GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 15 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-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)

INDEX

THE CHAIRMAN: Good morning, everybody. Mr Langdale?

MR LANGDALE: Sir, thank you for the opportunity yesterday afternoon for us to take stock and to see whether it was first of all justifiable and, secondly, whether it was appropriate to make any submissions with regard to the charges as drawn.

I have considered the matter with the assistance of Mr Jenkins and Mr Barker very carefully. I hope I have made the right decision. The decision is, I am not going to make any submission on any matters relating to the charges at this stage. May I just say this. There are certain allegations contained within the charges, say, for example, an allegation with regard to the prescribing of a dose of Oramorph in a particular case, just by way of illustration, where it may well be that there would be a basis for submitting that the evidence at this stage does not support a prima facie case in relation to that aspect of the charge. That may be wrong but there are certain instances where, in my view, there is a proper basis for making a submission. However, none of those alters the radical nature of the case. In other words, if I were to make the submission to the Panel and the Panel found in our favour, it would not fundamentally alter the structure of the case and the nature of the case that Dr Barton has to meet.

A disadvantage with approaching it in that way, if there is a justifiable basis for a submission, is that it creates a problem for the Panel in trying to separate out a particular part of a charge and might warrant an awful lot of consideration – consideration which might result in a judgment that there was a prima facie case or a judgment that there was not. At the end of the day, the Panel would have spent quite a lot of time dealing with a specific bit of a charge without it really affecting the general course of the proceedings. I am confident that even if some of those submissions at the end of the case turn out to be justified, it will not affect in any way the presentation of Dr Barton's defence. That is my cardinal objective and the thing I have to bear in mind more than anything else. I am confident it will not in any way disadvantage the presentation of her case if we do not seek to take those matters up now.

Those are the reasons why I am not going to pursue it. Whatever submissions there are on the evidence at the end of all the evidence no doubt I will be able to advance to the Panel in due course.

THE CHAIRMAN: Yes, indeed. Thank you very much for sharing that with us. It is very helpful.

MR LANGDALE: I had obviously indicated what the position was to Mr Kark. It follows from that the Panel will now be hearing evidence from Dr Barton. I will ask her to be sworn and we can deal with her evidence.

JANE ANN BARTON, Sworn

THE CHAIRMAN: You need no orientation from me, so I will pass you straight to Mr Langdale.

Examined by MR LANGDALE

Q Dr Barton, it is Jane Ann Barton. Is that right?
A It is.

Q You are a registered medical practitioner. You qualified in 1972 – is that right?
A I did.

Q Oxford University, with degrees. The degrees being?
A Master of Arts, Bachelor of Medicine, Bachelor of Surgery.

Q I think you joined the GP practice which we are concerned with in this case in January 1980, initially as an assistant for three months, and then as a minimum full-time partner?
A I did.

Q After you had qualified, until the time that you joined the GP PCC in Gosport in 1980 what was the position with regard to any medical work or training that you received after you had actually qualified?
A I did a surgical house job in Reading. I did a medical house job and a medical SHO job in Plymouth. I then had a baby. I joined a practice in Weymouth as what was then called a trainee (but is now a registrar). I qualified on the Wessex GP training scheme. I became a partner in that practice. I then had another baby and we went to Australia on exchange with the Royal Navy for two years, during which time I worked as a partner in a practice in Sydney and carried out family planning clinics in any spare time.

Q Roughly how long when you were in Australia were you in practice?
A Nearly two years.

Q That covers that particular period.
A It does.

Q If any more detail is asked of you, you can give it. Bringing ourselves more up to date with the times we are concerned about, or the years we are concerned about in this case, in general practice as we know at Forton Road in Gosport. Let us take as a starting point the year of 1989, say. At the time, just before you applied for the post of clinical assistant at the Gosport War Memorial Hospital, how many patients were you responsible for roughly speaking?
A I had a personal list of approximately 1500 patients, and I think there were 8000 patients in the whole practice.

Q What I am going to ask you to do is to have in front of you now a statement that the Panel already have, that you made to the police in 2004. This is in the Panel's separate file of Dr Barton's statements. I hope you have that file there. Can we go to the beginning of the file. This is the document that was provided to the police, headed "Statement of Dr Jane Barton". You set out obviously in that who you are and set out your history, which we have covered already. Then, in relation to the third paragraph on that first page, I was asking about patients, which you deal with. Would you just help us with regard to the general practice surgery sessions and so on. Is that an accurate statement as to what the position was – working eight general practice surgery sessions weekly. Yes?
A That is eight half days.

Q Yes?
A House calls on my own; personal patients but also generally house calls if I was on duty for the practice. I had a lower rate of out of hours on-call work than the other partners because of my reduced clinical commitment to the practice.

Q Then in the next paragraph you deal with taking up the post as the sole clinical assistant in elderly medicine at Gosport War Memorial Hospital in 1988. Can we leave that file for a moment. Would you leave that on one side because I want to go to the documents which are contained in file 1. Do you have it there? It may be somehow it is not. Dr Barton, I am going to ask you to keep the statement that you made to the police readily available. Keep that file open because we are coming back to it. Perhaps you can put it on one side for the moment.

MR KARK: I think the witness version of File 1, I am afraid, went off with Professor Ford. It is winging its way back from Newcastle, but in the meantime this is a spare. (Handed to the witness)

MR LANGDALE: As long as Professor Ford has not been writing on it! We can use this volume perfectly sensibly, I think. (To the witness) Would you look in that file, File 1 at tab 2, please, and in tab 2 go to page 5. This is your application in 1988. I am not going to take you through the details you set out about yourself. You have already given evidence about the basic background. At the bottom of that application form you set out your employer, as it were, as the Hampshire FPC, as it was at that time and so on. We move over to the second page of that document because I want to ask you about why it was you applied for the post. We are going to be hearing an awful lot about what you did and the patients you treated. You said in the application form, by way of context:

> "In general practice locally since 1980. We have an average number of geriatric patients viewed nationwide, but the general feeling locally is that they are well served and well looked after, both within the community, in sheltered care and when they need inpatient care."

Dealing with that, what was the general picture in terms of your experience with regard to geriatric patients?
A We were not a South coast retirement home like Brighton or Worthing, with large numbers of elderly people. The feeling locally was that because the population was relatively static, they tended to look after their own elderly people, elderly relatives. They took care of them. We also had the enormous advantage of our own cottage hospital. At that time in the cottage hospital there was a male and a female ward, as well as a little surgical ward and we could look after our own patients at the end of their lives in a hospice type hospital environment, and do it well.

Q And that was?
A The Gosport War Memorial Hospital.

Q Exactly.
A So I felt that with the experience I had already gained in Gosport, looking after my own patients, I was ideally suited to extend that role and look after other elderly patients in a similar background.

Q You went on:

"It will be a pleasure to extend the care that we as a practice give to our elderly with the support we get from our district nurses and community health nurse/health visitors."

A Yes.

Q

"As a minimum full timer only working 20 hours weekly on practice commitments I am ideally placed to offer continuity of care and my partners have agreed to share the on call cover."

Help us please with "As a minimum full timer only working 20 hours weekly on practice commitments...". What does that signify?
A That was what Hampshire Family Practitioner Committee accepted in those days as a minimum full time. It is not 20 hours a week because obviously your administrative work, your house calls, your other business within general practice takes longer than 20 hours a week, but that was what the Family Practitioner Committee recognised as my commitment to the practice. It did mean that I had time outwith what I was doing in the practice to offer to the hospital job, but that was the understanding with my partners; that it was in my own time. It was not to intrude onto my practice time.

Q Then can we look back in that same section of that same file to the beginning of tab 2, we can see the job description – the job for which you were applying. I am not going to read through all of this, but it set out at that stage what the position was with regard to the number of patients. We appreciate, of course, that the Gosport War Memorial Hospital changed physically ---?
A Yes.

Q --- in the early nineties. We will be coming on to that in a moment, but at that stage, that is something like a total of 46 patients, I think?
A Yes.

Q Accountable to consultant physicians in geriatric medicine, liaison with – and I need not trouble you with that. The job summary – we have already dealt with this.

"This is a new post of 5 Sessions a week worked flexibly top provide a 24 hour Medical Cover to the Long Stay patients in Gosport. The patients are slow stream or slow stream rehabilitation, but holiday relief and shared care patients are admitted. An important aspect of this role is for the postholder to be seen not only as a medical adviser but as a friend and counsellor to patients, relatives and staff."

Then there is a mention of consultant physicians and so on. Before I move on, is that indeed the nature, does it reflect the nature, of the patients that you began to deal with as a clinical assistant at the start of this history?
A Exactly.

Q We will hear about things changing in due course. The two names that are mentioned with regard to consultant physicians are Dr Wilkins and Dr Grunstein. I think by the time we are concerned with in this case in particular with regard to the charges, both of those doctors were no longer in post. Or were they still in post?
A Dr Grunstein is mentioned in one of the cases as providing a locum cover up at Queen Alexandra but Dr Wilkins had certainly retired.

Q Your duties are set out:

"1. To visit the Units ... be available 'On Call'...

2. To ensure that all new patients are seen promptly after Admission.

3. To be responsible for the day to day Medical Management ...

4. To be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date and reviewed regularly."

We will be coming back to that.

"5. To complete, upon discharge, the Discharge Summary ...

6. To ensure the prompt preparation of death certificates ...

7 To take part in the weekly Consultant rounds."

Then over the page:

"8. To prescribe, as required....

9. To participate ... in multi-disciplinary case conferences and discussions ...

10. To provide clinical advice and professional support to other Members of the Caring Team.

11. To identify opportunities to improve services ...

12. To be available when required to advise and counsel relatives.

13. To be responsible for liaison with the General Practitioners with whom the patient is registered, and with other Clinicians and Agencies as necessary.

There may be a possibility that the sessions can be split between two separate General Practitioners, ideally from the same Practice."

That did not arise, so you are not concerned with that. In that same section, moving on to page 7, having looked at what the post description was, we can see the letter to Dr Grunstein from the assistant personnel officer of the then Portsmouth and South East Hampshire Health Authority making clear – and three is no dispute about it – that you in fact were the sole applicant for this particular job. Correct?

A Yes.

Q And then page 9, please, we see the letter from the Health Authority confirming the offer of appointment of you in that post. All right?
A Yes.

Q We take on board the remuneration for the post will be £9375 per year. Did that remain the same throughout the period we are talking about?
A It increased, very slowly.

Q Perhaps you can just help us a little bit more as to what it was – you made mention of it in your application – why take on this job? What was the interest here that you had and what was the attraction?
A I very much enjoyed looking after my elderly patients in the practice. I very much enjoyed my visiting rights at Gosport War Memorial Hospital, the possibility of admitting my patients at the end of their lives, and I had a great deal of respect for the nursing staff who worked at Gosport War Memorial Hospital and the visiting consultants who came. So I liked the whole ethos of the job I was asking to take on. I was not asking for the job for the money.

Q That comes to the next point I was going to ask you about, thank you. I think you were a member – would this be right – of the Gosport Medical Committee at that stage?
A Yes.

Q So you had already admitted patients yourself to Gosport?
A I belonged to what was known as "the bed fund' and we were entitled to admits patients to the War Memorial Hospital.

Q That side of it, the GP ward side of it, in effect was what Sultan Ward became after the re-arrangements and rebuilding or redevelopment in 1993.
A Exactly.

Q What familiarity did you have at the time when you were appointed to this post with regard to matters such as step-down care, respite care and end of life care? What experience had you had or what familiarity did you have with that?
A I was familiar with my patients with chronic problems being offered and taking advantage of respite care in the hospital. This was a scheme by which every six weeks somebody could be offered two weeks in the hospital to give the carers and the family a break and a rest and recharge their batteries before the patient went home again. We continued doing that until about 1996, when it became too difficult. End of life care I was fully familiar with, both people dying at home and people dying in the GP beds at the War Memorial Hospital under my care. "Step-down beds" was not a term that was used in those days, because there was not the enormous pressure to discharge people from acute beds to convalesce somewhere else that began to develop in the mid 1990s. So I would not have used the term "step-down" in those days.

Q We will come on to the change obviously as we move through the history. May I just ask you this in terms of your experience with regard to the administration of drugs in the case of patients who were receiving what we can describe perhaps as palliative care or end of life care? At this time, before you actually start in post as the clinical assistant, had you had any experience of prescribing opiates for such patients?

A Yes.

Q Had that involved at times prescribing oral morphine, Oramorph, or MST?
A Yes.

Q Had it also involved prescribing diamorphine?
A Yes.

B

Q At that stage, at the time you took up the post, were syringe drivers a method of delivery with which you had any familiarity or experience?
A I cannot remember using syringe drivers at that time in the community. I can remember that at the time I started the job the district nurses kept one in a cupboard in the health centre which we could use in general practice, but they were like gold dust. In those days, we were reliant upon the district nurse team going out four-hourly to give diamorphine injections at home at the very end of life if they were required. I do not remember, before I took up the job as the clinical assistant, regularly prescribing a syringe driver.

C

Q That gives us the general picture. There is one other particular drug I am going to ask you about, because it features a lot in the later instances we are going to have to look at in detail. That is, midazolam. I do not know whether it is possible for you to remember or not, but had you prescribed midazolam before you took up your post as clinical assistant?
A I think without subcutaneous infusion, it would not be possible to use midazolam in general practice because it would be very short-acting given as an intramuscular and would not be appropriate for restlessness in terminal care.

D

Q You have told us about your experience at the time that you applied for the post and were appointed. I would like you to look back in that same section of file 1 to page 4, please. At page 4, there is a letter from Dr Grunstein, consultant physician in geriatrics, as we can see at the bottom of the page. The letter is dated 19 April 1991 – so you had been in post for two to three years by this stage – and he is saying in that letter:

E

> "I write to confirm the above-named ..."

In other words, you –

F

> " ... attended the Department of Geriatric Medicine for 10 half-day sessions from 27th-31st November 1989. During this time Dr Barton attended clinical sessions, studied service management and preventative medicine for acute, rehabilitation and long stay patients together with geriatrics in the community."

It is clear what that letter sets out with regard to your having attended that – do we think of it as a period of training in geriatrics generally? How would you describe it?
A I arranged it. I used that letter in order to gain my postgraduate credits for that year, which involves each year you attending 30 hours of postgraduate education. I set up the week to go and see what happened in the geriatric service in Portsmouth. I needed to know what the wards were, what the different wards did, I needed to meet all the other consultants, I needed to go and see the day hospitals and how they were run. So this was me setting up a week to acquaint myself with what happened in the geriatric service in Portsmouth. It was not a requirement of the geriatric department to give me this. I organised it.

G

H

Q Would that have involved visiting Queen Alexandra?
A Yes.

Q And Haslar?
A Not Haslar. St Mary's, the various day hospitals and meeting the various personalities who ran these different units, which was terribly important if you were going to be accepting patients from them later on.

Q That is a particular period of time when you received further experience and training, if you like, in the context you have just described. I would like to open up a slightly wider topic before going back to the chronology. In terms of training or anything else that would fall under that broad category, or gaining further experience, apart from your on-the-job experience over the years, what else took place in terms of your attending either meetings or any form of training?
A As I mentioned, we all were required to do postgraduate education. I used to attend something called the Portsmouth Refresher Course, which happened annually, was held in Portsmouth and you would find that at least one session during that course would be devoted to palliative care aspects of work that we were doing in the community, which was often quite relevant to what I was doing. There were also at various times arranged by Dr Lord a series of sessions for clinical assistants to attend. I only ever remember attending about four or five. I remember going up to Salisbury for one and I remember presenting a case, an interesting case, that I had had at a meeting in Portsmouth, but unfortunately I can find no record of the paperwork that I kept at the time. But there was an attempt to draw together different clinical assistants and give them ongoing training in how to do the job.

Q With regard to that phase you are talking about or those events, would that involve the consultants or consultants generally?
A The geriatric consultants came to the clinical assistant training sessions and of course when you are going to refresher courses, you are dealing with consultants from all different walks of your profession coming to talk to you and teach you.

Q We will be coming on to a certain amount of detail with regard to what happened with regard to some consultants in connection with the 12 patients that the Panel is concerned with, but in terms of your encounters generally speaking throughout the 1990s with consultants, obviously matters would be discussed between you during ward rounds or any other time when you might see them in the hospital. Was there any other contact you had by way of gaining experience or learning from others apart from what you have described?
A Not until the end of the 1990s, when I became involved with the health authority and gained a little bit of insight into how the more political purchasing providing side of geriatrics was done. I am not sure that is entirely relevant to my clinical practice, but it was an interesting insight.

Q We may be coming back to the question of resources, but while we are thinking about it, perhaps we can deal with that. That is at the end of the 1990s. Are you able to give us a year for that?
A I think I became a clinical purchaser to the health authority in 1997/98. There was a representative from each of the districts within the health authority area. We attended health authority board meetings, we attended presentations and we of course were lobbied by our constituents about requirements for services and money generally.

Q We have already heard from Professor Ford again very generally speaking about the difficulties of getting funding which was experienced really throughout the National Health Service. That is something you can speak to if we need to go into any further detail.
A Yes.

Q I am going to go back, please, to the statement that you made in 2004, the statement which is in the file. You can for the moment put aside file 1. You have set out in your general statement how you had taken up the post of sole clinical assistant in 1988. Then:

> "GWMH was a cottage hospital. It had 48 long stay beds and was originally on three separate sites, and was resourced, designed and staffed to provide continuing care for long stay elderly patients."

You say in the statement in 2004:

> "The position of Clinical Assistant is a training post, and for me it was a part-time appointment."

We have heard that it was not a training post as such. Can you just help with that?
A There is nothing in my contract which states that it is a training post. I did receive training, in that I attended sessions with other clinical assistants. It did not automatically lead on to a diploma in geriatrics or to promotion in any shape or form. So I suppose in that way it is not a training post; it is a substantive post.

Q We have heard the evidence about it generally and that is not something with which you disagree?
A Not at all.

Q in relation to the three separate sites that you mentioned at that point with regard to your statement, those are the three sites which eventually merged and were organised into Dryad, Daedalus and Sultan Wards. Is that right?
A Dryad and Daedalus.

Q Not Sultan?
A Not Sultan.

Q That is when the hospital was upgraded obviously. In terms of the elderly medicine beds at Gosport War Memorial, those were administered presumably by the local healthcare trust.
A Portsmouth Healthcare Trust.

Q Which would be the forerunner of the Primary Care Trust which we have seen on a number of documents.
A Yes.

Q Sultan Ward was not consultant-led, but led in effect by the local GPs in the way that you have already described. How many beds on Sultan Ward?
A Approximately 20.

Q Those patients, without going into all the details, would involve patients in different categories, but including convalescing patients and also respite care?
A Yes. And end of life care.

Q The people responsible for deciding about the admission of patients to Sultan were GPs.
A Yes.

Q The total number of beds on Daedalus and Dryad was I think 48. Is that right?
A Yes.

Q In later years, just dealing with the general picture, is it right that something like eight beds on Daedalus Ward were allocated to slow-stream stroke patients?
A Yes.

Q The remaining beds otherwise in effect being designated to provide continuing care for the elderly.
A Yes.

Q Coming back to your statement, you set out:

> "Initially the position was for 4 sessions each week, one of which was allocated to my partners to provide out of hours cover. This was later increased, so that by 1998 the Health Care Trust had allocated me 5 clinical assistant sessions, of which 1½ were now given to my partners in the GP practice for the out of hours aspects of the post. I was therefore expected to carry out my day to day responsibilities in this post in effect within 3½ sessions each week. This was of course in addition to my GP responsibilities."

In relation to the sessions, what are we talking about? What was a session meant to be in terms of the time?
A I think in those days a session was three and a half hours. So you are talking about me carrying out the duties within ten and a half hours. That was deliberately divided up to be done in my own time. I did not attend the hospital for three and a half half-days; I divided it up into a daily visit, more than one daily visit, and I always felt that I carried out at least the number of hours that I was contracted for.

Q We will come on to the general routine in a moment or two, but that was the general picture?
A Yes.

Q Did that change? You said "at that time". Did that change in any way, the period of time that was allocated to a session?
A By the Healthcare Trust or by myself?

Q First of all by the Healthcare Trust.
A That as far as I can remember did not change.

Q And yourself?

A I felt that I was needing to offer the job more and more time, more and more of my own time, to do it properly.

Q The next paragraph of that statement sets out matters that we have already covered in terms of the beds and so on on Daedalus and Dryad. Can we come on to the question of consultants and what the picture was there? At the start of your taking up your post as clinical assistant, was Dr Althea Lord there?
A Dr Althea Lord joined the team just before we moved up from Redclyffe Annex into Daedalus Ward. So she covered both periods of time. She took over from Dr Grunstein and Dr Wilkins.

Q So prior to the time of the changes, 1993 or whenever it was, was it essentially those two consultants who we think of as providing care in relation to the then existing situation?
A Yes.

Q Dr Althea Lord became responsible for Daedalus Ward and Dr Tandy, from whom we have heard, for Dryad.
A Yes.

Q You make the point with regard to the consultant that:

> "... they had considerable responsibilities elsewhere and thus their actual time at the Gosport War Memorial Hospital was significantly limited. Dr Lord for example was responsible for an acute ward and continuing care ward at the Queen Alexandra Hospital in Portsmouth, and had responsibilities at a third site, St Mary's Hospital, also in Portsmouth. As a result, Dr Lord's presence at the hospital was limited ..."

Can we just deal with Dr Lord? You have set out the picture there. During the period of time that we are concerned with in this case, particularly really from 1995 through to 1999, what was the general picture with regard to Dr Lord? She would be visiting every other Monday? Is that how it worked out?
A To do the continuing care round. She would be visiting on a Thursday afternoon to do a slow-stream stroke round. I was unable to attend that because I had an antenatal clinic on that afternoon and she would be in the hospital doing an outpatient clinic on a Thursday morning. So it was possible to contact her, speak to her, on a Thursday morning. I think she ran the Dolphin Day Hospital on a Monday morning and so again, it was possible to speak to her or pop in and have a word with her on both those occasions. So she was there in effect for two whole days a week.

Q In any given week?
A Provided that she was not on holiday or study leave or doing something else.

