the Hospital - in March 1988. Indeed, I believe that she was the only applicant for the post at the time. I think we were very glad to get someone who had an interest in elderly medicine, who had a liking for frail, elderly patients, and who was competent. Unfortunately, in my experience there were others involved in elderly medicine who were less competent, reliable and dedicated than Dr Barton. For example, when asked to see a patient one might have the impression that they were somewhat reluctant to do so. Dr Barton was certainly in the category of a good Clinical Assistant.

D

As a Consultant in Geriatric Medicine I did not send patients to Gosport whose medical needs were unsorted or where rehabilitation had realistic prospects for discharge from hospital. This was because fundamentally it was a long stay or so called slow stream unit not equipped to deal with patients requiring this type of active management. Thus patients sent to Gosport were in the main those we did not think could be discharged to their own homes or residential homes.

E

Exceptions might be those with large sores requiring lengthy healing and those awaiting transfer to alternative accommodation.

F

Over the period 1988 to 1992, when I ceased to have responsibilities in relation to Gosport. I think the needs of patients did not alter that much. I, and the other Consultants, chose to send patients to the hospital who needed care, as opposed to investigation and very active treatment. The patients we admitted there were not those in need of rehabilitation, diagnosis and active medical management. We would have admitted patients there because we had concluded that there was no other place for them to go, and they were unlikely to improve. Geriatricians and other specialists need to keep empty beds in District General Hospitals (DGH) so that it is always possible to admit emergencies. None the less I resisted attempts to fill vacancies in our Gosport beds with unsuitable patients, when there was pressure on DGH beds, for the reasons outlined above.

G

I recall that when I arrived in 1971, some of the patients had been there for many years, inevitably due to the initial unsuitable selection for the unit.

H

A

I believe that in 1988 Dr Barton as Clinical Assistant was not likely to have been required to care for patients with technically demanding medical needs on a day-to-day basis. I felt that Dr Barton was able to do the amount of work required of her at that time within the allocated sessions. (I have been reminded that this was 4 sessions to include out-of-hours work). I believe the wards were visited daily, new patients were briefly clerked and there were weekly ward rounds with the consultant. I think we alternated both consultants and annexes.

B

In working with Dr Barton, I felt I was in the presence of someone who knew her stuff. I am conscious that Dr BARTON did not write much by way of medical records. However, I felt she was doing a very reasonable job. It is fair to say that in my last years as a Consultant we had much better notes in long stay units because we had doctors there who were expected to create much more detailed notes. However, I believe that by the time I retired we would have effectively had 1.5 doctors to cover what Dr Barton was responsible for at Gosport.

C

As a comparison, Kingsclere Ward at St Mary's Hospital was a double ward with acute rehabilitation patients on one side, and long stay beds on the other. I think there were about 40 beds on the Kingsclere Ward. By comparison with Gosport, I remember being surprised that we were able to fund a full-time medical appointment to look after the medical needs of those patients.

D

Over the period of Dr Barton's appointment until 1992, I thought that in the context of the type of patient coming to the hospital, the patients were being properly and adequately assessed on admission by Dr Barton. At the same time, I knew that it was impossible to insist on the dotting of Is and the crossing of Ts which might seem to have been required by the job description.

E

I felt it was extremely important for the referring unit (preferably the consultant) to write usually no more than about a paragraph with essential information for the admitting doctor at Gosport, as I know how difficult it was for the receiving doctor to go through what would be a very thick set of notes and distil the most pertinent information. I am afraid this did not always happen.

F

Although I was not at the War Memorial Hospital after 1992, my understanding was that the Wards there started to be used for patients transferred for rehabilitation. Certainly in the 90s there was a great deal of pressure on District General Hospitals to get patients out of hospital who were perceived to be bed blockers. It would have been patently obvious that work at the War Memorial Hospital would have become much more onerous, with more patients being taken on for rehabilitation.

G

When I retired, I was involved in the transformation of the long stay ward in Petersfield to a Rehabilitation Ward. In consequence of this, the GPs who were involved in providing care were given more sessions. None the less there were protests from the GP's, nurses and ancillary staff at the number of admissions.

H

A

Another difficulty was the tendency for patients to arrive from the DGH late in the day. This causes particular difficulties for GPs.

After my close Gosport involvement ceased in 1992, I was not directly aware of acutely ill patients being sent down to Gosport, although it is possible that I might have been made aware of disquiet from Dr Barton that patients were being transferred to the Hospital who were too ill. Certainly I would never countenance the transfer of an ill patient – ie someone in need of active management. The transfer of an ill patient would only be appropriate where everything possible had already been done for them at the District General Hospital. Geriatricians recognise that the act of transferring a frail ill patient often has a deleterious effect on their health. Mortality rates amongst this group are increased.

B

I have a recollection of being aware of some sort of problem on one of the Annexes with one or two of the nursing sisters there at some point before I ceased working at Gosport in 1992. I do not recall any Nursing Staff expressing concern about the use of opiate medication and syringe drivers.

C

I understand that Dr Barton came to employ a method of prescribing for patients on an anticipatory basis – where it was perceived that the patient might require medication at some point in the near future. I can see that from a background in general practice, someone might be concerned to consider provision of medication in anticipation of the development of pain for example, over a weekend when a doctor might not be immediately available.

D

I recall that we had policies whereby it was not necessary to call out a doctor from the Surgery or at night in order to confirm death if a patient had died. The nursing staff could then confirm the death. I believe that this was permitted at the War Memorial Hospital. I do not recall a specific phrase being utilised to the effect that the doctor was happy for the Nursing Staff to confirm death, but there would be nothing odd about this. Indeed I do recall that some such instruction was sometimes written in the notes, if the Clinician perceived that the patient might die.

