DRAFT REPORT

regarding

STATEMENT OF DR JANE BARTON

RE: Code A (BJC/71)

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AT THE REQUEST OF: Hampshire Constabulary

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1. INSTRUCTIONS

To examine and comment upon the statement of Dr Jane Barton re: Code A Code A in particular, if it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This Report is based on the following documents:

[1] Statement of Dr Jane Barton RE: Code A as provided to me by Hamsphire police (signed and dated 3-3-05).

[2] Statement of Dr Jane Barton as provided to me by Hampshire police (undated).

[3] Report regarding Code A BJC/71) Dr A Wilcock, 25th April 2005.

3. COMMENTS

Having compared and contrasted the above documentation, I make the following comments that in my view may be relevant. They are in the order in which they arise in the Statement of Dr Jane Barton RE: Code A

Points 3 and 4

In the statement of Dr Jane Barton, Dr Barton outlines that in 1998, the demands on her time were such that firstly her note keeping suffered in consequence and that the medical records did not set out each and every review with a full assessment of a condition of a patient at any given point. Secondly, in relation to prescribing she felt obliged to adopt a policy of proactive prescribing. In the statement Dr Jane Barton RE: Code A Dr Barton states that this also applied to 1996.

Point 13

Dr Barton states that given the very considerable interval of time she now has no real recollection of Code A Given the lack of adequate documentation in the medical records, subsequently a number of the points she makes are based on what she believed she would have done (e.g. points 15, 18, 21, 23, 24, 25, 29, 31, 34, 41, 42).

Point 16

Dr Barton clarifies that the illegible words in the medical notes entry of the 9th of January 1996 were not '*try hot water*' but 'try arthrotec'. It remains unclear what assessment Dr Barton made of Code A painful hand, the possible cause(s) of it and therefore why arthrotec was deemed an appropriate treatment.

Point 18

Dr Barton highlights that the arthrotec was prescribed on the 8th January 1996 prior to her entry regarding the pain in Code A hand on the 9th January 1996. She states she does not know if the date is an error or she had seen him the previous day and prescribed the arthrotec, and made a substantive note the following day.

She also states that she noted Code A had increased anxiety and agitation and raised the possibility that it might be necessary to increase the diazepam and prescribe opiates. Dr Barton should be asked to clarify exactly why she felt the opioids were indicated. In my view opioids are not indicated for the primary relief of anxiety or distress.

Point 19

Dr Barton states that Dr Tandy noted Mr Code A's dementia. I think this should be depression. Code A 's depression was a major problem and well documented. However, dementia was not previously mentioned anywhere in his medical records.

Point 21

Dr Barton states that she prescribed oramorph for Code A on the 10th January 1996, 'no doubt in consequence of liasing with Dr Tandy at the time of the ward round'. She indicates that it would have been for the relief of pain, anxiety and distress. Dr Barton does not clarify which pain this refers to. In my view opioids are not indicated for the primary relief of anxiety or distress.

Dr Barton also states that she proactively wrote up a prescription for diamorphine and a dose range of 40–80mg subcutaneously over 24hours, together with the 200–400microgram of hyoscine and 20–40microgram of midazolam. She states that 'we were concerned that the oramorph might be insufficient and that further medication should be available just in case he needed it'. Dr Barton does state who 'we' refers to, clarifies the basis for the concern that the oramorph might be insufficient, nor justifies why that dose of diamorphine was considered necessary. Dr Barton should be asked to explain why, given her stated concern, 'as required' oral or SC doses of (dia)morphine or a benzodiazepine (e.g. diazepam/midazolam) were not considered appropriate.

Point 23

Dr Barton states that the following day she rewrote the proactive prescription for the hyoscine, diamorphine and midazolam, with the latter two drugs at a slightly greater level than had been written the previous day, i.e. diamorphine 80–120mg and midazolam 40–80mg. Dr Barton states that she would have been concerned that although it was not necessary to administer the medication at that stage, Code A pain, anxiety and distress might develop significantly and that appropriate medication should be available to relieve this if necessary. I do not understand the logic behind this explanation. Code A had not required the syringe driver prescribed from the day before and so Dr Barton would have no way at all of knowing or in anyway anticipating that an even greater level of these two drugs would be necessary.