Q In terms of her actually dealing with patients in Daedalus, how many times would you be with her on the every other Monday ward rounds?
A She would start at half past one, two o'clock. She would go on at least till half past five, six o'clock. She would often have to see families at the end of the actual ward round, so it was a long afternoon for her.

Q Normally speaking, do we envisage you being present assisting with regard to that ward round?

A Yes, if I could.

Q What was the picture? Most alternate Mondays you would be there?
A Yes.

Q Then you move on in your statement over the page, page 3 at the top of the statement, to deal with the position with regard to Dr Tandy. You set out the picture there of her taking annual leave towards the end of April 1998, followed immediately thereafter by maternity leave, so she did not return to work until February 1999. Just dealing with that position for the moment. Up until the time that she took annual leave, what we can think of is really a gap in consultant care from April 1998 to February 1999, before that what was the picture with regard to Dr Tandy in terms of her presence as a consultant in relation to Dryad?
A As far as I can remember she did not do any other work in Gosport, so her presence in Gosport would be limited to her weekly ward round. Initially, when she first started I think she did Wednesdays but she then moved to Mondays, so Mondays were difficult, I had to be with either one consultant or another, and she was not in the building available in Gosport in nearly the same way as Dr Lord was.

Q So in terms of her ward rounds, we think of you being there with her 50% of the time spent on ward rounds or less or more? Is it possible to give a general picture?
A No more than 50%.

Q Did you find, so far as Dr Tandy and Dr Lord were concerned, that they were both people with whom you could readily consult if necessary?
A Yes.

Q No difficulties of communication between you about the matters?
A Very approachable and very helpful always.

Q As you set out in your statement, during the period of time that Dr Tandy was, in effect, really not there for that period of time, the Trust took the decision that her post should not be filled by a locum. What actually happened? Did somebody ask that the post be filled or did it just remain not being filled? What actually went on in terms of trying to get proper cover?
A I was not privy to the decision that was made by the healthcare trust. I was not involved with the decision-making but I imagine that at that time it was possibly a cost-cutting measure, because she was on maternity leave, not to employ somebody full-time or substantive to take over her job while she was not there.

Q When she returned to work in February 1999, assuming all these days are spot on, what was the position with regard to Dr Reid? Did he take over?
A He took over her role. He took over Dryad Ward as part of his portfolio within the Trust, but the problem with him was as clinical director he was very busy with other meetings and his other commitments and did not always make his Monday round.

Q Again, just looking at it in the same general way we were with Dr Tandy and Dr Lord, when Dr Reid was in post in terms of his ward rounds how often would

you be able to be with him when that occurred?
A Every other week, if he did it, if he was available.

Q Again, with regard to Dr Reid, did you find communication about matters you needed to communicate about perfectly viable, sensible or was the position any different?
A I felt that he was singing from a slightly different hymn sheet in that his priorities were already beginning to be the more effective use of those beds. He was already looking at the pressures being put on the acute beds at the main hospital sites and how our beds could be more effectively filled to help with the pressures. He was receiving pressure from the acute hospitals trust into the healthcare trust, "Give us more beds", "Make more beds available", and he was responding to that.

Q In any event, if you needed to consult with him about any material topic ---
A Not ever in the building, again, as much as Dr Lord was, not on site as much and a very busy man.

Q I think he indicated in his evidence there had been times when you had contacted him to seek his advice or opinion. Is that right?
A Occasionally, yes.

Q During the period of time then that Dr Tandy was - I am going to use the expression "away", 1998 into 1999, does that in effect mean that there was no consultant cover, if that is the right experience, on Dryad?
A There was no continuous consultant cover. Occasionally senior registrars or locums were sent down but the problem with some of the locums was that they were not from within the hospital trust and they did not really understand the infrastructure of the hospital, let alone what we did on the wards, so they were of limited help in looking after patients.

Q You move on in that statement to deal with the situation with regard to the position when you resigned in April 2000, and I think we have really covered the matters that you referred to in the statement there. "The consultant normally in charge of Dryad was also Clinical Director", obviously referring to Dr Reid.
A Yes.

Q I am going to turn to a topic which you referred to in the statement in the next paragraph to invite you to assist with regard to the general picture so far as your physical presence at the hospital was concerned. You indicated that you would arrive at the hospital each morning when it opened about seven thirty, so we think of that as being the general picture?
A Yes.

Q About how long, first of all, on the average day, it may be that no day is average but in general, would you be at the hospital in relation to patients on Dryad and Daedalus in the morning at that sort of time?
A I had to start my morning surgery at nine, so I had an hour and a half within the hospital to visit and review both wards; Dryad first and then Daedalus.

Q In general terms, we will obviously come onto individual cases later, what would you be doing? What is the picture?

A I would arrive on Dryad Ward. They would just be finishing the hand-over between the night staff and the day staff and I would be taken around the patients by the senior day staff on duty and I would ask of each patient a series of basic questions about how they had been since I last saw them and I would be given the information, both given to the day staff by the night staff and from notes from the previous day.

B Q So in terms of information, first of all, from nursing staff, assuming that the night staff had completed their notes and so on, you would be able to see those?
A Yes.

Q You would also get verbal information?
A Yes.

C Q Would that always be through the route of the sister in charge? Let us take Sister Hamlin as an example. Would that always be through her or might individual nurses communicate information about the state of the patient themselves?
A Generally individual members of the day staff would not because they would have already communicated with Sister Hamlin. It was quite possible if there was a particular problem that one of the leaving night staff would have a word about a particular patient because they were still on the ward, but the main communication, the channel, was through the senior nurse with whom I went round on the ward.

D Q Do we think of you as actually seeing every patient, as it were, stopping at the bedside, or just getting information about patients from ---
A At Dryad Ward I actually saw every patient. I walked round through all the single rooms and the four bedders.

E Q If the patient was somebody with whom you could communicate, assuming there were no difficulties in terms of dementia or something like that, was it your practice to speak to the patients?
A Yes.

Q You say that was the picture on Dryad. Just dealing with that aspect of it, what was different about Daedalus?
F A Daedalus Ward, the ward round was done more as a business round in the office with the papers, with the night staff leaving, with the day staff taking over, and I would then go out and see particular patients I had concerns about. I would go out into the ward, having been given all the basic information.

Q What is the reason for the difference?
A It seemed to be the way the senior nursing staff liked to run their ward and
G they were more comfortable with doing it in a business way on Daedalus Ward and in a more informal way on Dryad Ward. It seemed to work equally well and I was happy to do whatever they wished to do.

Q I think in terms of Daedalus, certainly in the latter part of the period we are concerned with, that was Philip Beed who was in charge there.
A Yes.

H Q His predecessor?

A Sister Joines. She liked to do that.

Q Throughout the period we are concerned with, Dryad would involve Sister Hamlin?
A Yes.

Q Would those meetings in the morning involve you from time to time writing up prescriptions in response to whatever situation had changed?
A Yes.

Q What physically would happen? You would write up a prescription, whatever it was for, although we will concentrate very much on controlled drugs. What would actually happen? You would write up a prescription on any given morning. What would then happen with regard to that prescription? You would go to somebody? It would be given to somebody?
A It would be given to the senior nurse in charge and she would then action it, deal with it, do something with it.

Q So there would be information provided to you in the way you have described, discussion with relevant nursing staff and your taking whatever the particular actions that you thought were sensible at that stage.
A Yes. In addition, if I might want to write up blood forms or investigations for a patient in which there was a particular problem, I would have to do that at that time also because the blood lady came round when I was not in the hospital.

Q What would that actually involve you doing? Give us the practical picture.
A Finding the relevant form in the pile of forms and writing out the patients' information and what I wanted doing and signing it.

Q Would you be getting results which had come in from previous ---
A I would also be getting a clipboard of results to look at, comment on and initial.

Q Once your morning visit was completed and you are back, as it were, in general practice, when would you normally re-visit the hospital?
A I would re-visit the hospital if I had any admissions to clerk in and I would be told about those as they arrived by the admitting ward. They would say a patient has arrived on Daedalus Ward so I would go back to do that. I would be phoned if they had any particular concerns about a particular patient and they would either speak to me during surgery or if it was not convenient they would leave me a message and I would go back and see them at lunch-time, or if there was a particular family who were available and very keen to see me I would be happy to see them at lunch time.

Q So while you are back in general practice, as it were, at the surgery, you might be contacted about an admission?
A Yes.

Q Which would require your presence, as it were, to clerk in the patient, we will come on to that in a moment, or maybe a situation had developed which needed some advice or attention from you?
A Yes.

Q Were there periods of time when you would not be available if the nursing staff wanted to get hold of you during the morning?
A Yes, and the understanding was that the duty doctor within the practice would cover that for me and they would be asked to visit at lunch-time.

Q Did that always work satisfactorily in terms of attendance by others?
A They did grumble a bit but they generally went. They knew how important it was to clerk in an admission.

Q Yes. Whether it is in response to a need to see a relative or a response to a medical situation or response to information about a new arrival, we can then picture you going back to the hospital at lunch-time. Did the length of time you spent at the hospital at lunch-time vary according to the situation which had or had not developed?
A Of course. It would take a substantial period of time to clerk in a patient or to see a family or, possibly, to organise the management of a particular situation. I was quite often constrained by having to get back to general practice, for example, antenatal or postnatal clinic or a surgery, so my time was tight again at lunch-time.

Q What sort of length of time would you normally expect to be there if your presence was required at the hospital?
A I would have to probably be back in the practice at half past one, two o'clock. I would also have my ordinary house calls to fit in during that time, so it would not be to go home and sit down for a three course dinner. The time was very limited in the lunch hour.

Q Let us deal with a situation where you had gone back specifically, maybe you had gone back for more than one reason, but you had gone at lunch-time specifically because there was a patient who was newly admitted. Would it be right for us to picture that most of the patients arriving, the new arrivals, would be coming from a hospital?
A Yes.

Q We have heard, obviously, just about every incidence here with regard to either QAH or Haslar.
A Yes.

Q Let us take a patient in that sort of category. They have arrived, from one or other of those two hospitals. What is your normal procedure? What would be happening?
A I would hope that their notes had arrived with them rather than just a skimpy transfer letter. So the first thing obviously to do would be to look through the notes and get a clear picture of what had been happening before and what plan the transferring team had for this particular patient.

Q So, in general, were the notes normally coming with the patient or was it 50/50?
A They should have done.

Q How often would you find you had problems?

A We went through a spell with Haslar that they did not like releasing notes from a military hospital, so all you would get would be a rather enthusiastic transfer letter and we would have to ring them up and ask then to send the notes on, but probably 70% of notes from the Queen Alexandra arrived on time to the right place, which made life a lot easier.

Q Yes. So if information was there, you would read through and it absorb it, as it were, to see what the picture was?
A Yes.

Q Then what?
A Then go and apply that information to the patient in bed in front of you.

Q Then what?
A Then a full clinical examination, as you would do with any patient either in general practice or in hospital. Not as full as a junior hospital doctor clerking in, but just a basic general examination of the various systems.

Q Without going into every detail, what, in general, would that involve, so we can get the picture with regard to your examination of new arrivals?
A Cardiovascular system, respiratory system, abdomen, GU system if necessary, musculoskeletal system and a very cursory central nervous system examination. This was after you had said "good morning" and "hello" and exchanged pleasantries with them, if you were able to.

Q Yes. What about things like blood pressure and so on?
A I would expect that those had been done by the nurses.

Q Can we take it that they were done?
A Yes.

Q What would the nurses be doing? Blood pressure; what else?
A Pulse, temperature. Both they and I separately would be trying to get an estimate of the Barthel score. I would probably do that both from the referral letter that I had received and also my impression of the patient lying there in front of me, and they would be doing a similar sort of thing to put on their charts. They had lots of other forms to fill in about the state of the patient.

Q Just pausing there on the Barthel score, I think in one or two instances we have seen you have recorded a particular score, and the nurse or nursing staff recorded a particular score. They do not always tally.
A No.

Q But that is how you might get a difference?
A Yes. But it was a matter of single figures, not a major difference.

Q What about Waterlow? Would that be something that would ---
A I did not do Waterlows. I understood what they were but I was not responsible for measuring them.

Q Can we take it that if a patient had a particular problem, say just by way of an example, a significant sacral sore or ulcer, would that also be something that you examined in the course of your examination?
A They would make me look at them, yes.

Q Having carried out that sort of examination, what sort of periods of time are we talking about? What would that normally take?
B A That is going to take you 30-35 minutes with the reading and the examining and then the thinking, and then a very brief recording of what I found and the plan.

Q That is what I want to come onto. First of all, before we come on to your recording of things, what would happen with the nursing staff in terms of any record being made by them, normally speaking, with regard to blood pressure, pulse and so on? Would they make a record of that or not?
C A It should have been put in the cardex.

Q The cardex being?
A That thing that they keep in the office that they look at. They should have recorded it in the clinical notes. I am afraid I did not go hunting for it.

Q No, but that is what you---
D A I just assumed it would be there.

Q If everything was moving as it should that is what you would expect?
A Yes. It was all being done for you, yes.

Q Then your note-keeping or note-taking. We have seen in the twelve patients we are concerned with in this hearing a variation – some are briefer than others. First of all, why did
E you not make a fuller note than the note that you in general did?
A Because as a general practitioner by trade, I was used to making very minimal notes, really succinctly putting down my thoughts and feelings about the patient, not recording very negative finding as you would do in a hospital clerking of a patient, for my future information and for the information of my nurses.

Q So you would categorise yourself in general terms, not just in terms of note-taking at
F the Gosport War Memorial Hospital but in general for somebody who took brief notes? Briefer notes than most? How would you see it yourself?
A No briefer notes than other general practitioners in the same situation. I can think of one or two notable exceptions who write essays on every patient, but most of us did not have the time to do that.

Q I was going to ask you about that aspect of it. One could take any individual patient
G who has been newly admitted and one can say, perhaps, "Surely" – I have to ask you about this – "you could have spent an extra five minutes making a rather fuller note".
A Yes.

Q What do you say to that approach?
A I could have done, but to me it did not seem like time well spent because that very succinct note covered what I needed to know about that patient. It was adequate.
H

Q Would it be right to thing that time constraints might also be affected by any other matter that you had to attend to at a lunch time visit?
A Yes.

Q If there is more than one thing to do?
A Yes. It was not a priority to write full and extensive notes about admissions or review of patients by the same token.

Q You have accepted ---
A Yes.

Q --- in relation to the heads of charge that your note-taking, note-keeping, was inadequate. I am not going through every word of it. I would just like to ask you this. Did you ever have or find that there was any problem caused either to nursing staff or medical staff, in the sense of doctors, consultants, whatever, with person in that category having any difficulty understanding what should or should not be done with regard to a particular patient?
A None at all.

Q I think we have already heard evidence about this, so I do not think it is in dispute. Nobody, in the same of any consultant or indeed any senior nursing staff, seems to have approached you or picked you up on it and said, "Dr Barton, your notes are too brief. You should be giving a fuller account"?
A No one.

Q Although we will be coming on to this with individual patients in a while, in terms of the plan for the patient, you are seeing a newly arrived admission. You have checked whatever records there are as to what the history has been – the relevant history. You carried out your own examination and assessment. Was it always possible to think of a precise plan at that time, or provide a precise plan, or did it vary? What was the general picture?
A There were a few patients in which it was patently obvious what was going to happen to that patient.

Q What do you mean by that?
A There was one of our cases that we are considering that the lady had come for palliative care.

Q Yes?
A A diagnosis had been made. She had been on the palliative care ward up at the acute hospital. She was being moved down to Gosport. I was going to continue her palliative care. That is easy. There were a number of patients who had come down with the diagnosis of rehabilitation given to them in which, again, it was patently obvious that they were or they were not going to rehabilitate.

Q Would you give us the sense? When you say it was patently obvious, I appreciate these things may be dealing with feel and experience and know-how.
A Yes.

Q But what does that mean when you thought to yourself, "It's obvious rehabilitation is not really a practical course". What sort of situation would tell you that?

A You have looked through the notes of what has happened so far during the preceding admission. You have looked at the state of the patient there in front of you in the bed. It is obvious to you, with clinical experience, that that patient is not going to be able to rehabilitate.

Q Again, as I say, we will look at individual patients later.
A Then between those two extremes there were people who were going to get the chance, if it is possible, to make a limited amount of rehabilitation, and there were those people – there were lots and lots of people – who did. We are not considering any of those particular patients in this list of twelve.

Q That provides a basis, I think, as a suitable moment for me to ask you about two related or associated topics as to what you just described. First of all, patients generally. Can we deal with it at this stage. Over the years, as we all know, we are dealing with twelve patients here between 1995 and 1999, but over the years – I am sure you were not keeping count – what sort of number of patients were you responsible for as clinical assistant from the time you started to the time of your resignation?
A Thousands. Possibly 3000, possibly more.

Q And in relation to the same topic we have just been dealing with in terms of newly admitted patients, and your trying to decide what is an appropriate course for their treatment to take, what the plan should be, in terms of elderly patients, very often frail with various problems, no longer on the face of it any need for any acute intervention, what allowance did you make for the fact that the patient was newly arrived? In other words, they had been on Dryad or Daedalus for maybe a matter of minutes or a very few hours. How did that affect your view as to what was the appropriate thing to happen in terms of the transfer itself?
A There was always a degree of deterioration in a patient's general condition having been transferred. However short the journey is, the disturbance of being packed up, the disturbance of being transferred, meeting new people, new are admitted, there was always a deterioration in their general condition and you had to factor this in to your feeling for how much improvement they were going to make, again, or whether they were not going to improve from that state when you admitted them.

Q So sometimes a patient might settle in a positive way, if you like, in 24 hours?
A Yes.

Q Or maybe a couple of days. It may be three days?
A Yes.

Q Sometimes the deterioration would not stop?
A Yes.

Q How would you judge it when you say that, as it were, always or nearly always there would be some deterioration? How would you be able to assess that there had been a deterioration?
A I think the most obvious one that we have been looking at is the relative Barthel scores – the score that somebody had been given in activities of daily living on the ward they had left bore no relation to what was happening when they got to us. Now, either that was imaginative scoring or it was a deterioration in the condition of the patient on transfer, or it was both.

MR LANGDALE: Sir, I am moving on to another phase in terms of Dr Barton's daily routine. I can deal with that now, or if it is suitable to take a break, we can take a break.

THE CHAIRMAN: We will take a break. What I would like to do, because I anticipate the doctor is going to be on the stand for a considerable amount of time, is to try to keep around the general view that an hour of questions, then a break, then an hour of questions. It will not be exact. You will be looking for appropriate moments, but maybe we can do that. Of course, Doctor, if at any time you feel that things are getting a bit much, and towards the end of a hard day they can, you only have to indicate and we will always stop and make time.

THE WITNESS: Thank you.

THE CHAIRMAN: We will break now, returning at 11 o'clock, please.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Mr Langdale.

MR LANGDALE: I would like to continue with the general pattern of the day at this stage, please. You have dealt with the general picture with regard to a lunch time visit. I think it follows from what you have already told us, that apart from dealing with newly admitted patients, clerking them in and so on, examination, there might be other problems which you would have to attend to. Supposing a problem had developed with a patient. The nursing staff report that the patient has been particularly distressed, or whatever it might be, or that they are concerned that the patient has deteriorated and you are on, let us say, a lunch time visit and you receive that information. Would you see the patient concerned yourself if something was specifically reported to you?

A I would.

Q Would that be the case whatever the time constraints were?

A I would.

Q And it might be, I suppose, that you would need to give some further instructions as to what should happen in terms of the patient's care, or possibly write out a further prescription, or something of that kind?

A Yes.

Q Then coming back again to the hospital, you would sometimes be visiting the hospital in the evenings - yes?

A Yes.

Q It is possibly very difficult to say, but how many evenings in a week is it ---

A It would be probably only one evening a fortnight, if that.

Q All right.

A And it would be specifically usually because of a particular family had an express wish to see me, and it was impossible for them, because they were coming from a distance or they were working, to see me at any other time. I would make myself available to speak to them.

Q So sometimes the message might come from the family themselves? Or would it always come through the nursing staff?
A Or from me.

Q You might be saying, "I need to see you"?
A I would like to see this family. If it is not possible at any stage during the day, what about in the evening.

Q And again, if I can ask you this by way of generality to cover another topic that has arisen in this case, that is in relation to seeing the family, relatives, whatever one can describe them as in any given case, what were you trying to do? What is the object of the exercise?
A I was trying to make a relationship with the family so that we could help them through what might well be the last few days and weeks of their relative's life.

Q How important was that in the scale of things that you had to deal with?
A It was desperately important but it was the most difficult thing to do, and it was probably the most time-consuming thing to do, to make a relationship with a family who possibly had not come face to face with thinking about the problem, had been given unrealistic expectations or had their own particular problems to deal with, to try and make them aware of what was going on and help them through the process.

Q And what sort of difficulties – you have already outlined some of them – might you encounter if they had, or had been given, unreasonable expectations?
A One of the previous witnesses mentioned the idea that people were told, "Your relative will have a couple of weeks in the War Memorial Hospital and then be fit to go home." Totally unrealistic, and they would then be quite resistant to the idea that in fact that was not what was going to happen.

Q So what would happen?
A They would be hostile.

Q Yes?
A They would be unwilling to accept and we know in interviews like that, that people only probably are able to take in one piece of information and lose the rest, and that piece of information was not what they wanted to hear.

Q Again, we shall be coming on to certain instances in relation to evidence that the Panel has heard about, but let us take it to the crunch point. You simply cannot reach any measure of agreement with the relatives. They remain hostile to the idea of the fact that there is no acute intervention or something of that kind can be carried out. Their expectations have not changed as a result of what you tried to explain to them. Where might it end up if there was a meeting which had not really achieved any resolution?
A At that point I would probably ask if they could see my consultant – if I had a consultant.

Q Yes?
A And reinforce the picture, reinforce the ideas and support me during that process because I was not making any headway with the family.

Q Do you recall any occasion when you did have to try to bring in a consultant into the picture? Does that ring any bells with you?
A I do not think it is relevant to any of these.

Q Not in relation to any of these ---
A Any of these cases.