E

Of Dr Barton, I would say that she was someone in whom one was able to place confidence. She was intelligent and knew her stuff. She could be quite blunt on occasion, but she looked after her elderly patients in a way which I felt was caring and expert.

F

She was assiduous in attending the educational training sessions provided for her upon her appointment and subsequent sessions described in my statement to the police.

G

We thought ourselves lucky to have her as a colleague in Gosport."

That statement is signed by Dr Grunstein.

THE CHAIRMAN: Thank you very much indeed.

MR JENKINS: We have run out of evidence, I am afraid, for the day.

H

A

THE CHAIRMAN: Good, because I think we are out of time too. Thank you very much indeed. You have given us a great deal to digest. I think we are going to rise now and we will resume tomorrow at 9.30, please.

MR JENKINS: May I tell you what I have for you. There is another nurse that we are going to call who deals with a number of patients. I do not propose to go in great deal with the entries that she has, but it is right that you should know that a number of patients can be dealt with tomorrow.

B

THE CHAIRMAN: It is always helpful to have an insight into what is coming. Thank you for that.

MR KARK: Speaking of what is coming, can I just raise timing. I know it is late in the day, but I will just raise timing and try to look forward for a moment.

C

Tomorrow it is very likely that Dr Barton will be closing her case and that is the last of the evidence that we are going to hear on her behalf. Then we come to the issue of speeches, unless there are any further submissions to be made, but I do not think there are.

So far we have managed to get through, I think, seven weeks of the case without asking for any time, but I am considering asking for time, just for a day in fact. That is in order to prepare speeches. What we have been working on as the evidence has progressed is a document which we hope is going to assist. The nature of the document is this. We have broken up the case into the various issues that you are going to have to decide and then in relation to each patient, and within each of those sections we have put what we view to be the relevant evidence from every single witness.

D

Taking an issue such as Patient A, by way of example, you have a précis from the transcript, with transcript references, of every witness that the GMC called or read who spoke about that patient, coupled with direct lifts from the transcript of everything that Professor Ford said about that particular patient.

E

It is a fairly lengthy document. I do not hesitate to tell you – I think at the moment it is about 130 pages long. However – however – it does distil what is in fact, so far as we are concerned, the first 24 days ---

F

MR LANGDALE: Sir, I am sorry to interrupt. It is always irritating. I was aware today of the general nature of the document that my learned friend Mr Kark is talking about. I would rather he did not go on any more telling you about it because I think whatever document is produced by the GMC will be something which more properly would be a product of discussion between us. I can see certain difficulties which may arise in relation to the format. What I ask is that we have an opportunity of discussing it. My learned friend has been kind enough to indicate he is going to send me, much as I am enjoying the thought of 100-plus pages to look at tomorrow, the document as it is – it may not be in its final form – so I can see what it is in general terms. I can see there may be an issue as to what should or should not be placed by way of a document before the Panel.

G

I can fully see, and I join with him in suggesting that we have a day to consider speeches, which will probably mean what Mr Kark has in mind – beginning his speech on Tuesday rather than Monday. If that is what he is asking for, and I think it is, I certainly agree that

H

A would be sensible. However, I think we had better have some discussion about what may or may not be appropriate, as I stress, to place before the Panel as a document, as opposed to references and so on.

THE CHAIRMAN: I agree with that entirely, Mr Kark. At this stage in the proceedings, I think we can hear about this tomorrow if you do not mind.

B MR KARK: Yes, sir. I was raising it because we were asking for time. I was going to invite you on Monday to take time to read that document because that will shorten matters considerably on which I have to address you. I was not revealing what was in the document, rather the nature of it. This is not going to be an agreed document necessarily. It is part of our case. There we are; we will raise it again tomorrow.

THE CHAIRMAN: But your aim would be that we would spend Monday reading that

C document? And whilst we were reading, that would give counsel the opportunity to be ---

MR KARK: Elsewhere.

THE CHAIRMAN: Yes. Very well. Can I ask you – is that document going to be a preface to a skeleton argument or is that, in a sense, the skeleton itself?

D MR KARK: It is not a skeleton. It is all of those transcript references to which I will be referring in my speech. It is to avoid you having to turn up transcripts.

THE CHAIRMAN: Yes.

MR KARK: That is the point of it.

E MR LANGDALE: Perhaps we can have some further discussion of that tomorrow when I have seen what it is. In any event, whether the Panel needs time on Monday to read any document or not, I suspect it will still be appropriate for us to have a day, apart from tomorrow and no doubt the week-end, so that speeches will be given on Tuesday.

THE CHAIRMAN: I think that must be right. I think the Panel have an interest in knowing not today, but tomorrow perhaps after some discussion, whether we will have the benefit of

F written skeleton arguments or whether that is not going to be the case.

MR LANGDALE: As I say, it is not going to be a case of skeleton arguments but perhaps we can discuss this some more tomorrow.

THE CHAIRMAN: I will just put a marker down for one other point that perhaps can be dealt with immediately after we finish evidence tomorrow. That is that the Legal Assessor

G himself has a number of points which he would like to raise with counsel, to ensure that they will be dealt with by counsel in your later submissions.

Very well. Thank you very much. 9.30 tomorrow, please.

(The Panel adjourned until Friday 31 July 2009 at 9.30 a.m.)

H