B Q Of these twelve. But did it ever happen?
A It would certainly happen that I could ask if they would see Dr Lord on her next ward round, and an appointment would be made for them, which would have given them time to reflect and time to think about it anyway, think over what I had said, and I might even have arranged to see them again to try and make more of a relationship. That was also the role of our Pastor Mary who would come in at that point to try and offer a softening of the ideas, support, ways they should be thinking about it. Although she had officially retired, she came
C back and helped on the ward.

Q And in your experience with regard to the nursing staff generally, did it seem to you that they were aware of the importance of that aspect of things with regard to their responsibilities towards relatives or not?
A They gave enormous amounts of time to helping relatives through this period. It was much – I do not say 'easier' – for them; they saw them more frequently anyway. They were
D there on the ward with them more often, and I think from that point of view it was easier for them to make a relationship with the relatives as well as the patients and start the process of explaining.

Q Do we see it as being in terms of any evening visits, that that would in effect always be to see a relative or relatives?
A Unless there was a particular problem with a patient. Either I was on call or I had just
E finished an evening surgery, in which case I would be happy to call in on my way home. It was not very far away, so it was technically easy to do for me.

Q We will be coming on to the question of your availability to provide medical attention of one kind or another with regard to the whole issue of anticipatory prescribing, but I am going to leave that, and that side of it, until a little bit later. Might there be situations where you could be contacted but where you yourself were not able to respond, actually able to do
F anything yourself? I am trying to see what would happen if that was the case – that you could be contacted but you could not give any practical response, and therefore you would have to pass it on to somebody else. Did that ever happen or not?
A I suppose it could happen out of hours if they tried to ring me at home but I either was not available or was not able to give any help at that stage, then they would contact the duty doctor.

G Q Yes?
A The same thing would apply during the working day. There was always somebody who was responsible for covering both the wards, and the same at week-ends.

Q And in your experience, in terms of what you understood to be the position with regard to attendance by other doctors in your practice, did that always work smoothly and on time, or not? Just by way of general picture?
H

A They were usually reasonable, certainly about giving advice and verbal orders, and they would then generally follow that up at some later stage by a visit, if only to write up the verbal order and check that everything was then all right. I would not say that they would drop everything and immediately attend. Sometimes in general practice it might be difficult.

Q So apart from your normal routine: morning visit, lunchtime visit and visiting in the evening if occasion demanded it, what other situations might arise where you would be contacted or have to go to the hospital? You might be contacted because a problem had arisen and you could give a verbal instruction.
A Yes.

Q If that was the case, you would try to follow that up with a visit yourself, if you were not already going to going in.
A Yes.

Q Any other circumstances where you might be called out to attend?
A I think that covers it. If you think of the working day, the out of hours and the weekends, we hopefully had all the eventualities covered, either by myself or somebody standing in for me.

Q Going back to your statement to follow some of these topics through – I am still on page 4 of the statement – in the top paragraph on page 4 you deal with the question of visiting in the evening and then you go on to say in the second paragraph on that page:

> "I was also concerned to make myself available even outside those hours when I was in attendance at the hospital."

We have covered that in general terms.
A Yes.

Q Then I want to move on to another topic which you move on to in the statement with regard to the level of dependency and the changes in terms of the patients. You begin that paragraph by saying:

> "When I first took up the post, the level of dependency of patients was relatively low. In general the patients did not have major medical needs. An analogy now would be to a nursing home. However, over time that position changed very considerably."

I am not going to go on reading out the rest; we will cover that later. First of all, what was the situation that you were presented with initially? How would you describe the category of patient who was there or coming into Gosport War Memorial Hospital before the change?
A These were patients who were nursing home patients. They were not at the end of their life and they were probably not near the end of their life, but they were sufficiently dependent that they needed full-time care by nursing staff: the sort of bread-and-butter nursing home patients that all general practitioners look after.

Q Would some of those patients reach a suitable state for them to go back home or somewhere else, or what? What is the situation?
A Very few of them would ever go home again and there was not the pressure before the changes in continuing care for them to go anywhere else. The health service were happy to

look after them in these surroundings. So they were stable from that point of view. Yes, they were reaching the end of their lives and they would need end of life care, but they were relatively stable.

Q Therefore, just to get the general picture, would those patients be patients who were staying in the hospital for quite a long period of time?
A Yes. For the rest of their natural lives.

Q Which might be?
A Five years, we had. Ten years, we had. A couple of years, we had. There was no pressure to move those sort of patients on anywhere because the health service provided for their care.

Q Then the change, with patients coming in increasingly dependent. We have heard about this already in some instances, but I would like to hear your account of it, please.
A Very ill, very dependent patients, with multiple co-morbidities and not medically stable, moved on because it was felt that there was nothing further that could be done for them in the acute setting and their bed was needed for another patient with very serious needs. So where did they go? They went to continuing care.

Q What is the effect of that in terms of your job and the job of the nursing staff?
A It ceases to be running a very efficient nursing home and it becomes something much more frightening.

Q What do you mean by that?
A Because you have patients who are quite likely going to deteriorate and deteriorate quite dramatically. They are very ill and they are going to need quite a lot of care and attention and looking after. It is not done in a measured, gentle fashion as in an ordinary nursing home. It becomes more like an acute hospital but without the back-up of the acute hospital, without proper diagnostics, without the proper blood tests, without the proper back-up, without blood transfusions, without ECG technicians. It was just trying to do a job in the wrong surroundings.

Q Can we just use this stage to look at what was available at Gosport War Memorial Hospital? We have heard something about the ability to deliver, supply and utilise intravenous fluids or whatever it might be.
A There was none. We had no facilities for administering intravenous fluids.

Q If you had had such facilities or means available, what would that have meant in terms of medical cover, as opposed to nursing cover?
A You would have to have full-time medical cover at least, if not on site, but not very far away.

Q Could you explain why?
A For inserting and re-siting and writing up and dealing with the complications of intravenous fluid administration and drug administration.

Q Was there any facility for ECG?
A When I first started the job, there was a lady in the outpatient department who did ECGs for the consultants, but I think again as a cost-cutting measure, they stopped using her

and we had no access at one stage during this time to an ECG machine and certainly not anyone to read them if they were done.

Q In terms of x-rays?
A We had a very small x-ray department with a rather outdated imaging unit in it, run by radiographers. A radiologist came down from Queen Alexandra once a week to report films taken for general practitioners and within the hospital during that week. Reports were typed up and then sent out, either to the wards or to the GPs, depending on where they were supposed to go to.

Q So a patient could be x-rayed?
A They could.

Q And, normally speaking, they would have to be moved from wherever they were on any particular ward to the x-ray department. Was the x-ray department on the same level, or where was it?
A Down that main corridor and off to the right-hand side in a sort of portacabin arrangement. So it was technically quite difficult sometimes when they were seriously ill to move them down and x-ray. Sometimes the radiographers were not keen to x-ray them if they were seriously ill and you would then wait quite a long time for the report on that x-ray.

Q I would just like to explore the general picture about x-rays a little more. We will obviously be looking at it in detail with regard to certainly one particular patient. In the normal course of events, if you had decided that a patient should be x-rayed – this is your decision and you want it done – what would actually happen?
A I would write up the form, one of my nursing staff would take it down to the x-ray department and negotiate a time for it to be done, the patient would go down at that time and have the x-ray done.

Q The x-ray has been carried out.
A The patient has come back to the ward, but the x-ray does not at that stage come back to the ward.

Q What would happen ordinarily?
A It would be reported on the next day the radiologist came to the hospital.

Q That might be the day after?
A Or it might be six days after, depending on what day the radiologist came down.

Q What happens if you, as the doctor, want an x-ray result, you want to actually know what the product is and be able to look at it?
A Then you would take yourself down to the x-ray department and ask to look at the films yourself. It would be the only way around the problem until they were reported.

Q We remember the situation with regard to Patient E, Gladys Richards, where it appears that an x-ray was taken I think the day after she had had the fall.
A It seems that it was fortunate that was a day when someone was in the x-ray department and it was reported right away and the message was sent back to the ward that there was a dislocation.

Q So in general terms, if a consultant decided, having done his or her ward round, that a particular patient needed an x-ray, for whatever reason, what would normally happen? Assuming you, as the clinical assistant, were not present.
A He would write up the x-ray request form in the same way, the nurse would take it down to the department, it would be booked. I do not know whether he was aware of how long it took for an x-ray to come back on to the ward. If he had wanted to see an x-ray urgently, he would have presumably had to make his own arrangements to speak to the radiologist or attend the x-ray department himself or do something else with that x-ray.

Q I suppose a consultant, if you had not been present, had asked for an x-ray to be taken and all the form-filling is carried out and so on, and the consultant wants to know what the result of the x-ray is as soon as is reasonably possible, he would be in a position to ask you, as the clinical assistant, to see to that if he wanted it.
A If he had wanted it, yes.

Q Does it follow then that if a consultant, on his weekly ward round, asked for an x-ray to be taken and the clinician assistant was not involved in that process, the normal circumstance would be what? That the x-ray would be seen by the consultant on his next ward round or what?
A That would be my understanding.

Q Any other facilities in terms of Gosport War Memorial Hospital?
A We had a phlebotomist, a lady who came round and took bloods on weekday mornings. Those were then transported up by van to the Queen Alexandra and processed there. So the results generally came back two days later in hard copy form. There was one occasion when an attempt was made to notify somebody on a ward of a blood result, but they claimed they were unable to get through the switchboard. Normally they came back two days later.

Q Does that cover the facilities available, apart from obviously the basic facilities you have already covered?
A Unless you want to mention physiotherapy and occupational therapy, which were in the building.

Q We might as well deal with those at this stage. Physiotherapy and occupational therapy. What was the position there? We have heard something about it in terms of the availability of physios, but how would you describe it?
A The physiotherapy department in the hospital had mainly been set up for general practice use and I think they offered a certain number of hours to the continuing care wards. More of those seemed to be biased towards the stroke stream rehab on Daedalus Ward and I think we were offered one visit a week by the physiotherapy team girl on Dryad Ward, although obviously if you had a particular concern about a patient, you could always go up and have a word and say could they come down and have a look. Occupational therapy, the same: allocated so many hours, very easy to go up and have a word with the occupational therapist and say, "We have a problem. We need somebody fitting with something. Would you come and have a look?" They were in the building, they were available, but you had to go and be nice to them.

Q When we think of somebody in relation to whom steps are being taken to remobilise or rehabilitate, whatever the appropriate description is, apart from nursing care, you have

physios, occupational therapists available in the way you have described. What else could be done in terms of rehabilitation or remobilising?
A You would also be making overtures to social services.

Q So that they could be doing what?
A Their assessments of the patient and their help in finding accommodation for them, deciding what their future placement might be. We also had of course mentioned in a couple of the cases input from CPNs coming down either from upstairs or in from the community to see their patients.

Q CPN?
A Community Psychiatric Nurses.

Q That would be a particular nurse coming in to see a particular patient?
A And liaising back to her elderly mental health consultant.

Q Perhaps we can deal with anybody in the shape of a nutritionist or dietician. Was there anything of that kind? What was available?
A There was one based at Queen Alexandra hospital. She came down to assess swallows. This is more relevant particularly to the slow-stream stroke patients and management of people with swallowing difficulties, but you could request her, you could contact the department in QA and ask her to come down and assess a patient.

Q I think it would follow from what you have told us that in terms of CPR, there would be no team available, no crash team or anything like that, no defibrillator?
A No.

Q In terms of the changing nature of the patients which you have been giving evidence about and the impact of that upon pressures in terms of nursing staff and indeed medical staff, in the sense of the clinical assistant and I suppose the consultants, how marked was the change?
A It turned the job from being enjoyable for both myself and my nursing staff into something very worrying. We began to feel that we were not able to give appropriate care to a lot of the patients we were looking after.

Q Not able to give appropriate care in what sense? What, as it were, suffered as a result of that change?
A The first thing was, the hardest thing to deal with was the expectations of the relatives. That suffered tremendously. When we were a nursing home serving our local population, with families locally, everyone understood what we did at the Gosport War Memorial Hospital. The community supported us, they had a fete every year, they had a League of Friends. We were part of the Gosport community. Gradually, over this time we were accepting patients who were beyond my skills, beyond the skills of my nurses to look after properly and inappropriately in our beds.

Q Beyond your skills. Would you enlarge upon that?
A Because I did not have intravenous fluids, I did not have resus facilities, I did not have all these things that you take for granted in your district general hospital, as well as the medical support. Instead of doing it by myself part-time, I would have had a whole team of people working with me to look after these patients.

Q I am going to come on to what steps you took or tried to take and indeed the situation reaching the point where you resigned. I am going to come on to that later, but just staying with the same topic in terms of those matters, the hospital redevelopment, Gosport War Memorial Hospital redevelopment takes place in 1993.
A Yes.

Q We have the set-up you have already described with regard to these wards and so on. When about, if it is possible to give a time, did you start to notice the change in the nature of patients who were being admitted under a consultant to Gosport?
A I think about 1996 ...

Q Something like that.
A ... it began to ramp up. Portsmouth seemed to be very slow in getting rid of continuing care. I think it happened more quickly in other areas but I think Portsmouth held on to continuing care and respite care longer in Gosport, perhaps, than in some other areas, but by 1996 it was beginning to become apparent, but not desperate at that stage. By 1998 it was difficult.

Q One further question about that general issue. You have mentioned already, and we have seen cases involving some of the twelve patients under consideration, the fact that patients might be admitted to Gosport who were not medically stable. I will use that as a broad brush description. About what sort of proportion, if it is possible to give any figure, would you say of patients who arrived at Gosport who it appeared really were not in a suitable state?
A It was no more than 10-15%.

Q Something like that.
A Something like that. It was not the vast majority.

Q No. Can we deal with that in general terms before we start looking at individual patients? What do you say to this, "Well, doctor, when the patient was admitted and you formed the view that really it was not suitable for the transferring hospital to have sent them to Gosport, why not send them back?" Would you like to address that, as a matter of practicality?
A The patient had survived the transfer down to my ward. The reason the patient had been transferred down was that their bed was needed for someone else. Had I rung the relevant department and said, "This patient is not well enough to be here", they would have been sentenced to a transfer back and a long wait on a trolley in A&E while a bed was found for them.

Q At the initial hospital?
A At the initial hospital. It was not as if there was a nice cosy spot for this patient to be slotted back into. There was already somebody else in that bed and several already waiting in A&E to be transferred into that bed. I felt that my duty lay with the patient at that point not to put them through further misery and distress to transfer them back, but, if you like, to make the best of what we had got, to make them as comfortable as possible and, in many ways, at that point to accept that they were for palliative care. I could not justify to myself transferring them back again, unless, of course, there was something that could obviously be done, like the lady who had dislocated her hip. That is a different issue altogether.

Q Yes. Again, just dealing with the practicalities, might it also be the case that a patient would arrive at Gosport and one would not know whether they were medically stable or not but it might transpire over a day or a day or two that, in fact, they were not in a suitable state for transfer. Would the same process of thought apply in those cases?
A Exactly.

Q Back, please, to the statement that you made about this on page 5 at the top. You dealt in the second paragraph with the position with regard to 1998 as an example:

> "... the bed occupancy was about 80%. However, the Trust was concerned to increase that still further and it then rose to approximately 90%. There would therefore be as many as 40 or more patients to be seen and/or reviewed by me when I attended each day. There was no increase in nursing staff, support staff, occupational therapy, and physiotherapy, and no support from social services to assist with the increase in patients, and the increase in dependency and medical needs. On a day by day basis mine was the only medical input."

We have covered all those matters. That is the way you expressed it in that statement.

Then we can move on:

> "Part of the list of duties laid down for me, as Clinical Assistant was to be responsible for the day-to-day medical management of patients. My work involved looking after a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. The vast majority had undergone treatment in the acute sector and were transferred to our care for rehabilitation, continuing care or palliative care after their acute management was completed. A major group of these patients were suffering from end stage dementia as well as major organ failure such as renal failure. A lot of my time would be spent attempting to forge a relationship with families and helping them come to terms with the approaching death of a loved one. This aspect of the job was often not helped by unrealistic expectations of the level of rehabilitation available at our cottage hospital or possible in these individuals patients and difficult dynamics within the families. The act of transferring such frail patients also further compromised their condition, sometimes irreversibly."

Again, we have covered those topics in my asking you to speak about them. I just want to take up one part of that last paragraph. You spoke in that section about patients being transferred to your care at Gosport for rehabilitation, continuing care or palliative care after their acute management was completed. I would like to ask you about your understanding of these terms. Continuing care, we have heard about it from other witnesses, but what do you see that as when you talk about a continuing care ward or a patient coming for continuing care? Is that back to our nursing home type situation?

A Yes, these are patients with a low but stable Barthel score, a low but stable mini mental test score, requiring a level of continuing care day and night from nursing staff and unqualified nursing staff, as you would get in a good nursing home.

Q Palliative care, just looking at it generally for the moment. Again, we have heard evidence from witnesses who might describe it slightly differently and we have to bear in mind that a distinction can be drawn between palliative care and end of life care, but what would you say palliative care meant in general terms?
A People in which no cure was possible but who were not yet at the end of their lives, they were approaching the end of their lives, you did not know what the time-scale was going to be. You knew that you could not reverse the changes that had happened but that all your care would be aimed towards giving them a reasonable quality of life during that time.

Q That would also embrace palliation of their symptoms?
A Palliation of their symptoms, entirely.

Q Again, in general terms, if you as a doctor concluded in respect of a particular patient that palliative care was what was to happen, that was, if you like, the plan, what did that signify in terms of whether the patient might ever recover from that?
A Palliative care does not imply that they will not recover, it implies that they were unlikely to recover. You have not ruled it out but you have not ruled it in, so it is a whole series of interventions in order to keep their dignity, their quality of life, their comfort, as much as you possibly can at that stage.

Q Whilst at the same time controlling their symptoms, presumably?
A Whilst controlling their symptoms.

Q It may follow on and may not need much explanation from you but we had better just deal with it. Then a patient who is at the end of their life, end of life care, reached a terminal stage, people have different expressions to cover the same thing. What does that signify in terms of your approach as a doctor?
A All their systems are running down. Everything is shutting down. They are losing interest in life, they are sleeping more of the time, they are not interested in eating, eating is not valuable to them, they stop drinking, they stop interacting with their relatives and they are then approaching the end of their life. Again, you cannot give a time-scale but it is a process with one end.

Q That, in general terms, is the picture in the way you would describe it in the terms we are talking about?
A Yes.

Q May I move back again to your statement to provide us a framework for these topics? Back on page 6 where we stopped a moment or two ago. You went on to say:

> "In carrying out my work I relied on a team of nurses both trained and untrained to support the work I did. Between us all we tried to offer a level of freedom from pain, physical discomfort, unpleasant symptoms

and mental stress, which is difficult to offer in an acute setting and is more allied to palliative care."

First of all, numbers of nurses. Did the change in the nature of the patients who were arriving for treatment at Gosport have an impact on the staff level in terms of the demands on the staff?

A I was not aware of any marked increase in the number of staff on either wards. I was aware that increasing the pressure on these girls made them more stressed, made them have to take more time off sick, made life more difficult for them. I was aware that both wards had a budget for bank staff and they had to always watch their pennies when employing people to replace nurses who were off sick on holiday. So there was constant pressure on them, if they wanted to do the job properly, which they did.

Q In general terms, we have a nurse in charge of Dryad, a nurse in charge of Daedalus, we have covered the particular personalities we have heard about in this case. Was there a number two to the person in charge? How did the structure work?

A Generally, each ward manager had a senior staff nurse and, generally, it worked out that she would be on duty when her senior was days off or on the alternate shift.

Q It may be testing your recollection too far, I do not know, but how many nurses during an average dayshift on duty on Dryad Ward?

A Probably three trained staff and four untrained.

Q Something like that. Daedalus?

A I would imagine comparable numbers.

Q Pretty much the same?

A Whether it increased slightly when the stroke beds came in, I do not know.

Q Then night staff, what sort of numbers, as you recall it, operating on Dryad and Daedalus?

A Two trained, two untrained and one of those two trained might also be carrying the bleep, might be responsible for the whole of the hospital, so she would be going round checking on the other wards as well as her duties on the ward she was based on.

Q So on any given night, whether there are bank staff in or whatever it might be in terms of the lowest grade, as it were, of nurse, would there always be somebody available at a senior level?

A Yes.

Q They might be looking after more than one ward but available if any problems arose requiring their attention?

A And going round regularly, yes.

Q In general terms, how did you find the nursing staff that you had to deal with in relation to both those wards? What is the general picture as you saw it?

A I had the greatest faith in all my nursing staff. I knew that they were not rocket scientists but I knew that, on the other hand, they cared for their patients

and they cared how they were looked after, that they were fed, washed, turned, seen to and comforted.

Q In terms of the more senior nursing staff, can I ask you, first of all, about Sister Hamlin? Somebody who was at Gosport War Memorial Hospital right from the time you started having anything to do with the hospital or did she come on the scene later?
A She came to Redclyffe very shortly after I started doing the job.

Q So you had known her, obviously, by the time of your resignation for a number of years?
A Yes.

Q I do not think there is any dispute about this: had developed a close working relationship with her?
A Yes.

Q Obviously got on well. Any social life shared by the two of you outside the confines of the hospital?
A None at all.

Q Would it follow that in relation to nurses, generally speaking, below that level, I will come on to Sister Joines in a moment, depending on how long they had been there you would know them pretty well?
A Yes.

Q Sister Joines, how long had you known her for?
A She had been working at the War Memorial pretty much since I joined the practice. I had known her on the male ward before she took over Daedalus ward when the hospital was redeveloped.

Q Yes, so we can think of her there throughout all the relevant time.
A Yes.

Q Again, a close working relationship with her?
A Very. I respected her as a very competent sister and ward manager.

Q Help us with the sort of balance between you. You would be listening to what they said, they, presumably, hopefully, would be listening to what you said. How did that work out if there was a difference of view as to what should happen?
A Neither would defer to the other simply because of your perceived rank or status but a discussion would go on and, hopefully, the right decision made for that particular patient. I was not really frightened of her but I respected her.

Q Maybe she was frightened of you. We do not know. In general terms, so far as the nursing staff were concerned, what was the atmosphere like? Was there a build up of a kind of team spirit or was it disjointed?
A I felt we had a very good atmosphere. For example, when the new wards were opened in 1993 we arranged a bed push, I did not actually take part in it, to raise money for the Pegasus Airwave mattresses for nursing these very frail dependent patients on. The nurses between the hospital between them raised several thousand pounds to provide mattresses for our new ward. That was the

sort of camaraderie there was between the nursing teams.

Q I am going to be coming on later to the difficulties that arose in the early 1990s. We have heard some evidence about that and I will come on to that separately, if I may, now you have given us the general picture with regard to the nursing staff. I think it would follow that, obviously, you placed a measure of trust in them?

A Yes.

Q And would rely on the information they gave you?

A Totally.

Q Just going back to your statement, on page 6 you set out:

> "Over the 12 years in which I was in post, I believe I was able to establish a very good relationship with the nursing staff ... found them to be responsible and caring ... experienced, as I think I myself became, in caring for elderly dependent patients. I felt able to place a significant measure of trust in the nursing staff.
>
> Over the period in which I was in post there was only a marginal increase in the number of nursing staff. With a significant number of patients and the considerable increase in dependency over the period, the nurses too were faced with an excessive workload.
>
> The picture therefore that was emerging, at least by 1998 at the hospital, was one in which there had been a marked increase in the dependency of the patients, and indeed an increase in their numbers. There was limited consultant input reduced still further by the fact that no locum was appointed to cover Dr Tandy's position. By this time the demands on me were very considerable given that I was expected to deliver this significant volume of care within a mere 3 ½ sessions each week.
>
> I raised this matter with management, albeit verbally, saying that I could not manage this level of care for the number of patients, but the reality was that there was no one else to do it. In due course I felt unable to continue. I resigned from my post in 2000."

MR KARK: I am sorry, but before we have an answer to this long question, can I just raise a flag? What Mr Langdale is doing is taking Dr Barton through her pre-prepared statements. I do not know how these were prepared – I expect with the assistance of solicitors. Then he is asking for a comment on it. That is precisely the conduct that he objected to when we had Professor Ford here.

I appreciate you have read these, and I appreciate that Dr Barton has been living this case for many, many years, and I have not taken exception so far. When we come to more contentious elements, particularly in relation to the patients, I thought it right just to raise a flag and warning that I might well have an objection to this sort of examination in chief, which is entirely leading, taking place.

THE CHAIRMAN: Mr Langdale, it is right that you are doing something which you were objecting to in Mr Kark. There is one difference here, though, which is that the Professor Ford reports were not before the Panel, whereas you are taking your witness to, and transcripting, paragraphs that are already before the Panel and put there without objection, I might add. I am not sure of the value in any event of reading line by line what we already clearly have an understanding very clearly the significance of.

MR LANGDALE: Sir, two things. I am doing absolutely, with my deepest respect, what I am entitled to do. The situation is completely different to the situation that pertained with regard to Professor Ford. I would be entitled, and I am not seeking to do this, to take this witness through every line of every statement she has made because that is what is before the Panel and I could do it in that way, and that would be her evidence. I am not seeking to do anything that is improper or inappropriate.

What I have been trying to do is, having arrived at a certain topic in her general statement, is then ask her about it, and then go back to the statements so we can take on board what has been said. I will avoid repeating passages if I think the witness has already covered it in her answers, but it is simply to keep pace with the development of the statement. I have been, with respect to my friend, trying to ask her about a topic in her own words, based on her recollection and response now, and then referring back to the statement where necessary. I will avoid any unnecessary repetition. I bear in mind, of course, that the Panel has read this, quite possibly more than once. I shall try to avoid repetition in that sense, but I am absolutely entitled in my respectful submission to take her through what she has said because it is there in front of you. Professor Ford's report, for obvious reasons, was not. *I* did not object to Professor Ford referring to this report and saying, "In my report I said...". He was absolutely entitled to do that. I did not object. I simply raised a point which had arisen with Mr Kark when he quoted a chunk from the report, without having even introduced the topic. We agreed to continue because it was not contentious. With respect, I am entitled to do what I am doing, as I say, and I will take as much care as I possibly can to avoid reading out any lines where the witness has already covered the topic, albeit in different wards.

THE CHAIRMAN: I certainly was not for my part disputing your entitlement. I was merely questioning the value of significant reading of paragraphs to a witness when we already do have them before us, and they are of importance, and significance has already clearly been flagged up for us.

MR LANGDALE: I will bear that in mind and try and avoid any possible problem with that regards.

THE CHAIRMAN: Since we have, I am afraid, successfully interrupted you, perhaps this would be a moment for us to break and you can resume when we return. We will do that. Fifteen minutes, please, ladies and gentlemen – ten past twelve.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Langdale. Sorry for the interruption.

MR LANGDALE: Not at all. I want to ask about the period of time which we just touched upon in your statement with regard to the increasing pressure on you, your raising the matter

with management and so on. In terms of management, in case some of these names come up, I am leaving aside consultants for the moment – all right? But in terms of management, was there somebody who was a hospital manager – given that title?
A There was a gentleman called Bill Hooper, who had an office in Gosport War Memorial and who I would see occasionally in the corridor and in passing. I started to mention to him in about ---

Q It is not your fault. I just want to establish personnel first of all. That is somebody called "Bill" or "Phil"?
A Bill.

Q Bill?
A William Hooper.

Q Bill Hooper?
A Who was the general manager for the Gosport War Memorial Hospital.

Q We will be seeing the name on correspondence. I just want to get the picture with regard to certain people. There is somebody called Isobel Evans. What was her position?
A She was, I think, the equivalent of the sort of matron for the whole hospital. I am not sure what her official title was.

Q I think up to about the mid-1990s.
A Yes.

Q Just so we know who she is, because we will see her name on some documents that I am going to ask you to look at. She fulfilled that sort of role. There was somebody called Max Millett?
A He was the Chief Executive of the health care trust.

Q Which ultimate became the primary care trust. Yes?
A He did not move over to the primary care trust.

Q I see. So when does he ---
A He resigned at that point. 2002, I think.

Q That is in relation to those names in particular. In terms of Bill Hooper, General Manger of Gosport War Memorial Hospital, was he succeeded in due course by a lady called Barbara Robinson?
A He was.

Q In terms of your raising the matter, raising the problems that you were facing by this stage, did you have any conversation first of all with Bill Hooper?
A I would have had an informal conversation with him to the effect that I was doing a lot of work for five sessions a week, clinical assistant remuneration, and that it was getting more difficult to do. I would not expect him to be looking at the clinical aspects of this problem, but more the financial aspects of it.

Q So when you spoke to him about the difficulties in an informal sense, were you actually asking that you should be paid for more sessions to do the work, or what?

A I was.

Q And what was his response?
A I suspect he laughed. After he had stopped laughing, I suspect he said that the financial constraints on the health care trust were such that they could not afford any more sessions for the job.

B Q Was he the person who actually held the budget?
A He would have been responsible for reporting back to those who held the budget.

Q Was there an indication from him that he would pass it up the line or he was going to do nothing, or what?
A I suspect he would have passed it up the line.

C Q Did anything come of that?
A I do not think so.

Q When abouts, without your being asked to give a precise date, did you have that conversation with Bill Hooper?
A Probably in about 1997 or 1998.

D Q Something like that. He was succeeded by Barbara Robinson. Did you have any sort of conversation like that with her at any time?
A A similar sort of conversation about how the workload was impacting on her nursing staff as well as on me not, probably, with any sort of financial motive in mind at that point in time, but more concern for the nursing staff.

Q Again, what response did you get?
E A I imagine that she passed it up the line.

Q Then consultants: did you ever discuss these issues or raise these issues with Dr Althea Lord?
A I did. Again, informally. I never wrote her a letter, but I would have discussed with her the increase in workload. I was always aware that Dr Lord tried to very carefully select the patients that she sent to Daedalus Ward as being appropriate for us to look after at the F War Memorial Hospital. She would not accept some patients, because she felt that they were not sufficiently stable. I was aware she was trying to do that for us. I was also aware that she did not have any political clout when it came to asking for more clinical assistant time or more manpower.

Q What was her response when you discussed these matters with her?
A She was sympathetic and she was well aware.

G Q Did she indicate as to whether she was able to do anything about it herself?
A She indicated that it would be very difficult for her to do anything about it, and she was also feeling the pressure herself at that time.

Q First of all this: when abouts would you have spoken to Althea Lord? Maybe you spoke to her about it more than once, but what sort of period of time?
H A A similar sort of period of time; 1998-1999.

Q And in terms of Dr Reid?
A Basically, as soon as he came to the job. As soon as he became the consultant in charge of Dryad, knowing that he was clinical director. I had an informal conversation with him, probably at the end of a ward round where we discussed the way forward, which he felt was to suggest to me that I might like to do the job full time. I pointed out that I was at heart a general practitioner and therefore that would not be possible, and he intimated to me that the pressure would continue to increase in the job. It was not going to get any better.

Q So it would seem then he was aware of the problems?
A He was very much aware of the problems but he was not going to be able to do anything about it.

Q Was that something you spoke to him about once or more than once?
A Probably only a couple of times, through 1999, culminating in my writing to him.

Q We are going to look at that letter in a moment, which was in January 2000?
A Yes.

Q Can I just ask you this. If you were raising these problems and finding that no one was apparently able to do anything about it, why not just stop? Why not resign in 1998 or 1999?
A Because I felt that I owed an obligation to the patients, to the staff, to my colleagues in the town, none of whom else wanted to have anything to do with the job, and to continue to do my best to do the job to my best ability. It was a very foolish way of thinking really, in retrospect.

Q Then the situation changed. You carried out but there came a point when you wrote to Dr Reid, and I am going to invite us to consider that period of time, in terms of what led to your resignation. Sir, there is a small collection of documents. Dr Barton is the author, if I can just indicate to my learned friend, of a letter I am going to put in, a response from a Dr Jarrett, which she will be dealing with, together with an accompanying document and another letter from Dr Barton to Dr Jarrett about these issues; then a letter from Dr Jarrett to Dr Barton together with another letter from her, and then a letter indicating that she has resigned, "Thank you for all the work..." and so on. Those are the documents I am seeking to put to the witness. I am going to ask that she receives them as a small bundle. There are about seven or eight pages and I will see that the Panel is provided with them and also, of course, Mr Kark.

THE CHAIRMAN: Has Mr Kark seen them yet?

MR LANGDALE: I do not think he has.

THE CHAIRMAN: Perhaps he should before we ---

MR LANGDALE: He may be aware of them in any event because they would be amongst the papers in the case.

THE CHAIRMAN: Mr Kark, are you content for these to go in before you have seen them?

MR KARK: If this is correspondence written by Dr Barton and to Dr Barton, then it is unobjectionable.

THE CHAIRMAN: Then we will receive them now as exhibit D6, please.

MR LANGDALE: I will just double check. I think every one of them is. There may be a letter from Dr Lord, but we will be calling Dr Lord. I think it is a covering letter. I feel absolutely sure there is absolutely no difficulty.

THE CHAIRMAN: We shall mark this D6, ladies and gentlemen.

MR LANGDALE: Mr Jenkins suggests, and I think it is sensible, if this collection could go behind Dr Barton's general statement which we have been looking at in that tab? It is a matter entirely for the Panel.

THE CHAIRMAN: If it is given an exhibit number, it is probably best for it to go with the other loose leaf defendant exhibits, otherwise we might find difficulty in finding it at a later stage.

MR LANGDALE: Whatever seems easiest. This would be ---

THE CHAIRMAN: D6, Mr Langdale.

MR LANGDALE: (Document marked and distributed) Thank you very much. That is for the whole bundle. (To the witness) Dr Barton, I think you have a copy of this as well. The Panel now have that. Would you look, please, at the first document which is a copy of a letter you wrote to Dr Reid. All right?

A Yes.

Q It is dated, as we can see, in the top right hand section, 28 January 2000.

"Clinical Assistant Elderly Medicine Gosport War Memorial Hospital

I feel that this is an opportune moment to examine my post for a number of reasons.

Firstly there is currently a review of the arrangement of Elderly Services and their relationship with future Primary Care Trusts and a future Trust configuration. These will undoubtedly impact on the future use of present continuing care beds throughout the District.

Secondly the Clinical and Managerial Integration between the Hospitals Trust and DSCA and the possible future implosion of acute work at Haslar will have a major effect upon the types of subacute and post acute care offered at Gosport War Memorial Hospital in reconfigured services on the peninsula in the future.

Thirdly and perhaps more relevantly at the moment, the type and throughput of patients who are currently using our beds is completely different from those I looked after when I took up the post twelve years ago. The types of patients and their medical conditions have changed markedly and perhaps this issue has not been looked at comprehensively within the Trust. There is no such thing as Continuing Care

nowadays, and Palliative care is something that I do perforce without a great deal of specialised back up.

At a clinical level this manifests itself in a number of ways, the most strikingly obvious of which is the expectations of patients and their relatives.

In part I feel that this stems from a mistaken perception that Gosport War Memorial is a Hospital with a capital 'H', ie resident medical staff and full on site resuscitation facilities. It is also apparent during discussions that relatives take the word rehabilitation literally and expect a much higher level of care and expertise than the current staffing levels and my time allow.

Whereas as recently as three years ago I would expect to spend a specific period of time with a worried relative over and above the normal consultation process once every few weeks, currently I find myself having to do this on a more frequent than weekly basis, in addition the climate of complaint, litigation and actual prosecution fuelled by intense media interest at present in care of the elderly and the issue of dying makes my position as a General Practitioner attempting to provide day to day care extremely difficult.

I am finding the pressures on me to continue to provide what I considered appropriate care for patients, proper consultation with their relatives and support of my hard pressed nursing staff almost intolerable. The current Police investigation into a charge of attempted murder only service to highlight the almost impossible task faced by a team dedicated to offering seriously ill patients a dignified and peaceful passing.

I would be most grateful if you would give this matter your earliest attention as I feel that the issue is placing considerable stress on the nursing staff and I personally feel extremely vulnerable to litigation for reasons that are outwith my control.

Yours Sincerely"

There is a copy to Dr Lord and a copy to Max Millett. To put certain things in context, what were you referring to when you were talking about the current police investigation, and so on? Had there been any complaint with regard to the treatment of patients prior to your writing of this letter?

A Yes.

Q The short answer is yes. And that was in relation to – do you remember by that stage?

A Gladys Richards.

Q And your reference to "current police investigation into a charge of attempted murder" relates to?

A Gladys Richards.

Q That?

A Yes.

Q I think in terms of the statements that you made to the police, the first statement that you made did indeed relate to Gladys Richards when you were first seen by the police in

2000 --- I am hesitating. It is thought to be 2000. We can check on the date. In terms of that letter to Dr Reid, did you receive any response from him?
A I did not.

Q Can we look, please, at the next page in the bundle, which is a letter to you from Dr Jarrett dated 16 February 2000. Dr Jarrett being whom?
A One of the consultant geriatricians based up at Queen Alexandra Hospital. This was distributed to a whole list of people.

Q You were one of the recipients of this, were you?
A Yes.

Q It begins:

"Dear Colleague

The bed crisis at Queen Alexandra hospital continues unabated. Routine surgical operations have been cancelled now. It has fallen on us to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some underutilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post acute patients. A policy offering guidance is enclosed. We shall trial the flexible use of the beds for a few weeks and I would be happy to co-ordinate any comments.

Thank you for your help."

Over the page I think is the document he refers to in the letter, "Emergency Use of Community Hospital Beds". That is the document, is it?
A Yes.

Q Then he refers, without my reading out every word of this accompanying document, in the fourth line down to:

"Some continuing care beds remain underutilised in Petersfield ... Gosport War Memorial Hospital and St Christopher's Community Hospital Fareham."

Was that correct in your view, that beds were remaining under-utilised at Gosport at that time?
A No.

Q

"These beds have no resident medical staff and weekly, or less than weekly, consultant ward rounds. There is basic nursing care and only minimal rehabilitation staff and facilities.

Therefore patients referred to these beds for post acute care should be:

Waiting for placement ...

Medically stable ...

No outstanding investigations ...

No interventional therapy ...

The patient lives near the community hospital ....

The patient and family consent to the move

The patient, family and staff ... clearly understand that the placement is in a post acute bed, not continuing care bed ...

GP beds in community hospitals are independent of the department's continuing care provision ..."

Et cetera, et cetera. Did you find that reply helpful to what you had been saying?
A I was very upset to receive that reply to what I had been saying about the pressures already existing on our beds at the Gosport War Memorial Hospital.

Q Did you accordingly write to Dr Jarrett soon after that, the next page in the bundle, on 22 February?
A I did.

Q The body of the letter reads:

"I was very disappointed and also quite concerned to be shown a letter from yourself dated 16th February on the subject of the bed crisis at Queen Alexandra and addressed to the various ward managers and Sisters.

Less than a month after I wrote a letter to the Clinical Director expressing my concerns about the situation in our continuing care unit, I find that we are being asked to take on an even higher risk category of patient.

These post acute patients have a right to expect a certain standard of medical care, appropriate levels of therapy and supervision and appropriate out of hours cover during this period of time in hospital.

I find myself without a consultant or seamless locum consultant cover for a period of a further month on one of the wards and the other consultant cannot be expected to provide anything other than firefighting support during this time."

What was that a reference to, you finding yourself without a consultant or seamless locum consultant for a period of a further month?
A I think Dr Reid was not going to be available on Dryad Ward for that time and Dr Lord was being asked to cover both Daedalus and Dryad Wards during that time.

Q It goes on:

"As a result I am unable to do the clinical assistant job to a safe and acceptable standard which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition, my staff are subjected to ever increasing pressures from patients and relatives, causing stress and sickness levels to rise.

I would also question the term underutilisation in a unit which is handling approximately 40% or the continuing care done by Elderly Services at this time.

I hope you will give this serious consideration."

Did you then get a letter back from Dr Jarrett, which we can see on the next page, dated 7 March 2000:

"Dear Jane

Thank you for your letter dated .... making me aware of your concerns about the use of continuing care wards.

My original letter was an attempt to ease some of the acute pressures at Queen Alexandra Hospital. As you know there are a huge number of elderly patients as outliers who are blocking the surgical beds. There has effectively been little elective surgery from the Christmas crisis period.

A brief survey, a few weeks ago showed that there were some continuing care beds that were unfilled.

After discussion between John Bevan and my consultant colleagues ..."

John Bevan?
A He would have been the medical director of the acute hospital trust at that time.

Q

"... we felt it might help the dire situation here if we used some of those unfilled continuing care beds for patients who are clinically stable and awaiting placement in say a rest home or nursing home. It was envisaged that the patients would require little medical input and that we would only move patients who they themselves and their families were happy to move.

I understand that the continuing care workload at the Gosport War Memorial hospital is quite large certainly in comparison with other community hospitals."

Would you agree with that description?
A I would.

Q Then:

"Gosport is busy in other areas with an ever increasing number of referrals from Haslar Hospital and an increasing need for consultant input to the GP beds. With that in mind we will need to look at ways of trying to improve consultant cover for the Gosport peninsular. I will try and incorporate this into our plans to try and expand consultant numbers.

Thank you for letting me know of your concerns."

Did you then take the step of writing to somebody called Peter King, if we turn over the page?
A I did.

Q He was Personnel Director of Portsmouth Healthcare Trust, as we can see, and you wrote to him on 28 April 2000, enclosing your letter to Dr Reid and your letter to Dr Jarrett. Correct?
A Yes.

Q You say:

"Dear Peter,

Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport ... I have highlighted these worries on two occasions previously in the enclosed letters.

I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example on one of the wards I will only be having locum consultant cover until September."

Which one of the wards was that? Do you remember?
A No.

Q

"In addition an increasing number of higher risk 'step down' patients continue to be transferred to the wards where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.

The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation.

My original contract of employment signed in 1993 indicates I am required to give you two months notice. However, I wish my serious concerns and anxieties to be placed on record during the notice period."

Was that resignation letter setting out everything that was of concern in your mind at the time or not?
A Yes.

Q Then on to the next page of the bundle, please. On 19 May, did you get a letter from Fiona Cameron, who was the Divisional General Manager, saying that she had been passed a copy of your letter of 28 April tendering your resignation and Peter King had apparently formally responded. Is that right? Had Peter King formally responded?
A I cannot remember.

Q She says:

"I am writing to offer my thanks for your commitment and support to Gosport ... over the last seven years. There is little doubt that over this period, both the client group and workload have changed and I fully acknowledge your contribution to the service whilst working under considerable pressure.

Acceptance of the above pressures coupled with your resignation has led to a review paper being produced which outlines the current service at Gosport ... for Elderly Medicine patients, the medical support to this and the issues and pressures arising. The paper proposes enhanced medical input and rationale for that, which is in keeping with current intermediate care discussions.

I hope that you will be able to give your support to this proposal, given your knowledge of the current situation ...

My thanks for your contribution .... and my good wishes ..."

And so on. Then over the page, we have "Guidelines for Admission to Daedalus Ward".
A No. There are no guidelines.

Q One less document for us to be concerned with! It was in the bundle I had received and I am afraid I had not cross-checked. That takes care of bundle D6 and deals with the circumstances leading to your resignation in the way that you have described. When you ceased to work at the War Memorial Hospital in 2000, what replaced you in terms of clinical assistant or anybody occupying a similar role?
A I understand that a full-time staff grade position was engaged to be present on the wards from 9 until 5 every weekday. All of my partners but one agreed to continue providing a proportion of the out of hours care which was not covered by HealthCall completely out of hours in order to provide continuity of care between 5 and 6.30, when HealthCall took over.

Q Some time later – later in terms of years rather than months – was further medical cover provided as you understand it?
A I understand it, but I can give you no details.

Q We will deal with that in another way. I do not think there is any dispute about it. Further medical cover was provided in due course.
A Yes.

Q What do you say to the suggestion that really you were not sustaining an excessive workload? What do you say to that?
A I felt I was sustaining an excessive and dangerous workload by 2000.

Q I have dealt with the question of your note taking and your response to that. I think this refers to something that was given in evidence by Dr Reid. Given the choice between taking fuller notes and devoting your time to the care of patients, which would you choose?
A I would always prioritise taking care of the patient to the detriment of my notes.

Q I am now going to turn to the question of prescribing in terms of what is sometimes described as anticipatory prescribing and sometimes described as proactive prescribing. Before I deal with that specifically as an issue in context, I would like to ask you about the prescribing of certain types of drugs. What I am going to do is ask you about that in general terms without going through a mass of detail, then I am going to ask you about the issues which arose in 1991 and then I will come specifically, having put matters in context, to the issue of proactive/anticipatory prescribing, why you did it and what you understood would happen. First of all, in relation to particular controlled drugs – not in every case controlled drugs, but in general that is what one is dealing with. In terms of opiates – I will come on to the milder opiates in a moment – just dealing with the higher level opiates, starting with Oramorph, what was it that you found from your experience was the need for the administration of Oramorph and what were its advantages? What would create a situation or what sort of situation would it be that would involve ---
A Continuing pain, distress, anxiety in a patient undergoing palliative care. I was well aware of the analgesic ladder, both in general practice and in the hospital setting, and like one of my consultants mentioned in his letter earlier on, I felt that a small dose of Oramorph was much more beneficial to the patient than large does of step 2 analgesics, which were unpleasant to take and had unpleasant side effects associated with them, whereas a small dose of Oramorph would often give a slight feeling of euphoria and well-being to the patient in addition to controlling their symptoms of pain and discomfort.

Q Dealing with the practical problems, if you like, in terms of the administration or provision of a large number of, say, co-codamol tablets or co-proxamol or DF118 or co-dydramol. Just taking those as a group, what is the advantage, assuming the patient is in a situation which requires treatment with opiates, of Oramorph over those?
A Much smaller volume to take. They are large, unpleasant tasting, difficult tablets to swallow and I never felt that their analgesic properties were as effective as the opiates. I think in those days we were not frightened of opiate use in the way that we are now.

Q What would you classify as a small dose in general terms?
A 2.5 to 5 mls, i.e. 5 to 10 mg of Oramorph four-hourly and an extra dose at night to see them through the small hours.

Q That is the general picture.
A That is the general picture.

Q In terms of your past experience of administering Oramorph, prescribing it and seeing to it that it was given to the patient, had you been prescribing Oramorph in those sorts of circumstances from the time you started as clinical assistant at Gosport?
A I had.

Q Had you ever experienced the adverse effect on a patient of Oramorph causing excessive drowsiness or any other problems: agitation or anything of that kind?
A I had come across it causing constipation and it was almost mandatory to co-prescribe laxatives at the same time, because you knew it was going to make people constipated. I had

had problems with it causing nausea in one or two patients, which again could be controlled by another drug or step down, use a different drug for a while and then go back to it.

Q I think we have seen in one of the 12 patients there is a reference by you to the patient being Oramorph sensitive, or something like that. We will see that in due course. In general terms, had there been any problems in relation to your prescribing and administration of that drug?

B A No. I found it a very user-friendly drug.

Q May I just ask you this, albeit in the context of Oramorph, but generally. In terms of the BNF, how familiar would you have been at that time with what the BNF said with regard to opiates generally and opiates individually in terms of Oramorph and diamorphine?

A I would have been quite familiar with the passages in BNF.

C Q In general terms, were you aware of what the BNF said about the general position with regard to elderly patients receiving opiates?

A I was.

Q In relation to the Palliative Care Handbook, or the Wessex protocols, whatever they are properly described as, were you aware of that document?

A I was. It was usually in my pocket or in my briefcase.

D

Q Were you aware of what was said in that palliative care handbook with regard to the general approach so far as conversion from morphine taken orally to subcutaneous administration?

A I was aware of the conversion.

Q It would follow from what you said that you were aware of the other general

E guidelines that are set out in that document?

A I was.

Q Did you take into account any feedback from nursing staff when you prescribed and administered controlled drugs like Oramorph? Would that signify to you?

F A It would be very helpful in choosing which drug, which range of dosage, to use on that patient. I could not do it on my own just looking at the patient as a snapshot once a day, I relied on what they told me had happened for the rest of the 24 hours.

Q Did their account of the effects of the administration of Oramorph bear out what you yourself thought or not?

A It did.

G

Q Did any consultant or, indeed, anyone else ever query your use of Oramorph with regard to any patient?

A No.

Q Turning to the administration of subcutaneous analgesia, and we are focusing not exclusively but very much on diamorphine and midazolam, so I am going to focus on those two. Again, in general terms, what sort of situation would

H cause or bring about the actual administration? I am not talking about prescribing

in advance at the moment, but the actual administration of subcutaneous analgesia. In general terms what situation would bring that about?
A There were the obvious reasons like the patient was no longer able to swallow or the patient was vomiting continuously or the patient was too frail or unwilling to take oral medication, but there was also the additional consideration that when adding the midazolam I had the help of an anxiolytic mild muscle relaxant to add to the pain relief I wanted to give to control the patient's very distressing symptoms. So it was a tool to control symptoms at the end of life.

Q When a patient was provided with subcutaneous analgesia and diamorphine being, as it were, the lead drug, not always but very often, together with midazolam, what did that signify in terms of the patient's status in terms of continuing care, palliative care, end of life care?
A It signified that palliative care was now moving into end of life care, into terminal care. It was the time when all the other medications the patient had been taking, for whatever reason, were probably stopped, for whatever reason, and you then focused on making the patient comfortable and peaceful.

Q What about the situation where a patient, just in general terms, is receiving analgesia in the form of Oramorph and the reason for the change to subcutaneous administration of diamorphine is that the patient can no longer swallow, not because the patient's condition has deteriorated?
A You could then make a direct comparison of dosage, based on working out from the one third to one half conversion table as to what you would give in the syringe driver. Now that would not necessarily mean that is the patient was right at the end of life, although why had they stopped swallowing? They were probably nearing the end of life anyway.

Q There might be some other problem?
A There might be some other problem.

Q But in the abstract, that sort of situation would not necessarily import a change of status?
A No.

Q When you made a calculation as to what was appropriate in terms of the dose to be administered, I am just talking about the minimum dose prescribed, when you hit on the figure of 20 or whatever it might be, were you taking into account in terms of any calculations that you made what would be the conversion from Oramorph to diamorphine? In other words, were you applying a one third conversion or a half conversion or what?
A In those days I think a half was used more commonly than a third. I was also taking into account that in general practice it would be very unusual to start at 10 mg of diamorphine in 24 hours because that did seem, in practice, a very low dose. It did seem very ineffective. 20 as a starting dose in the opioid naive or not opioid naive seemed a very satisfactory starting dose and I did not ever see any major side effects or problems with that dose.

Q In a patient who was opiate naive, they have not had any opiates in the immediate past, as it were, why not start at 10 to address that issue?
A Because, in my experience over the years of using it, it did not seem very effective in the dose of 10 mg. You would very quickly have to go back and

increase it to 20.

Q We will be coming on, obviously, to particular doses with regard to particular patients in a moment, but may I just ask you about your understanding, still staying with diamorphine for the moment - well, we had better go back to Oramorph, taking that as a starting point. Your understanding as to the effect, the impact, of the administration of Oramorph in terms of when it starts working and when it declines, in effect, that general picture, what was your understanding as to what the sequence would be?
A I am not a professor in clinical pharmacology but in my understanding in those days, by the end of four hours it was pretty much ceasing to be effective and that it would reach its maximum effect at approximately two hours. That is how I used to dose it.

Q Yes. If we imagine a patient receiving a teaspoon full, 5 mg, it would reach its maximum effect, in your mind at the time, when? After two hours?
A I suppose between the two and the four and then be starting to - that was why we, presumably, gave it four hourly.

Q Exactly. Then in terms of diamorphine by subcutaneous, leaving aside intravenous or intramuscular injection but administered subcutaneously, what was your understanding as to how the process would work in terms of controlling pain?
A I was surprised to hear that experts felt it took as long as 17 to 24 hours to build up to a steady state level. I always imagined, using it clinically, that it kicked in more quickly than that, but that you would reach a steady state during the first 24 hours of administration.

Q Perhaps you can deal with that very point because we will need to address it at some stage. Professor Ford was making the point in relation to subcutaneous analgesia, and still staying with diamorphine, that very often a preferred course of action, so you can establish the dose required, is to administer an immediate injection, "loading", I think was the expression he used, and then you wait to see what happens with that before deciding what level of subcutaneous analgesia should be applied. What do you say to that?
A It would be a luxury to be able to do that in a community hospital.

Q What would it actually involve, this process, if you had ---
A An assessment and then the drawing up and the giving by two trained nursing staff every four hours of the relevant injection. Then, presumably, at the end of a certain length of time, when they felt the pain had been controlled, converting that into the amount to go into a subcutaneous infusion. I had never seen it done in the community and I had never used that method in my hospital practice.

Q When you say you had never seen it done in the community ---
A No, that is not correct. Before we had syringe drivers, of course we did it in the community but it was not satisfactory for the patient because they got breakthrough bleeding, it was very unsatisfactory for the unfortunate nursing staff who had to keep going back every four hours and give another injection and that is why we went over to subcutaneous analgesia because it was so much more convenient for the patient and for the nursing staff.

Q Whenabouts did you start using syringe drivers to administer subcutaneous analgesia?
A I cannot remember but I certainly started using them at Redclyffe Annex, so that would have been 1989. I cannot remember how often I used them in general practice before that time.

Q Perhaps we can just deal with the economics, if you like. How many syringe drivers would have been available on Dryad and Daedalus in 1995?
A Two on each ward, if they had not been pinched by Sultan Ward.

Q They were ---
A They were in very short supply and they were like gold dust.

Q Yes. So your understanding as to how quickly the subcutaneous diamorphine would take effect would be what? Let us say you are starting at 20: how long would you think it would take for that to be achieving the level of ---
A I suppose I would have thought three or four hours you would be starting to get a significant level in the blood stream, depending on how well the patient was perfusing and where you put the syringe driver and how it was operating. I did not realise it was as long as 24 hours.

Q In your experience ---
A It seemed to be more than 24, yes.

Q Were you ever conscious of the fact that ---
A Had not worked by the next morning? No.

Q Yes. Did the nursing staff ever report to you that there was a problem with a delay in terms of pain control in general terms?
A No.

Q I think we have probably already covered what were the advantages of administration by means of syringe driver and I am not going to go over that again, but may I just ask you one other thing about them generally with regard to boosting the level of analgesia being administered. What did you understand that process would or might be?
A There was a button on the side of the Graseby syringe driver that increased the rate of administration of the drug. I do not know how long it boosted it. I have to confess that I always felt the nursing staff benefited more from the boost than the patient did.

Q Explain that, would you?
A I could not believe that you would get a significant increase in the amount of opiate or drug in the blood just by pressing the button on the side. Otherwise, it would have run out long before the 24 hours and they did not.

Q Yes, I see. How often would that sort of thing happen, or to what degree were you aware of it apparently happening? Was it a rare event?
A With the sort of prescribing of the opiates that I was using in the syringe driver, it should not have needed to happen. I would have chosen an adequate dose to cover that 24 hour period.

Q Then just one thing I would like you to deal with, please, with regard to midazolam. I will ask you about it in more general terms in a moment, but can we just note in relation to the *BNF*. This is tab 3 of bundle 1. Would you turn up page 4? There is the section there in the *BNF*, halfway down the left hand column, "SYRINGE DRIVERS", and then moving over to the right-hand side, can we pick up, just below halfway down the right-hand side, "Midazolam"?
A Yes.

Q

> "Midazolam is a sedative and an antiepileptic, and is therefore suitable for a very restless patient; it is given in a *subcutaneous infusion dose* of 20-100 mg/24 hours."

Q Were you aware of that?
A I was.

Q Did it seem to you that the administration of 20 mg, as if you were doing a dose range, was high, bearing in mind what the *BNF* said about it?
A I did not feel in practical usage that it was a high dose to give.

Q In terms of subcutaneous use ---
A In terms of subcutaneous, not as an anaesthetic.

Q I just want you to indicate please before, perhaps, we adjourn, in terms of why use midazolam? It is still in very general terms. You think it right that the patient's condition warrants the administration of subcutaneous analgesia, first of all, diamorphine, to control, essentially, pain, although we appreciate, it has been said already by you and other witnesses, that you were of the view that it was also useful for dealing with anxiety and so on. We will come back to that, but, essentially, pain is what we think of. Why administer as well, it does not happen in every case but in most of these cases at some point, midazolam which has a sedative effect? What is the point of it and what are you trying to achieve?
A I think the professor mentioned this concept of terminal restlessness. I do not know if anybody has ever done any research into what it is but it is a very distressing symptom, both for the patient and those looking after the patient. It was very good at controlling that. I also felt that as a sedative it replaced the antipsychotics and antidepressants and other drugs that had been present in a lot of these patients, particularly the end stage dementia patients, so that it would cover any withdrawal or restlessness they got from not being able to take those drugs any more, and it was a drug that I became familiar with through using it over the years and comfortable with using.

Q I was just going to ask you about that. Is there any guideline or indication anywhere as to whether doctors should be using a wide range of different drugs or not?
A I think the *Wessex Guidelines* makes the point that you should use a small number of drugs and be thoroughly comfortable and familiar with them and the possible problems you are going to get with them, and I had the three that I used routinely really, or made available routinely.

Q Yes. Whenabouts had you started combining diamorphine and midazolam in terms of subcutaneous analgesia, if you can give us any rough idea?
A I would have thought in the early 1990s.

Q Were you aware of the risk with the administration of diamorphine of over-sedation?
A Yes.

Q Did it bring about, so far as you could judge it, over-sedation in the sense that it was not appropriate for the patient's needs and should have been reduced?
A No.

MR LANGDALE: I appreciate we get into an area as to what is happening with a patient who is deteriorating, in any event, but we can come on to that, perhaps, later.

Sir, if that is a convenient moment?

THE CHAIRMAN: Yes, indeed. Thank you very much. We will rise now and continue at five past two. Thank you, ladies and gentlemen.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Mr Langdale.

MR LANGDALE: Dr Barton, I was asking you about your general approach with regard to subcutaneous analgesia. Of course, we will come back to it in a slightly different context later on. I want to ask you now, before I ask you directly about pro-active or anticipatory prescribing, about events in 1991. Here we will need to go back to File 1, please, and in that file the collection of documents put in by Mr Kark on behalf of the GMC, which we find at tab 6. The first document in tab 6 is a summary of a meeting held at Redclyffe Annexe, 11 July 1991. You are not present. There is Mrs Evans, who I think was the matron of Gosport War Memorial Hospital. Is that right?
A Yes.

Q And a number of other nurses – Sister Hamblin, Staff Nurse Giffin, Barrett we can pick up, Tubbritt and Turnbull, amongst the names that are there. Concern about the use of diamorphine on patients; some reservations being expressed about whether it was always used appropriately. Concerns – without my reading through all of them are: not all patients given diamorphine have pain; no other forms of analgesia are considered; sliding scale is never used; the drug regime is used indiscriminately; individual needs are not considered; deaths are sometimes hastened unnecessarily; use of the syringe driver on commencing diamorphine prohibits trained staff from adjusting the dose; too high a degree of unresponsiveness from the patient was sought; sedative drugs such as thioridazine would sometimes be more appropriate; diamorphine was prescribed prior to such procedures such as catheterisation when diazepam was just as effective; not all staff views were considered. Now, I am not going to go through all the detail of that, but we can see that Mrs Evans acknowledged the concern and felt, half-way through the last paragraph, that

"... both Dr Logan and Dr Barton would consider staffs views so long as they were based on proven facts rather than unqualified statements."

Were you aware at the time that this happened – that is the meeting in July 1991 – that there were such concerns?
A I was.

B Q Were you aware of the concerns being expressed on that first page?
A I was.

Q Had any nurse ever expressed any such concern to you?
A My understanding was that the problems were raised initially by a couple of the night staff and at that time I do not remember ever seeing the night staff very often on the unit when I went there in the morning. So I was made aware indirectly by the trained staff on C days, that there was some concern by night staff.

Q Did you yourself carry out any inquiry as to what these concerns were?
A I did not.

Q Would you help us why not?
A I felt that it was at that point in time a matter for the nursing staff to take through their D hierarchy.

Q Is this right? No nurse who was making any complaint about procedures ever addressed you face to face about it?
A They did not.

Q From what you had gathered, were the concerns just the views of some members of E the night staff, or did it include day staff, or what?
A My understanding was that it was much more a concern raised by night staff. I felt that the day staff were much more au fait with the use of opiates at the end of life, and more comfortable with them.

Q I am not going to go through all the rest of the detail of that meeting, but one can see on page 3 of that section of the bundle, that tab – we might as well deal with it here. One of F the queries was, is it appropriate to give diamorphine for other distressing symptoms other than pain. What was your view? What would your answer be to that question?
A My feeling was that it was entirely appropriate to use diamorphine for such symptoms as anguish and distress and fear of dying, as well as purely pain.

Q Then over the page to page 4, we can see what the conclusion of the meeting was:

G "To try and find the answer to these questions Mrs Evans would invite Kevin Short...".

Does that name mean anything to you?
A No.

H

Q

"... to talk to staff on drugs on drugs and ask Steve King from Charles Ward Q.A. if he would be prepared to contribute."

Does that name mean anything to you?
A I know that Charles Ward was the elderly medicine, a palliative care ward, up at Queen Alexandra, and I imagine Steve King was the clinical manager, but I did not know him personally.

Q

"This would take time arrange meanwhile staff were asked to talk to Dr Barton if they had any reason for concern on treatment prescribed as she was willing to discuss any aspect of patient treatment with staff."

First of all, were you? Is that a correct summary of your position, that you were willing to discuss any aspect of patient treatment with staff?
A Absolutely.

Q Did any member of staff after this meeting talk to you about having concern on the treatment prescribed?
A I cannot remember, but I am quite sure, this concern having been raised, that I would have been scrupulous to try and explain to the nursing staff I was dealing with why, in that particular case, we were intending to use opiates.

Q Then can we go on, please, in that same bundle, there is another meeting recorded at the end of October on page 6. Thursday, 31 October, the report of a visit to Redclyffe by the community tutor, continuing education – Gerardine M Whitney. Does that name mean anything to you?
A Yes.

Q The purpose of the visit:

"The visit was in response to a request by Staff Nurse Anita Tubbritt to discuss the issues of anomalies in the administration of drugs."

We can see that present – just using the surnames – Giffin, Tubbritt, Turnbull, Howard, and that appears to be it. There are certain things that Giffin said and, again, at item 4:

"... concerned that diamorphine is being prescribed indiscriminately without alternative analgesia, night sedation or tranquillisers being considered or prescribed."

Then Nurse Tubbritt recited certain instances and I am not going to go through those. You were not present at this meeting, obviously. The conclusion to that meeting:

"1. The staff are concerned that diamorphine is being used indiscriminately even though they reported their concerns to their manager...

2. The staff are concerned that non-opioids, or weak opioids are not being considered prior to the use of diamorphine.

3. The staff have had some training, arranged by the Hospital Manager, namely:

- The syringe driver and pain control
- Pain control"

which is repeated.

"4. Staff Nurse Tubbritt wrote to [the matron] Evans ..."

and there is some literature, and so on. Then we can move on, please, to November 1991 at page 10. Were you aware that there were concerns still being expressed by the end of this year, 1991?
A Yes.

Q Had anybody, any consultant, approached you about any of these concerns?
A No.

Q Had anybody from hospital management approached you about the concerns in terms of asking you to do anything?
A No. I was aware of Gerardine Whitney's involvement in their concerns as I knew that Anita Tubbritt was doing a course at the Portsmouth Nursing School and had used this subject as the subject for her dissertation. That was why it had come to Gerardine Whitney's attention. I knew that the subject was becoming important to them again, so I knew there was going to be a meeting but I was not directly involved, other than knowing about it.

Q Again, were you of the same frame of mind, that this was a matter to be dealt with through the nursing channels of communication and so on?
A I think I was beginning to be aware that perhaps there ought to be some medical input, but I did not feel it was appropriate for me to be talking to the nurses about this problem. It was obviously a consultant issue to be dealt with.

Q Is this right – that by the end of the year, that no nurse had actually said anything to you about any of the prescriptions you prescribed?
A Not at all.

Q Moving on to page 13, this is the beginning of December. Keith Murray is writing to Anita Tubbritt and he is keeping her informed about what the position would be. I am not going to trouble you any more with that. Then the letter from Keith Murray at pages 14 and 15 to Mr West, the District General Manager, setting out what the position was. The fourth and fifth paragraph down:

"... two study days on 'Pain Control'...".

Last paragraph:

"Regrettably the concerns of the staff have once again returned..."

That is the thing we have just been dealing with?
A Yes.

Q And then over the page, certainly in the view of some people, it was only a small group of night staff who were making waves and so on. But, again, you were not involved in that correspondence?
A No.

Q And I am not going to trouble you with the next page as between Isobel Evans and Nurse Tubbritt on page 16. Can we move on, please, to page 17. This is November 1991, still the year end. This is a note from Isobel Evans. You received a copy of this, we can see at the bottom?
A Yes.

Q

> "It has been brought to my attention that some members of the staff still have concerns over the appropriateness of the prescribing of diamorphine to certain patients at Redclyffe Annexe.
>
> I have discussed this matter with Dr Logan and Dr Barton who like myself are concerned about these allegations. To establish if there is any justification to review practice we have agreed to look at all individual cases staff have or have had any concerns over and then meet with all staff to discuss findings."

Had there been a discussion with Dr Logan and with yourself with Isobel Evans about these allegations?
A Yes.

Q Was that a meeting between the three of you? Do you remember?
A During one of Dr Logan's ward rounds at Redclyffe Annexe, Isobel Evans would have come down and expressed her concerns and asked for his advice.

Q And it says:

> "...we have agreed to look at all individual cases staff have or have had any concerns over and then meet with all staff to discuss findings."

Is that right? There had been agreement between the three of your to look at the cases the staff had concerns about?
A Yes, yes.

Q Did that happen?
A No.

Q Why did it not happen?
A No names were given to me.

Q If they had been given to you, any particular patient that anybody had any concern about, would you have applied your mind to it?
A Of course.

Q The note continues:

> "I am therefore writing to all the trained staff asking for the names of any patients that they feel .... [inappropriate administration]"

and so on, saying at the end, because this of course went to every nurse as well as a copy to you and others:

> "I am relying on your full co-operation and hope on this occasion everyone will be open and honest over this issue so we are able to address everyones concerns and hopefully resolve this issue in a constructive and professional manner."

Then over the page, just so we can note its presence, there is the letter from Murray to Turnbull, page 18. Then another letter from Murray at page 19 to Isobel Evans and referring to the continuing situation. We can move on, please, to page 21, December 1991. Isobel Evans is communicating to all the trained staff, top right hand corner at Redclyffe, copy to night sisters and that is Bill Hooper?

A That is Bill Hooper.

Q Dr Logan and Dr Barton. So you, it appears, got this.

> "Due to the lack of response to my memo of the 7th November Dr Logan will be unable to comment on specific cases, however, we have arranged a meeting for all members of staff at Redclyffe who have concerns .... on ... 17th December ... to discuss the subject ...
>
> It is not our intention to make this meeting in any way threatening to staff, our aim is purely to allay any concerns staff may have...".

That was the situation at that point in December. Can we move on to page 23, 17 December. That is a meeting at which you were present?

A Yes.

Q Isobel Evans, Dr Logan, you, Hamblin, Donne, Barrett, Giffin, Tubbritt, Wigfall, Turnbull.

> "All trained staff were invited to the meeting if they were concerned with this issue, no apologies were received."

Then the matron, Mrs Evans, opens the meeting and rehearses some of the history. We can go on over the page, perhaps.

> "As Mrs Evans had presented staff's concerns she stated the problem as she saw it and invited staff to comment if they did not agree with her interpretation:-
>
> 1. ... increasing number of patients requiring terminal care.
>
> 2. Everyone agrees that our main aim ... is to relieve their symptoms and allow them a peaceful and dignified death.

3. The prescribing of diamorphine to patients with easily recognised severe pain has not been questioned.

4. What is questioned is the appropriateness of prescribing diamorphine for other symptoms or less obvious pain.

5. No one was questioning the amounts of diamorphine or suggesting that doses were inappropriate.

All present agreed with these statements, no other comments were asked to be considered."

Then staff were reminded, this, that and the other. Then Dr Logan spoke to the staff at length on symptom control covering the following points. We have seen what Dr Logan said in his notes of this same meeting. We have looked at that more than once. It is on page 27, but in general terms did you agree with the views expressed by Dr Logan?
A Entirely.

Q He indicates at (f) on that page that diamorphine has added benefits of producing a feeling of well being.

"g. The difficulty of accurately assessing level of discomfort with patients who were not able to express themselves fully or who had multiple medical problems. The decision to prescribe for these patients had therefore to be made on professional judgment based on knowledge of patients condition, to enable patient to be nursed comfortably.

h. It was not acceptable for patients who are deteriorating terminally, and require 2 hrly turning, to have pain or distress during this process. They require analgesia even if they are content between these times."

Then over the page a record of the fact three was general discussion, and answering of staff questions.

"Dr Logan stated he would be willing to speak to any member of staff who still had concerns over prescribed treatment, after speaking to Dr Barton or Sister Hamblin."

Did anybody ever approach you after this meeting to say they had concerns about a particular case?
A No.

Q Did you yourself feel that any more could be done to try to deal with these concerns than had been done by this stage, in terms of you, Dr Logan or hospital management?
A I felt that by holding a meeting, and by reiterating to the staff that we were available and willing to answer their queries, there had hopefully been the opening of a sufficient dialogue, that this sort of feeling of being excluded and feeling of decisions being made without them and all of those sort of issue which were highlighted by the use of the opiates would not recur, because particularly the night staff would feel more involved in the decision-making, and their opinions perhaps more carefully listened to.

Q As I understand it, in general terms, apart from night staff coming off or just about to come off duty in the morning, you would not normally have any contact with them?
A Not at that time.

Q No?
A No. It was easier later on, but it was also a problem of communication between the day staff and the night staff about decisions that had been made or were going to be made that had led to some of these problems. The night staff did not feel that they were consulted.

Q What was the position in terms of the nature of the problem with regard to what day staff had to contend with, in terms of nursing of patients, and night staff?
A There is a lot more procedures have to be done to patients during the day time. There is a lot more potential for the patient becoming very uncomfortable when you are thinking about washing, bathing, turning, dressing, administering medicines than there is for the night staff to do.

Q And the consequence therefore in terms of observance of symptoms?
A You may well find that a particular patient has a greater need for analgesia when assessed by the day staff than was thought to be necessary by the night staff. I think that is where some of that misunderstanding had initially arisen.

Q I am going to come on to matters relating to Nurse Hallman in a moment or two, but just carrying on with this particular phase, after this stage in 1991, did you feel that the problem which you had become aware of, or the concerns, continue or did those concerns appear to have been allayed?
A I felt that the problems had largely been allayed, mainly because two of the night staff mentioned in this were very much on board with what was going on and the other one concerned moved to another ward.

Q The other one being - ?
A Giffin.

Q So the two you are talking about are the two the Panel has heard evidence from: Nurse Turnbull and Nurse Tubritt.
A They felt much more involved, felt more concerned and felt more comfortable with what was going on.

Q It goes on:

"All staff had great respect for Dr Barton and did not question her professional judgment.

The night staff present did not feel that their opinions of patients were considered before prescribing of diamorphine.

Patients were not always comfortable during the day even if they had slept during the night.

There appeared to be a lack of communication ...

Some staff feared it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms."

What do you say to that last point, that it was becoming routine to prescribe diamorphine to patients that were dying regardless of their symptoms?
A Absolutely not.

B Q

"All staff agreed that if they had concerns in the future related to the prescribing of drugs, they would approach Dr Barton or Sister Hamblin in the first instance for an explanation, following which, if they were still concerned, they would speak to Dr Logan."

C And so on. "No-one felt there was a need for a policy", more about the communication problems between day staff and night staff and I am not going to go through all the detail of what Dr Logan indicated were his views in his record or minute of that meeting at page 27. Did you yourself feel that there was any basis for concern that patients were being given diamorphine inappropriately?
A Not at all.

D Q Were you aware in terms of the night staff, having seen what view they expressed about your professional judgment, having any hostility towards you or having any problems communicating with you or anything of that kind, if they wanted to do so?
A Not that I was aware of.

Q In general terms, how would you describe your relationship with the night staff during the period of time that followed: 1992 onwards?
E A Good.

Q In this context, before we come specifically on to proactive prescribing, I would like to deal with the position with regard to Nurse Hallman. This is probably as convenient time as any, although of course it occurs rather later on in terms of our span of time. The Panel will already have the documents D1 through to D5. Perhaps you could be given copies. (Same handed) The Panel has already heard evidence about these matters when the evidence F of Nurse Hallman was considered. We see her letter of 24 March 2000, in which she is complaining about the way she is being harassed at work, "almost to the point of leaving my job and the Trust", and she sets out her feeling that an attempt is being made to shift her out to QAH. I am not going to go through it all. D2, the second page, relates to a meeting between Shirley Hallman, Betty Woodland and Rosemary Salmond, who was investigating this on 30 March. We can see what it is that Shirley Hallman was saying. It is right to say – we heard her evidence about it – that she did not actually mention anything to do with syringe G drivers in either her letter or the notes of that meeting we have just taken on board. I want to move on, please, D3, which is the fourth page in, where there was a meeting between you and Rosemary Salmond on Friday 7 April:

"This meeting was convened as part of the investigation of a complaint of harassment brought by Shirley Hallman against Dr Jane Barton and Gill Hamblin."

H

You then set out that you had worked on the ward – I am not going to go through every word of it – and as a visitor to the ward you did not feel it was appropriate for you to be involved with management issues. Does that reflect what your view was?
A I felt that I was being dragged into a conflict between two members of the nursing staff and being used as a bit of pawn and that really was not included in my job description as clinical assistant.

B Q That is the conflict between Shirley Hallman and Sister Hamblin.
A Yes.

Q It goes on:

"In describing Shirley Hallman's manner Dr Barton felt that she could be aggressive in manner and would also have periods of apparent sulking. It was often easier not to C disagree with Shirley's opinion rather than upset her. In consequence changes to treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working. She described Shirley as 'working to her own agenda' and not really a 'team player'."

I will just complete the passage before coming back to that:

D "Asked how Shirley had managed when she acted up for Gill Hamblin during an extended period of sick leave, Dr Barton felt she had managed tolerably well, but the ward had not been as busy at that time ....

Dr Barton described how she had only wanted to give advice and support to Shirley Hallman and had never 'put her down or been beastly to her'. She described how Shirley had asked for her advice before applying for the G grade post at QAH ..."

E And so on.

"Dr Barton described a discussion between herself and Shirley, initiated by Shirley following her return to Dryad. Shirley had asked if there was a problem between them, to which she had replied 'no.' Dr Barton then asked Shirley how she was getting on with the job opportunities at QAH, assuming Shirley was still wanting to F do acute work. 'If I had known she did not work there I never would have inquired ... I bitterly regret offering support.'

She described how the work on the ward had changed. There had been limited consultant cover. Families were increasingly demanding ..."

And so on. In relation to that, what was the position with regard to the third paragraph of this G record of the meeting with you?

"It was often easier not to disagree with Shirley's opinion rather than upset her. In consequence changes to treatment routines particularly relating to opiate administration, would happen on shifts that Shirley was not working."

H

I would like you to deal with that, because Nurse Hallman said that she had indicated to you she had concerns about a particular patient being given subcutaneous analgesia. What is your recollection of that?
A It was a wider issue than that with Shirley. Shirley had come from a background in which she had not had a great deal of experience in palliative care. She freely admitted that herself. She did not feel it easy to make the judgments about when and what palliative care to be using in certain patients and that was the original reason for suggesting a spell up on the acute unit: to give some more opportunity to see how it was done up there, exposure to more patients, more experience, people who were more experienced in doing it. That was the reason for suggesting that she take the temporary post up at Queen Alexandra, to widen her experience a bit. She felt uncomfortable sometimes about making the decision about what sort of palliative care a patient needed.

Q When you say you had formed the view that she was uncomfortable about making the decision, can you elaborate on that?
A She did not feel she was experienced enough in assessing a patient and what level of pain relief they might need at that point. From what I can remember of that particular patient, she felt that opiates were not appropriate in that patient at that time from her assessment of the patient, but what happened on the subsequent night shift was that the night staff reported back that the patient was definitely very uncomfortable and restless and needed opiates.

Q In relation to that particular discussion with that particular patient, or indeed in general, was there ever a situation where she expressed a concern or queried the need for palliative care or whatever it might be, and you said, "All right. We will not go ahead with that" and then later took the steps to ensure that the palliative care was applied?
A On listening to her judgment, I would have made the decision in that case not to go ahead with the opiates at that particular point in time. I would have said to her, "Well, let's wait and see." On subsequently receiving the report from the night staff that the patient had definitely required opiates, I had gone ahead with them. It was not a case of waiting until she went off shift and then rushing back on to the ward and saying, "Let's start the opiates"; it was a case of the ongoing assessment of the patient.

Q That is why I wanted to check what you meant by:

"... treatment routines particularly relating to opiate administration would happen on shifts that Shirley was not working."

A Because Shirley was not there, not because we waited to do it when Shirley was not there.

Q Had you had any problems with her getting upset if you disagreed with her?
A Probably. She had a tendency to flounce if you had a disagreement with her.

Q Was there any question of you trying to, as it were, get rid of her by helping her to transfer to QAH for a period of time?
A Not at all. My interest was purely in helping her widen her experience and becoming more confident in doing the work on the ward. I thought she was a good nurse, but I thought she had deficiencies in the areas in which she was expert. I had no criticism of her general nursing ability at all.

Q That is all I am going to ask you about that, having dealt with that particular nurse. I am now going to ask you about the proactive prescribing, having hopefully set the scene in terms of the history and dealt with that one particular issue that arose during the course of the evidence. Why should it ever be necessary for you to prescribe subcutaneous analgesia in advance of a patient's actual need for it?
A Because, with all the best will in the world and for all that I was available to the ward, either in person or on the end of a telephone, I was not always there and, despite what the professor of pharmacology and palliative care felt, there was sometimes quite a considerable gap in time before a patient who patently needed subcutaneous analgesia was going to be given it.

Q What is the importance of that gap? What are your concerns?
A Because no-one suffering pain and distress and agitation right at the end of their life should be forced to wait more than 20 minutes, not four hours or more. It was quite inappropriate that people should suffer.

Q In practical terms, would it always be only a matter of four hours that a patient might have to wait?
A It could easily be longer.

Q What were you aiming to achieve when you prescribed in an anticipatory fashion?
A I was aiming to ensure the maximum comfort and dignity for my patients. It was not for my convenience, it was not for the convenience of the nursing staff. It was purely done for the comfort of the patient.

Q What was the alternative? Supposing you said to yourself, "Well, I'm not going to prescribe controlled drugs in advance of a patient actually needing them." What would have been the practical consequence of that?
A I do not think there was a practical alternative, because I do not think even with a verbal order from a duty doctor wherever or whenever the nurses were allowed to give opiates. Even with an immediate subcutaneous injection or intramuscular injection, it was only under very exceptional circumstances that you could give a verbal order for that to be given. So the patient could well be waiting several hours to receive adequate relief of their pain.

Q Perhaps you could deal with this. Thinking of alternative courses, why not prescribe a single injection of diamorphine, which would cope with immediate pain
---
A For four hours.

Q For four hours. Explain, please.
A Saturday morning, half past twelve. What are you then going to do for the rest of the weekend?

Q Would it not be realistic – I want your evidence about this – to suppose that a doctor would be able to attend to treat the patient over the weekend, say, after a period of some four hours?
A It was unrealistic to expect some of the doctors that one had providing out of hours cover to prescribe appropriately and sensibly.

Q What is the concern about that, if you would explain that, please?
A The possible calibre of the doctor that you were getting and that they might not be willing to prescribe opiates at all.

Q What sort of reason might prevent a doctor from doing that?
A Unfamiliarity with using opiates, unfamiliarity with palliative care. You were getting a doctor about whose provenance you knew nothing to come and look after your patients.

Q What was your experience in relation to patients before they got to Dryad or Daedalus with regard to adequate pain relief?
A They suffered.

Q How was this going to work, anticipatory prescribing? In what circumstances would you anticipate the need for controlled drugs to be administered?
A Are you talking about oral and then subcutaneous, or just the subcutaneous side of it?

Q Let us break it into two. You are quite right to make the distinction. First of all, anticipatory prescribing for oral morphine.
A I had a very low threshold, as I have explained to you, for anticipatory prescribing of oral opiates because I felt that they were valuable in managing all kinds of post-operative, post-travel, pain on transfer into the ward. They were not sentencing the patient to go down a particular route, but they could be very appropriate and very useful for patients. Some patients would get them prescribed on arrival.

Q Supposing you did not immediately prescribe Oramorph, but you thought, "I had better write out a prescription in anticipation." What sort of patient would that be, in very general terms?
A Somebody who has had their fractured neck of femur repaired and has apparently been on two paracetamol a day is going to have an ambulance journey and a transfer and they are going to be very, very uncomfortable on arrival: they are going to be cold and frightened and in quite a lot of pain. A small dose of Oramorph at that point is a very appropriate prescription.

Q That is immediate administration.
A When the nurses make their assessment of the patient when they admit them and pop them into bed.

Q Would you ever write a prescription anticipatorily for Oramorph in the sense that you were thinking, "Well, it might not be necessary for a day"?
A Certainly. I knew that it was there for the nurses if they felt it was appropriate for the patient. They did not have to get a doctor into the hospital, did not have to call a duty doctor. It was there, it was available and I trusted them to use it at an appropriate time and in an appropriate dosage.

Q So we come back again to the trust you had in the nursing staff.
A Totally.

Q Can we then look at the other side of the coin on this particular issue, which is in relation to subcutaneous analgesia? We are talking essentially about diamorphine and

midazolam. What sort of patient would justify you writing out in advance of the actual need a prescription for that kind of subcutaneous analgesia?
A This is a patient who has been with you maybe a very short time, maybe a very long time, when it becomes apparent to you clinically that they are reaching the terminal phase of their illness. They are reaching the end of their life.

Q When you are thinking, "I am anticipating the need for subcutaneous analgesia", are you envisaging that that will be administered in a palliative care setting?
A It can be palliative if, for example, the patient becomes unable to swallow or is unwilling to take their tablets or has particular symptoms, but it could also be when they have reached that point in your clinical judgment that they have become terminal. Everything is switching off. They are dying.

Q What were you relying upon when you anticipatorily prescribed in terms of the nursing staff, assuming you were not actually going to be there when the situation was reached where those drugs might have to be administered?
A The observations that they make every time they go to the patient's bedside, every time they do something to them, every time they handle them, the awareness that they have of the clinical state of that patient, it is not something you can measure or put into guidelines, it is a clinical impression that your experienced nurses and, to a lesser extent, your doctor becomes aware of dealing with the patient.

Q What was your understanding of the procedure that was to be followed if the nursing staff concluded in your absence that subcutaneous analgesia should be administered? They have the prescription there. What would happen, did you understand, if the nursing staff thought - and we appreciate this is always senior nursing staff making the decision - the time has come for subcutaneous analgesia to be administered?
A The first alternative is that I am going to be there or I am coming in, or I am asked to come in.

Q Can I just pause there? Were there ever instances where you had a discussion with nursing staff, because you were there already, and they said, "Well, I think probably the pain", or whatever it was, "reached such a stage that the only sensible option is subcutaneous analgesia"?
A That would be absolutely fine because I could then examine the patient, make my own assessment as well, agree entirely with the conclusion they had reached and say, "Go ahead with the subcutaneous analgesia".

Q So you are there, there is a discussion, everybody has agreed, having checked and so on, made an assessment, that that is right. Then supposing the need arises in the view of the nursing staff and you are not there.
A Then I can be contacted by telephone. I will have seen the patient within the preceding day, I am aware that they probably already, even at that stage, had concerns about the patient and I would be happy to say to them, "Go ahead, commence the subcutaneous analgesia and I will make a further assessment when I come in again in the morning".

Q So if you are not there ...
A But I have seen them recently.

Q ... your understanding of the procedure was that they would contact you, or endeavour to contact you?
A Yes.

Q You could then give, as it were, a verbal authorisation ...
A Yes.

Q ... for them to start. It might be, I suppose, if it was over a long weekend, a patient who you had not seen for more than a day, you had not seen for possibly two days or maybe even three.
A Yes. In that case I was relying much more heavily on their expert clinical judgment because I had not seen the patient for three days, but I trusted them.

Q In your experience over the years, had you ever formed the view that the nursing staff's judgment about the need to start subcutaneous analgesia was wrong?
A Never. There was only that one nurse whose judgment I felt was suspect, but that was working the other way; not starting it, rather than starting it. The others were very competent, very experienced.

Q Let us envisage the last of the three possible situations when the nursing staff have concluded subcutaneous analgesia is now appropriate. You are there, no problem. You are not there but they contact you. You just explained what would happen. What then did you understand the procedure was if you are not there and they cannot get hold of you?
A Then they would ask a duty doctor to come in. There was one occasion in the cases we are looking at where the duty doctor went in and sanctioned the use of the subcutaneous analgesia.

Q What about the situation when the nursing staff themselves, without being able to contact a doctor, felt it was necessary to start subcutaneous analgesia? Is that something they were entitled to do in the circumstances where an anticipatory prescription had been written?
A It is a difficult one, is it not, because it was written up, "PRN if required", but it was not actually written down in black and white what would be the requirement to start it. I do not know how comfortable they would have felt about doing that without any recourse to speaking to a doctor.

Q We appreciate we are in territory where there is no written protocol, as it were, but was it your understanding that the nursing staff would, in extreme circumstances in the sense that they could not contact a doctor, that they would be acting properly if they started subcutaneous analgesia without actually speaking to any doctor?
A I would have felt that that was their prerogative. I would have been unhappy about it but I would have felt it was their prerogative.

Q Again, does it come down to the same question as to what is appropriate for the patient?
A Absolutely.

Q In general terms, if the decision to start subcutaneous analgesia had to be

taken at a time when you were not available on the telephone or not actually there at the hospital, what sort of delay might there be before the patient was seen by you if subcutaneous analgesia was started in your absence?
A The minimum delay would be the next morning; the maximum delay would be the end of a long weekend.

Q Depending on ---
A Depending on where we were in the day or weekend time-scale.

Q Were the consultants with whom you worked aware or unaware of your practice of writing anticipatory prescriptions?
A They were aware.

Q I would like to ask you, please, about the range of dose, in general terms, when you carried out such prescribing. If you deal with this question: how could you know what was an appropriate range to write up if this was in anticipation of a patient's need rather than the need being right before your eyes? How could you know what amount to prescribe?
A The only thing you could write up would be the maximum possible range you would need in the worst case scenario, that the patient became seriously ill on Christmas Thursday, Christmas Eve, Christmas Day, Boxing Day, everybody has a day off after Boxing Day, and there could be a span of time to three to four days during which time they were only being given medical cover and the nurses would wish to have a sufficient range of doses to cover any eventuality of symptom control in the patient.

Q You have agreed that the dose range, not in every single case, but the dose rage here - and I am just going to focus on diamorphine, but the dose range in your prescriptions of 20-200, those dose ranges were too wide?
A They were excessively wide and the situation never arose that we needed them.

Q That evidence has been made clear, but I want you to deal with this: why did you write at that time prescriptions as wide as that which you say were, in fact, excessive? Where does the 200 figure come from?
A It is probably a calculation from doubling up, doubling up, doubling up of the dosage of diamorphine that you needed to control the symptoms which would reach 160 mg by the time you got to day four.

Q If the pain increased in that way?
A If the pain increased and they were not able to control the symptoms.

Q Why 200, because, as we have seen in a number of the twelve cases we are looking at, it is a sort of standard range.
A I wrote it up purely as a standard range.

Q So it does not depend on the individual patient in terms of that writing up?
A It does not.

Q Again, with midazolam, were you tending to write up a standard range?
A A standard range as in the *BNF*.

Q How was it that you would be able to anticipate that a patient would be needing not just diamorphine but also midazolam?
A Because in our clinical experience in the patients we looked after over the years the use of midazolam was very helpful in control of some of the general symptoms near to death.

Q Running in tandem, as it were?
A Running in tandem with the diamorphine.

Q We have to appreciate, of course, that in some of the patients we are concerned with, although the prescription had been written up for both, in fact, only one was started, the diamorphine. Was there any advantage to you in any way of writing up these prescriptions in an anticipatory fashion, apart from satisfying yourself that the patient's pain and other symptoms would be properly controlled?
A That was my prime motive in writing up the prescriptions.

Q Was there any other ---
A There was no other advantage to me at all.

Q Again, so far as you were aware, were all the consultants with whom you had dealings on these two wards aware of the sort of dose ranges you were writing up by way of anticipation?
A Yes.

Q I think there was one instance, we will perhaps deal with it now, when Dr Reid spoke to you about the dose range. I think his recollection was that it was - I have forgotten, I am afraid. Something like ---
A 20-200.

Q I think the one he could remember talking to you about he thought was a slightly smaller range but it does not matter. In terms of having a discussion with Dr Reid, what do you recall of the discussion about that?
A I would explain to him exactly as I have just explained to you how the situation could arise that the patient's requirement for opiates increase over a weekend or over a holiday period and I wanted to ensure that the nurses had available to them appropriate doses for that patient without recourse to using an out-of-hours doctor or waiting.

Q Did he appear to agree with that and understand?
A He seemed quite happy with that as an explanation.

Q I would like to ask you this in terms of your experience of the sort of increases that might be justified or expected in cases where subcutaneous analgesia had been administered. Let us say it starts off at 20 for diamorphine. It turns out that that is not controlling the pain or any other symptoms that applies. What in your understanding, and what would you advise, if you were there to advise, would be a suitable increase in the dose?
A I would go to 40.

Q So doubling up?
A I would double.

Q In general terms, was that the practice that you followed?
A Yes.

Q Can I deal with this: why double up? Why not indicate that, well, if an increase is needed, with the 20 mg dose, why not say this should be increased by 10 if the pain is not controlled?
A Because in my clinical experience that was not adequate.

Q When you, in general, wrote up an anticipatory prescription, were you having in mind, in terms of the dosage, that the patient would, normally speaking, be on some form of opiate, such as Oramorph, before the need for subcutaneous analgesia would arise?
A Usually.

Q Would it also be a matter to be taken into account, or would you disregard it, that the need for subcutaneous analgesia would only arise if the Oramorph was not controlling the pain?
A Or there was another very good reason for changing them.

Q Another reason such as the non-swallowing reason?
A Yes.

Q Were you allowing for that in any way when you set the dosages in your own mind for these anticipatory prescriptions?
A Yes.

Q Because if you convert directly and the pain has not been controlled, you are not going to achieve anything.
A No.

Q In general terms, what was your understanding as to the procedure with regard to what the nurses would do if they decided subcutaneous analgesia was required in terms of the dose that they would administer?
A They would usually, in the vast majority of cases, go for the minimum dose. The bottom end of the sliding scale.

Q We will look at, I think, one or two instances when that did not happen. We will look at those when we look at the twelve. That was your normal understanding as to what the procedure would be?
A Certainly.

Q Would they need your approval, say so, if they decided the patient needed an increase? If a senior nurse decided that 20 mg of diamorphine was not achieving its purpose, did you understand that the procedure was that they could, on their own judgment, their own decision, increase the dose or did they need to check with anybody?
A I would have been happy for them to increase the dose. I suspect they would have been happy to contact somebody, contact me.

Q What normally happened, just to give us the general picture, if the nurses in relation to a prescription of subcutaneous analgesia with a range and they needed

to increase the dose, would they normally contact you, assuming they could, or not?
A I think they would normally attempt to contact me, yes, just to let me know what was happening, or perhaps if they were changing the syringe driver at the end of the nightshift, knowing I was coming in, they would not bother to ring me then, they would know I was going to be coming in anyway.

B Q Let us also follow that through. In terms of subcutaneous analgesia having been started, let us say during the night and let us say they contacted you or an on-call doctor who said, "Yes, I think it is sensible to go ahead", because of the symptoms, you arrive the next morning, I just want you to explain to the Panel what would happen. You were not there and you did not specifically approve the administration of subcutaneous analgesia, you arrive in the morning, that is what has happened overnight. What would you do in terms of the patient and in terms
C of the nature of the dose?
A I would go and make my own personal assessment of the patient.

Q Is this something you would always do in a patient who had been on subcutaneous analgesia?
A Yes.

D Q What about the patient who is on subcutaneous analgesia when you see them on morning one? When you go in on morning two would you check on such a patient or not?
A Yes.

Q Would that mean seeing the patient?
A Yes, but not recording it necessarily.

E Q I want to get the picture. If you have a patient on subcutaneous analgesia, when you went to the hospital would you always go and see that patient?
A I would always like to check on their general condition.

Q Forgive me. That is not quite... Would you always go and see them?
A I would go to the bedside to check their general condition, whether they are
F comfortable, whether the drugs seemed to be working, whether they were very heavily sedated, whether they were still uncomfortable, whether they were rousable.

Q We think of any patient who is on subcutaneous analgesia, any time you are at the ward ---
A They are at an end of life time.

Q --- you will be specifically seeing them?
G A Yes.

Q As opposed to just relying on the nurse's report?
A Yes.

Q And what did you understand to be the picture? Because we heard from Professor Ford for the need for monitoring and continuing to assess, just the general picture again.
H

What did you understand the nurses would be doing when you are not there in terms of monitoring and assessing?
A Exactly the same thing. When they are seeing to the patient, when they are giving any treatments, doing any dressings, they will be forming an impression of how comfortable that particular patient is at that time. Again, there is not a form that measures the comfort of a patient at that time of their life.

B Q As you have already told us, when you were there, the nursing staff could always ask you to look at a particular patient in any event if there was something that they wanted to draw to your attention?
A If they were concerned, yes.

Q I am going to turn in a moment, perhaps after we have a break, to matters relating to some documents that Dr Reid was asked to look at with regard to protocols and so on. I just C want you to deal, before we do that, if I may, to cover two points. Would you just explain what the procedure was and how you and the nursing staff worked together dealing with these problems, what you understood would take place? Why not have a written protocol?
A I am always a bit suspicious of whether a protocol has ever been written that will cover all the different eventualities when you are dealing with real people at the end of their life. There would be so many "what ifs", it would run to about five pages and for the nurses looking through all that, would they have time to go and actually look at the patient.

D Q In relation to anticipatory prescribing, why not have a written protocol with regard to that, as to what the nurses could or could not do with a dose range and a prescription that was written in anticipation?
A In retrospect, why not? It would have been a very useful document, but as far as I was aware there was not one at the time, and the suggestion was never made to me.

E Q That I was going to ask you. No suggestion by any consultant ---?
A No.

Q --- or anybody to do that. One question: it is in a separate section but while it is in my mind, and I do not have to keep turning over pages to remind myself, the pharmacist. Can we just deal with that, please?
A Yes.

F Q What was the position with regard to the pharmacist? Was there one who visited?
A Yes.

Q Would that be visiting both wards?
A Yes.

G Q Weekly, we have heard?
A Yes.

Q And what did you understand the pharmacist would be doing?
A She looked at all the drugs charts, she checked whether there were drugs that were interacting or were inappropriate or unsuitable to any particular patient, in addition to all her duties checking the stock of drugs and the dangerous drugs kept in the hospital. So she had a H dual role.

Q Did the pharmacist ever discuss with you or raise matters with you about the prescribing of drugs generally? Was there ever any ---
A There were occasional discussions. I also knew that if I had a particular problem with a drug, I could ring her up or her team up at Queen Alexandra and ask for advice and support. So we knew where they were; they knew where we were, and she would say, "Are you happy to be using this antidepressant with something or other".

Q We have heard that the pharmacist never raised any query about either dose ranges or dose combinations?
A No.

Q Or indeed anticipating prescribing?
A No.

Q Did that give you any comfort in terms of what you ---
A I did not have any discomfort about it, so I felt comfortable about it at that time anyway.

MR LANGDALE: Thank you. Sir, would that be a convenient moment, please?

THE CHAIRMAN: Yes. Half past three please, ladies and gentlemen.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Yes, Mr Langdale.

MR LANGDALE: Dr Barton, some further documents that the Panel have already seen, but I need to ask you about. Do you still have that same little collection that you were looking at earlier on, beginning with D1? Can we go back to that, please. Look in that small bundle, a few pages in, to D4. We looked at D3 in relation to the complaint. D4. This is not your document. It is a document that I asked Dr Reid about. It is a memorandum from Barbara Robinson dated 27 October 1999. First of all, it is to Max Millett, whom you have already mentioned.

"Learning Points from the Wilson Complaint"

Again, sir, not Patient H. It is a different matter. (To the witness)

"Thank you for your memo and the copy of Dr Turner's letter."

There is something to do with microfilming/fluid chart. (2b) is nursing care plans. I am not going to deal with that.

"3d) Good Practice in writing up medication.

It is an agreed protocol"

I am stressing those words. Barbara Robinson said:

"It is an agreed protocol that Jane Barton, Clinical Assistant, writes up diamorphine for a syringe driver with doses ranging between 20 and 30 mgs a day. The nurses are trained to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient."

Then:

"Ian"

and Dr Reid indicated he thought that must be a reference to him –

"Ian may wish to raise this at the Medicine and Prescribing Committee."

She described it as "an agreed protocol". Is that a description you would give to your practice with regard to 20 to 200?
A I would agree with it, but I always assume that a protocol had to be in writing, and I never saw anything in writing myself agreeing with what I was doing in practice.

Q And would you yourself have reached any agreement with Barbara Robinson about this, or would it not enter into your discussions with her?
A I cannot imagine it would have entered into my discussions with her.

Q In any event, that is what she wrote?
A Yes.

Q I have asked Dr Reid about it. Can we move on please to the next document, which again I asked Dr Reid about, which is a Protocol for Prescription and Administration of Diarrhoea by Subcutaneous Infusion, of which he was the author, although he said that it was never put into practice. In the introduction he points out in the second paragraph how a situation may be created whereby patients who are experiencing increasing pain may not be able to have their pain control needs immediately met.

"To overcome this and also to give guidance to nurses who may be unsure as to how much analgesia (diamorphine) to administer within a variable dose prescription."

Does that appear to be consistent with anticipatory prescribing?
A Yes.

Q
"Dosage

Guidance from the palliative care service indicates that if pain has not been controlled in the previous 24 hours by 'Xmg' of diamorphine, then up to double the dose should be administered the following day, i.e. up to 2x 'Xmg' should be given."

Again, something that would be in accord with your practice?
A Yes.

Q "Pain Control Chart". As one will see, he suggests it should be completed on a four hourly basis.

"Prescription

Diamorphine may be written up as a variable dose to allow doubling on up to two successive days, e.g. 10-40 mg, 20-80 mg, 60-240 mg or similar. The reason for prescribing should be recorded in the medical notes.

Administration

B

If pain has been adequately controlled within the previous 24 hours, the nurse should administer a similar dose of diamorphine over the next 24 hours."

Agree?
A Yes.

Q

C

"If the previous 24 hour dose has made the patient unduly drowsy etc., the nurse should use his/her discretion as to whether the dose to be administered for the next 24 hours can/should be reduced, within the prescribing dosage rime. If the minimum dose appears to have made the patient too drowsy, the on-call doctor should be contacted."

Agree?
A Yes.

D

Q This may be a convenient moment just to deal another facet of the care of patients of the kind that we are talking about in this case – drowsiness.
A Yes.

Q How does one tell with a patient who is drowsy when on subcutaneous analgesia, how do you decide whether it is the subcutaneous analgesia that is causing the drowsiness or either the existing condition of the patient before the subcutaneous analgesia was administered or indeed the patient's deterioration anyway?

E

A I do not think that you can completely untangle which particular aspect is causing it. I imagine that a major overdose of an opiate would make the patient completely drowsy, unrousable, unconscious; there would be no fluctuation in the conscious state at all, whereas during the normal process of dying there would be a natural fluctuation as there would be possibly with the course of the terminal illness. That is the only way I could think to distinguish between those three threads.

Q Were you aware of the fact that diamorphine and midazolam might of themselves be causing at least some element of the drowsiness?

F

A Yes, but I was prepared to accept some level of drowsiness in exchange for adequate relief of pain and other terminal symptoms.

Q I wonder if you could just deal with another aspect that we have to consider in terms of a patient who is going downhill in terms of a terminals stage or about to enter a terminal stage. Is this in your experience a sort of static state, where you just keep pain control at a certain level and things do not change? What is the process in your experience over all these years?

G

A Anything but.

Q Would you explain that?
A There is what the nurses kept recording in the notes as "further deterioration", which would mean that the periods of being less conscious would become longer. The periods of wakefulness would become less. The patient would take less interest in their surroundings. There would be fewer involuntary movements. The whole system, the whole body system, is gradually winding down into death.

H

Q What is the importance of being able to observe, to see the patient at the bedside, when we are talking about patients in this sort of situation?
A Because, again, it is not something you can measure. It is only something you can make an assessment of by observation and by experience; by being there and knowing what you are looking for. That is what these nurses did.

Q Just to finish off this document, Dr Reid's proposed protocol said:

> "If the patient's pain has not been controlled, the nurse should use his/her discretion as to the dose to be given within the next 24 hours, i.e. he or she may administer up to double the previous 24 hours dose."

Then over the page:

> "Information to Patient and Relatives
>
> Where patients are mentally capable ... they must be told that an infusion of ... (diamorphine) is being started ....
>
> When patients are unable to understand such information ... the decision that diamorphine is being, or about to be, administered, should be communicated to their next-of-kin/relatives..."

and so on.

> "If the relatives express concern about the administration of diamorphine, despite the above discussion, the medical staff should be informed and the medical staff should make every effort to discuss the administration of diamorphine with the patient's next-of-kind/family."

Looking through that document, was there anything there which you would disagree with, or which did not square with your own practice?
A Nothing at all.

Q Dr Reid mentioned to the hearing that there had been an instance where a patient had been taken off morphine, I think by you, and there had been a complaint by members of the family. It did not ring any bells with you? Maybe he dealt with it, and I am not going to ask you any more about that. Then he set out a diamorphine infusion and pain control chart, which we need not trouble ourselves with. That is all I am going to ask you about that part of the matter. Before I turn to the position with regard to individual patients, I just want to complete the history in terms of you and your practice after you had resigned as clinical assistant at the Gosport War Memorial Hospital in 2000. Did you return to practice as a GP?
A I remained in practice as a GP.

Q I am sorry. You returned to full practice, I suppose.
A Yes.

Q My mistake, I am sorry. In terms of police investigation, I think the police were conducting interviews that you were aware of with a number of people. Is that right?
A Yes.

Q And you were interviewed under caution, first of all in relation to Gladys Richards?
A Yes.

Q And then – and I am not worried about the exact sequence – thereafter over a period of time, from time to time, about certain patients?
A Yes.

Q I am deliberately putting this to you in leading form. Were you advised by your solicitor in relation to those matters?
A Yes.

Q And on the advice of your solicitor, it is a matter for you to decide but, taking his advice, did you deal with the police inquiries by way of your general statement and a number of statements relating to individual patients?
A I did.

Q It does not cover all of the twelve because three did not come up in the police inquiries. Did there come a time when you voluntarily limited your prescription powers?
A There came a time when the health authority suggested that I be investigated under the "Failing doctors" procedure.

Q Would you just explain the history briefly, please.
A The Director of Public Health came to see me at home and suggested that there were doubts about my ability to practise in general practice. I objected very strongly to that, because the incidents that had taken place had not occurred in general practice. There had never been any complaints about my general practice and I thought that it was a trifle unfair to be investigated under the failing doctor procedure. There was a meeting held with the Director of Public Health and the then Acting Chair of the PCT, and it was agreed that I would voluntarily not attend the Gosport War Memorial Hospital other than the baby unit upstairs, which was run by the different trust, and that I would voluntarily not prescribe opiates and benzodiazepines until this question was resolved. That carried on voluntarily until a year ago.

Q When I think an Interim Orders Panel made an order which in effect came to the same thing.
A Yes.

Q Is that what it boils down to?
A Yes.

Q In other words, making an order that you should do what you had already been doing in effect?
A Since 2002, yes.

Q That is the reference in Mr Samuel's statement ---
A Yes.

Q --- that the Panel heard about from 1 October 2002 onwards, Dr Barton voluntarily undertook not to prescribe benzodiazepines or opiate analgesics?
A That is correct.

Q I am going to start now to ask you questions about individual patients. I am not going to ask you to go through the remainder of your general statement because we have really covered all the matters that you referred to there. I am going to ask that you have in front of you, in relation to each of these patients, not only the patient file, but also the statement you made about the patient. What I am going to try to do is to use the material in the files, but principally really the chronologies as you go through your evidence. If there is something that you are not able to deal with, or you have forgotten something, or we have reached a position where you are not clear about something, you can always look to your statement made closer to the time (albeit not that much closer to the time) to assist you in your recollection. In relation to your individual patient statements, a lot of them have a general history at the beginning, which we are not going to trouble with, but I do want that available to you when you are giving your evidence. Obviously we start with Patient A, Leslie Pittock. I am going to try to use the chronology. If you need to refer to any particular document inside the file,

please do. In relation to Leslie Pittock, when you made your statement in relation to what you provided to the police in their inquiries, did you have some of the medical records available, or all of them, or what? Do you remember? It does not matter if you do not.
A I think I had all of the medical records available.

Q Because you obviously make reference to certain documents.
A Yes.

MR LANGDALE: Sir, if at various times we need to supply a page reference inside the patient file with regard to your statement, then I will specifically mention it. Mr Jenkins has prepared the lists which give a page reference if one needs to cross-reference Dr Barton's statement to the file. (To the witness) If we go back to this patient, we have seen the history more than once; I do not need to go over all of it again with you. He had chronic depression and so on. You in your statement indicated what had been drawn to your attention in terms of the previous history and so on: Dr Banks, Dr Lord and a number of matters. We can move on to page 9 in the chronology, where the day before he was admitted to Dryad Ward. Dr Lord reviewed the position:

> "Chronic resistant depression. Very withdrawn."

Et cetera, et cetera. She says at the end:

> "RH place can be given up as unlikely to return there."

The bottom left- hand box:

> "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."

In general terms – we have heard about this from other witnesses, but I need to ask you – when you saw Dr Lord saying about a patient like this, "Prognosis poor", what was that signalling to you?
A It was immediately signalling to me that he was for palliative care and possibly bordering on terminal care. My feeling was that she had assessed him as very poorly, in need of definitely palliative, but quite soon terminal care.

Q In the context of this patient, can we deal with another general issue? It has arisen here and we might as well get your evidence about it. When a patient came into Dryad or Daedalus with, "Prognosis poor", or it looked to you as if palliative care was probably not very far off, that sort of situation, did that mean that everybody stopped trying or gave up on the patient or what?
A It meant that everybody continued to try, but they were realistic about the fact that their efforts were probably not going to bear fruit, that he was going to continue to deteriorate, despite our best efforts.

Q Then we can look at your admission note with regard to this patient:

"Transfer from Mulberry. Immobility. Depression. Broken sacrum. Small superficial areas on right buttock. Both heels suspect. Catheterised. Transfers with hoist. Long-standing depressive on lithium and sertraline."

Then the transfer details say "Poor physical condition" and so on. I am not going to repeat it. Then Nurse Shaw records at the bottom on the left:

"Appears to have settled well ... Has taken a small amount of puree as reluctant to eat sandwiches. Needs to be encouraged with diet and fluids."

Professor Ford indicted that in his view your initial description did summarise the problems. Then we move over the page, where you can see at the top of page 11 the drugs the patient was receiving: sertraline, lithium, diazepam, thyroxine. Of those, which, if any, would you think of as anti-psychotics? Any of them or none of them?
A Not any of them are anti-psychotics as such. An anti-depressant, a mood stabiliser, a tranquilliser and a bit of thyroxine.

Q If a patient has been on that sort of medication and that ceases, what effect would that have on your decision as to the correct medication in terms of opiates?
A I would have been well aware that they could have quite an unpleasant withdrawal reaction, certainly to the sertraline and certainly to the diazepam, and I would be allowing for that when I set the initial dose both of the opiate and of the tranquilliser.

Q We can see that you prescribed on the 8th a dose of Arthrotec, a painkiller. Nobody is questioning that. Then on the 9th, there is the note which was added to what was originally on the chronology:

"Reviewed by Dr Barton.

Painful [right] hand held in flexion. Try arthrotec. Also increasing anxiety and agitation. ? sufficient diazepam. ? needs opiates."

Would you explain your thinking there?
A I was thinking that this man was beginning to show signs of suffering pain, generalised pain, as well as this hand held in flexion, and that he was going to need opiates.

Q What is the significance to you of the right hand held in flexion? What are we talking about?
A I did not know what was causing it. I did not know whether it was a musculo-skeletal thing or whether it just was an expression of his anxiety, rigidity, immobility. That is why I had a go with the non-steroidal anti-inflammatory in the first instance to see if it would help and it did not.

Q 9 January, that same date, we see the nursing note:

"Stated that he has generalised pain. To be seen by Dr Barton in the morning."

Then over the page, the nursing care. I am not going to go through that. Two doses of Arthrotec were administered. Then on the 10th on page 12, he is reviewed by Dr Tandy and she says "For TLC". What is the significance of that?

A Tender loving care equals what we tried to do with palliative care.

Q

"Telephone call with wife – agrees in view of very poor quality for TLC."

Can we take it that in the ordinary course of events Dr Tandy would have seen your note relating to the previous day, when you had said "? needs opiates"?
A Yes.

Q Would there have been some discussion between you and Dr Tandy about this patient?
A Yes.

Q Obviously after this time it is impossible to remember precisely what, but we can see the nursing note records that you were there:

"Seen by Dr Tandy and Dr Barton.
To commence on Oramorph 4 hourly this evening."

This is a case where Professor Ford indicated that was entirely appropriate. Here we are starting off with an opiate, not a mild opiate, but one on the final rung of the ladder, I suppose. Is that right?
A Yes. In a small dose.

Q Dr Tandy, it appears, either agreed with you or agreed with what you proposed or suggested it herself. Who knows?
A Yes.

Q Indeed, looking over the page to page 13, we can see that you prescribed 5 mg to be given five times daily. The first administration of that appears to be at ten o'clock in the evening. Is that right?
A Yes.

Q Would the discontinuation of Arthrotec have any bearing on your decision as to what level of dose was appropriate with an opiate, or does it make no difference?
A It would make no difference.

Q At some stage – and the position is a little confused here – it may well be on the 10th, you wrote up a prescription for subcutaneous analgesia and also the following day. I am going to treat it as one. What it involves is diamorphine initially written up by you as 40 to 80, if we look on page 13.
A Yes.

Q Hyoscine 200 to 400 mcg and midazolam 20 to 40. Over the page, there is another anticipatory prescription written in relation to those same drugs: diamorphine is now 80 to 120, hyoscine remains the same, midazolam goes from 20 to 40 to 40 to 80, sertraline and lithium, which had been prescribed, were discontinued and we also bear in mind that on 11 January, Oramorph is administered at six o'clock in the morning, you then prescribe 5 mg

four times daily, plus 10 at night, which would work out, and indeed he did receive something like 30 mg in the 24 hours. All right?
A Yes.

Q The question I would like you to deal with is, why write up an anticipatory prescription for diamorphine at 40 to 80 first of all and then write up another prescription where it has become 80 to 120 and similarly with midazolam: it was originally 20 to 40 and then becomes 40 to 80. Obviously there is a doubling up of the initial dose in the dose range. What is the reason for that?
A Because having seen him on each of those days, in my clinical judgment he was not going to be controlled by the very lowest doses of my usual diamorphine and midazolam prescription.

Q What was it – and I appreciate again this is looking back at a patient who is way back in time in terms of what we are dealing with – what sort of thing would have been apparent to you which would justify starting off that much higher?
A It was the intensity and depth of his pain and stiffness and rigidity and discomfort. Under normal circumstances I would have been very happy to have started on 20 or possibly even 40. That was the original anticipatory prescription I wrote up, but when I reviewed him and looked at this guy again, he was in such discomfort, he was going to need more than that.

Q Can we take it that you would have seen this patient on the 11th as well as having seen him on the 10th?
A Yes.

Q Why not write up the fact of his deterioration, that his position was worse, his medical condition? Why not write that up?
A Because I did not make the time to write that up.

Q It appears in this case that there is no nursing note or notes relating to that particular aspect.
A No.

Q Can I just ask you this quite bluntly? Would you have increased the starting dose of midazolam and diamorphine for no reason at all?
A Absolutely not.

Q I think Professor Ford indicated that this man was in his view dying. What about the concern that this was going to cause respiratory depression or lowering his conscious level?
A I accepted that that was a price that we might have to pay in exchange for giving him adequate pain and symptom relief.

Q None of this is administered on the 11th ; it is anticipatory. On the 13th, two days later, we see:

"Catheter bypassing: Mr Pittock appears distressed."

Over the page, a similar sort of thing in the nursing care page. Then the drug chart on 15 January ---
A They waited for me to come back on the Monday morning.

Q So this is now four days after the anticipatory prescription.
A Yes.

Q The diamorphine is administered at 80, midazolam is administered at 60. 60 is not the lowest dose. Midazolam is now 60 as opposed to 40. It is still within the range.
A And that would have been in discussion with me on the morning of Monday 15 January.

Q We can see the note below that:

"[Seen by] Dr Barton. Has syringe driver at 08.25. Diamorphine ... midazolam ... hyoscine.

Douglas: 19.00: Daughter informed of father's deterioration during the afternoon. Now unresponsive, unable to take fluids and diet. Pulse strong and regular. Comfortable night."

What do you say to somebody who says, "Well, that is an indication. He is now unresponsive, he has deteriorated. The diamorphine and the midazolam are producing significant adverse effects." What would you say to that suggestion?
A I would have said that if I reviewed him the following morning and I felt on my assessment that that was genuinely the problem, I could have reduced either or both of those drugs in the syringe driver.

Q Then let us look at the next morning, the 16th, on page 16, where we can see the same administration of the subcutaneous analgesia.
A Yes.

Q With a prescription for haloperidol, which I will come on to in a moment.
A That would suggest to me that he was not still unresponsive or unconscious, but that he was restless and agitated and needed an additional anti-psychotic adding to his syringe driver.

Q In other words, can we take it you would not have prescribed it if there was no reason for doing so?
A Not at all.

Q 5 mg in 24 hours. That is by way of an addition to the mix, as it were, in the syringe driver. Is that right?
A Yes.

Q We see:

"Condition remains very poor. Some agitation was noticed when being attended to. [Seen by] Dr Barton. Haloperidol ... to be added to driver.
Night: condition remains poorly. All care continued."

Then we can see the nursing notes as to the problems on page 16. That is on the 15th and 16th. The same amount is being administered. Then on the 17th, the dosage was increased. Why was the dosage increased?
A Because he was becoming inured to the dose of diamorphine and he was beginning to get symptoms of pain and agitation and distress.

Q If we look at the note relating to this day, shown on page 18, so relating to
B 17 January, does that reflect what you have just been indicating?
A Yes, "... tense and agitated, chest very bubbly".

Q The significance to you of, "chest very bubbly"?
A It was either that he was developing bronchial pneumonia or that he was getting excessive secretions in the upper respiratory tract or both.

C Q What about the opiates themselves, the diamorphine, causing him to be tense and agitated? What would you say to that?
A I would disagree because, initially, the opiates had made him unresponsive and they were not now going to be making him tense and agitated. His underlying condition and his approaching death was making him tense and agitated, as was his developing bronchial pneumonia.

D Q And he, "Remains distressed on turning", as we have seen.
A Yes.

Q On that same day, on the 17th, when you had seen him in the morning, here we have an indication of you seeing him again, it seems. Is that right?
A Yes, I came back in the afternoon.

E Q I suppose it is impossible for you to remember whether you came back for him or whether you came back, in any event, for some other reason.
A 2.30, I probably came back for him.

Q Which would be in response, would it ---
A To the concern of the nursing staff.

F Q You reviewed and altered the medication. That is what brought about the increase? No, that cannot be right because the increase occurs at eight o'clock in the morning. Let us just look at the previous page and get the times right. I am sorry. I was trying to move on a bit too fast. On the 17th, on page 17, in the morning 120 diamorphine is administered, the dosage having been increased. Then it is administered again, same dose, at 1535 after you come back to see him in the afternoon. Right?
A The only change at 1535 is the midazolam has increased and the haloperidol
G has increased.

Q The reason for increasing the midazolam and the reason for increasing the haloperidol?
A Terminal restlessness, agitation. Not obviously felt to be, at that point, pain as much as restlessness and agitation.

H Q Why not just leave it like it was? Let me put that to you.

A Because they called me back and they felt he was uncomfortable and was suffering and I responded to that.

Q Why not leave it because of the risk of it having an adverse effect? I would like you to deal with that, if that is being suggested.
A At that point I was not concerned about any potential adverse effect. I wanted Mr Pittock comfortable and free of all these wretched symptoms that he was suffering.

Q Yes. What is the significance then of him remaining tense and agitated, having been on 80 mg for two days? What is that telling us?
A It tells us he was not having enough diamorphine.

Q Why increase the haloperidol as well? I think Professor Ford was raising a criticism of it was all right to raise one of them but not all of them. What do you say to that?
A We did not have time to play around with altering one at a time. We had to make Mr Pittock more comfortable. It seemed entirely sensible to make a reasonable increase in the dosage of both.

Q Then on the 18th, the following day, further deterioration, bottom left-hand corner of page 18:

> "[Subcutaneous] analgesia continues. Difficulty controlling symptoms. Try nozinan."

First of all, "Difficulty controlling symptoms", what does that signify?
A He remained restless and agitated and uncomfortable. I would not say so much in pain but terminally distressed.

Q Why did you say, "Try nozinan", and, indeed, nozinan was administered. Why add in an extra drug?
A I knew it was a different sort of sedative. I knew it acted in a different way and I was concerned to try and see if I could make him more comfortable that way.

Q Would you like to deal with this: why not take away the haloperidol altogether and replace it with nozinan?
A I should, in retrospect, have. I think they stopped the haloperidol the following day anyway, but I think I should have stopped the haloperidol and tried the nozinan on its own.

Q We know what Dr Briggs did and I know you are not in disagreement with that.
A No, not at all.

Q That was your rationale for trying nozinan?
A Yes.

Q Because it had a slightly different ---
A Different sedative effect from the midazolam and the haloperidol.

Q Over the page, page 19:

> "Poorly condition continues to deteriorate ... Syringe driver recharged with diamorphine 120mg, midazolam 80mg, hyoscine 1200ug, haloperidol 20mg and nozinan 50mg."

Over the page, on page 20, we can see what the drug charts show. I am not going to go over that because we know what the position was. Then on the 19th, the following day, the drug charts show diamorphine is now 120, as it had been, hyoscine same, midazolam the same, haloperidol and nozinan the same. Over the page, on page 21, still on that same day, the 19th:

> "Marked deterioration in already poorly condition. All nursing care continued. Breathing very intermittent. Colour poor."

Another sign that he is in the process of dying?
A Yes.

Q I think that is something that had been apparent before this date, that this man was coming to the end of his life. On the 20th the position remains the same, save for the call to Dr Briggs, and if we can just take on board what happened there. We have heard evidence from him. He had been unsettled on the haloperidol, a verbal order to increase nozinan, that is what Dr Briggs said on the telephone. You were obviously not available. Right?
A Yes.

Q Nobody is criticising what he did. He says quit the haloperidol, as we can see on page 22, and Mr Pittock, "appears comfortable". It is stated on the nursing care plan, if we can just look at the box for the nursing care plan on that date, on page 22, the second box down. When one looks at what is, in fact, page 227, the nursing care plan says:

> "Now unable to cope with dietary/fluid intake. Please give regular mouth care."

First of all, does that signify that he had been taking some kind of oral dietary substance or fluid at least?
A It does.

Q Why is this man on a syringe driver when he can apparently still take some form of oral intake?
A Because there would be no way that orally you could control his restlessness and agitation and general psychotic symptoms, even if you could control his pain.

Q Then 21 January, the situation continues. There is a note relating to Dr Briggs who has come in to see him:

> "Much more settled. Quiet breathing. Rate 6/min. Not distressed. Continue."

Dr Briggs has given his evidence about that. "Breathing quietly and slowly", appears on page 23. Then also on page 23, 22 January, these drugs continue,

"Poorly but very peaceful". Again, you would have been reviewing this man each day that you came in?
A I would have seen him again on the morning of the 22nd, the Monday, yes.

Q Assuming it is a day you were there.
A Yes.

Q So you would be reviewing him each day?
A Yes.

Q Did it seem to you that there was anything wrong with the treatment that he was receiving or that it ought to be changed or altered in any way?
A I could see nothing wrong with what he was being given and I made no attempt to change any of it.

Q 23 January, on page 24, the situation continues. We can see what the nursing notes record. The following day, in the early hours of the morning, Mr Pittock died. Cause of death bronchopneumonia. You have heard the criticisms that have been made by Professor Ford. Does that alter your view as to what you thought was appropriate at the time?
A Not at all.

MR LANGDALE: I am just pausing to see if there is anything else in relation to the contents of your statement that I need to ask you by way of supplementing what you have already said in your evidence. (Pause) That is all I need to ask you about Patient A.

I will move on to Patient B. I was imagining that a sensible time to adjourn would perhaps be something in the region of four thirty, but I can start on Patient B.

THE CHAIRMAN: It is a matter for you. If you are happy to make a start.

MR LANGDALE: I think it is preferable if we can keep going. We can at least make some progress.

THE CHAIRMAN: Use your discretion.

MR LANGDALE: Thank you.

THE WITNESS: Can we just also check the chronology again? Does this one have a subsequent or is just the original one?

MR LANGDALE: Mr Jenkins will just take a look and see what needs to be done.

MR JENKINS: The chronology is in a separate folder.

THE CHAIRMAN: Mr Kark, do you have spares?

MR KARK: There is a chronology file, so instead of looking at the chronology at the beginning of each patient folder, if Dr Barton could turn to the chronology file that has the up-to-date version of them.

MR LANGDALE: I had not realised this. So for the witnesses there is a separate file containing each one of the chronologies?

MR KARK: Yes.

MR LANGDALE: Thank you. I am sorry, Dr Barton. That is my fault. I did not realise that is what you were faced with.

B

Patient B, Elsie Lavender, the lady whose GP was Dr X. We can see on page 1 of the chronology she is one of a number amongst these twelve who had to go to hospital because of a fall. This is the lady who fell down a flight of stairs at her home address and we have seen the position more than once as to what had developed. We can look at page 2. She is complaining of pain. She is prescribed, on the bottom of page 2, co-proxamol and dihydrocodeine which is administered until transfer to Gosport War Memorial Hospital.

C

Over the page, page 3, we have seen this more than once, the complaints about pain continuing. Analgesia given but never ever gets on top of it, shoulders and arms and so on, and we can move to Dr Tandy's review of her on 16 February, on page 5, of the chronology, pain, long standing stress incontinence, atrial fibrillation, weakness in hands:

D

> "Most likely problem is brain stem stroke leading to fall. Might want to consider asprin. I'll get her over to Daedalus Ward for rehab as soon as possible."

This is the case where Dr Tandy had assumed that the x-ray of her neck was normal. Her note also actually says:

E

> "I'm not sure ... we'll get her home but we'll try."

Over the page, on page 6, 20 February, physiotherapist, still complaints about pain, the 21st, same situation continues and then on the 22nd she arrives at Daedalus Ward under Dr Lord, reviewed by you, and you recorded:

F

> "Fell at home top to bottom of stairs. Lacerations on head. Leg ulcers. Severe incontinence. Needs a catheter. Insulin dependent. Regular series BS."

A Blood sugars.

Q Thank you. "Transfers with 2". What does that mean?
A It needs two people to get her standing or back onto the bed again.

G

Q Thank you.

> "Help to feed and dress. Barthel 2. Assess general mobility ? suitable for rest home if home found for cat."

This is a lady who had ...
A A feral cat.

H

Q ... a somewhat singular-minded cat. She seemed to be the only person who could really cope with the cat. In terms of comorbidities, we are thinking of insulin dependence?
A For 40 years.

Q Atrial fibrillation; she had also got a problem in terms of her sight. When you assessed her, what was your view in general?
A I felt exactly as Dr Tandy had felt, that she deserved the opportunity to try some general rehabilitation but I was not very hopeful, as you say, in view of those comorbidities and the amount of pain she had, even at that time.

Q Why not (to deal with matters raised with Professor Ford) say to yourself, "this pain seems to have gone on an awful long time. I had better find out what is causing the pain"?
A I, like Dr Tandy, assumed that there had been normal x-rays taken at Haslar Hospital before her transfer and I would have been thinking in my mind was I going to find any cause for this pain that was treatable, and the answer was there was not.

Q What about the particular history of this lady, who was then 84, I think, I may have got the age wrong, having fallen down the stairs in the way that she had, a significant fall, perhaps. What was your view about the likelihood of pain remaining?
A If she had crushed a cervical vertebra or a thoracic vertebrae she would still have considerable and significant pain even at this time after the original injury, but other than adequate analgesia there would have been nothing I could have done for her. There was nothing that was remediable or treatable.

Q Would you explain that, please? Supposing she had had that sort of injury.
A There would be no operation or procedure that could be done to make it more comfortable for her. Somebody suggested immobilising the neck in a collar. I think she would have found that even more uncomfortable. She was a small, tubby lady and those proper neck collars are seriously uncomfortable to wear. So there was not anything we could do for her, other than give her adequate pain relief.

Q What about sending her back?
A What could they do at the acute hospital? Nothing further.

Q Explain that.
A They had an MRI, they could have put her through and determined if there was cord compression or not, but, again, there would be no treatment for that either. The treatment is expectant pain relief and gentle mobilisation when it becomes possible, if it becomes possible.

Q What would you have had to do if you were thinking to yourself, "Well, it may be there is some kind of fracture problem or crushed vertebra problem"? What would you ---?
A Nothing different from what I did for her anyway.

Q What about a lady of this age having had a fall like that on the 5th, so over a fortnight before, still being in pain as result of bruising and so on, or internal bruising – whatever it might be – from the fall? Would that be ---?
A Totally appropriate.

Q And the problems with grip in both hands, what in your view was the significance of that?
A She could have had a neuropathy associated with her 40 years of insulin dependent diabetes. She could have had a specific nerve problem, perhaps, in the carpal tunnel in the wrist. I did not think that the difficulty with grip was necessarily anything to do with the acute injury. It might have been pre-existing.

Q And what were the prospects when you put "Assess general mobility. ? [Query] suitable for rest home if home found for cat." What were the prospects if she had in fact got a crushed vertebra? That was the thing.
A She might slowly, slowly improve sufficiently to go to residential care, given enough time.

Q Yes. Then the analgesia that is given was dihydrocodeine in respect of this lady, as we can see at the top of page 8, when she comes in – all right?
A Yes.

Q May I ask you this: she has this pain. Why not put her straight on to Oramorph?
A Because, having come across on what I felt was a decent step two analgesic, I thought it was better to assess how she responded to that before starting on an opiate.

Q Then if we look down the page, page 8, we see what the position was on 23 February and then the 24th. On the 24th, when you reviewed her – you reviewed her on the 23rd and you reviewed her on the 24th. I had better just ask you, please, about the 23rd. The clinical notes by you say,

"*Catheterised last night. 500 ml residue. Blood + protein. Trimethoprim.*"

Would you just explain that?
A She had a urinary tract infection which probably contributed to the urinary retention she went into, and that was treated with an antibacterial.

Q So you are trying to cope with that problem there?
A Yes.

Q Sister Joines' note:

"The pathology phoned – Platelets 36 ? too small sample. To be repeated Monday. Dr Barton informed …".

Again, what is going on there in terms of what is being done for her?
A I did not know what the significance was of that platelet count, but I was happy to repeat the blood sample after the weekend and do it again.

Q With a view to checking what when you are ---

A Whether that was an artefact, or whether that was a genuinely low platelet sample.

Q Then reviewed by you on the 24th:

"*Pain not controlled properly by D.F. 118. Seen by Dr Barton – for MST 10 mg BD* [twice a day]. *Nocte* [Night]: *Comfortable night.*"

B A First comfortable night.

Q I am sorry, Doctor, I did not quite hear you. Sorry?
A First comfortable night.

Q Yes. Then perhaps you can just indicate what your rationale was for prescribing and having administered MST because over the page, on page 9, we can you prescribed it, C obviously in the morning, and it is administered, it appears... Presumably it was administered first of all at 18.00 on the 24th, and then 6 o'clock the following morning?
A Yes.

Q But why prescribe MST? I am sorry if the answer is obvious, but do explain.
A Rather than Oramorph?

D Q Yes.
A She was able to take tablets at this point, therefore she would be able to take the capsules. I felt a steady low dose of slow release morphine might be as effective – more effective – than her D.F. 118 that she had been having.

Q Professor Ford seemed to be saying, you do not usually convert to MST from D.F. 118 because it is very slowly absorbed. You might not get the right dose, and it was E recommended to start on Oramorph. What do you say to that?
A That was his opinion.

Q Then, the following day, MST again, 20 mg in all.

"*Appears to be in more pain. Screaming 'my back' when moved but uncomplaining when not. Son would like to see Dr Barton.*"

F

Over the page, please, to the 26th.

"Reviewed by Dr Barton."

So you are seeing her again.

G "*Not so well over the w/e. Family seen and well aware of prognosis and treatment plan. Bottom very sore. Needs Pegasus mattress. Institute sc* [subcutaneous] *analgesia if necessary.*"

And the note below:

"*Seen by Dr Barton. MST→ 20mg BD* [twice a day]. *She will see Mrs Lavender @ 14.00 ...*

H

14.30: Son and wife seen by Dr Barton – prognosis discussed. Son is happy for us to just make Mrs Lavender comfortable and pain-free. Syringe driver explained."

Obviously what is being recorded both by you and the nursing staff is contact with relatives?
A Something has happened over that weekend.

B Q Yes?
A 24th, 25th February she has definitely deteriorated. She is now moving from palliative care, gentle rehabilitation, to end of life. So when I examined her and assessed her on the Monday morning, I needed to see the family to explain that to them.

Q The Panel heard evidence from Mr Alan Lavender – and I am not going to go through it all. He indicated that he had had several conversations with you and it appears that all he C could remember was you saying to him, "You can get rid of the cat," and "You know your mother has come here to die." Is that the tenor and nature of your discussions with him?
A I hope it was not. I have no recollection of putting the facts to him as baldly as that. I knew the cat well and I would not have said, "Get rid of the cat." But I would have explained to him that something had happened to his mother over that weekend. She was not nearly as well and she was probably dying.

D Q Did he indicate, as the note records, that he was happy for "us" – in other words the hospital nursing and medical staff to just make Mrs Lavender comfortable and pain free?
A He wanted her comfortable and pain free.

MR LANGDALE: Sir, I think to go on to the end, because there is a bit more, may take a little more time that is not justified at the end of the day. If I may, I will stop there.

E THE CHAIRMAN: Absolutely. Thank you very much indeed, Mr Langdale. We shall break now, ladies and gentlemen, returning tomorrow morning at 9.30, please.

MR LANGDALE: In relation to tomorrow morning, we have – cross fingers – the video link with Dr Lord.

THE CHAIRMAN: You are quite right. We are starting at nine for that purpose, yes. So F nine o'clock start, please.

MR LANGDALE: We understand four hours, if everything works. Then at the end of that, no doubt after an adjournment for lunch, Dr Barton can continue her evidence tomorrow afternoon, hopefully. That may be as far as we will get, assuming everything works with Dr Lord, until Friday afternoon, when we will be stopping early.

G THE CHAIRMAN: Thank you very much.

(The Panel adjourned until Wednesday 16 July 2009 at 9.00 a.m.)

H