Points 24, 25 and 26

Dr Barton states that she believes she would have seen Code A on Monday 15th January 1996 and that she may have been told that his condition had deteriorated considerably over the weekend and 'he appeared to be experiencing marked agitation and restlessness and to be in significant pain and distress'. She anticipates that due a lack of time she did not make a clinical entry in the notes but that diamorphine 80mg, midazolam 60mg and hyoscine hydrobromide 400microgram were commenced via syringe driver at 08.25am that day.

Dr Barton has not described why she considered a syringe driver to have become necessary when Mr Code A appeared to have been taking his oral medications. There was no mention in the nursing notes of pain, retained secretions, agitation or anxiety that day. Dr Barton does not state for what pain

the diamorphine was used. Dr Barton states that she 'tried to judge the medication, including the increase in the level of opiates, to ensure that there was appropriate and necessary relief of his Code A condition, whilst not administering an excessive level, and to ensure that this relief was established rapidly and maintained through the syringe driver'. These are reasonable aims. However, Dr Barton does not illustrate in a clear way how the dose of diamorphine was determined and it would be helpful for Dr Barton to specifically state on what basis a dose of 80mg was selected.

She states that she had to take into account the fact that the lithium and sertraline with their additional sedative effects had previously been discontinued and that he would have developed some tolerance to the oral regime. Dr Barton should be asked to clarify which aspects of Code A oral regime she believes tolerance would have developed to. Tolerance to a drug means that over time an increasing dose would be required to have the same effect. It is likely he would have developed tolerance to benzodiazepines as he had been a long-term user of diazepam. As such it would be seen as reasonable to use a larger than usual starting dose of the midazolam particularly when taking the discontinuation of the lithium and sertraline into account. However, as Code A Code A had only been receiving opioids for four days, tolerance is unlikely to have developed and would not in my view be an acceptable reason to justify such a relatively large increase in his opioid dose.

Points 28 and 29

On the 16th January 1996, Dr Barton states that Code A condition remained very poor and that there had been some agitation when he was being attended to. It would appear therefore that the medication commenced the

previous day had been largely successful in relieving Mr Code A's condition, but not entirely. At the same time, it would seem that Mr Code A's pain, distress and agitation had been such that he was indeed tolerant to the medication given, including the level of diamorphine I felt appropriate'. I do not understand fully Dr Barton's final sentence and she should be asked to clarify exactly what she means by it.

It remains unclear if Dr Barton assessed the cause of Code A agitation and considered the possible underlying cause(s). Of particular relevance to Code A Code A would be drugs (or their withdrawal) particularly the use of opioids, hyoscine hydrobromide and benzodiazepines (e.g. midazolam).

Whilst haloperidol is a reasonable part of the approach to treating delirium for terminal agitation, its use should not be a substitute for considering other causes of agitation that may need to be addressed.

Point 31

On the 17th January 1996 Dr Barton states that due to Code A being tense and agitated she increased the level of his diamorphine to 120mg. She states this was with the specific aim of relieving the agitation. Dr Barton should be asked to state on what basis, recommendation or guidelines she was using diamorphine for the specific aim of relieving agitation. Diamorphine is not indicated for the relief of agitation and is not mentioned as a treatment for such in contemporary guidelines such as the Wessex Protocol or the BNF Prescribing in Palliative Care section. Again from the medical, nursing notes and Dr Barton's statement it remains unclear if an assessment of the possible causes of his agitation was undertaken. Increasing the haloperidol to 10mg and

the hyoscine to 600microgram were reasonable steps based on his agitation and retained respiratory secretions.

Points 34 and 35

Dr Barton states that in the entry dated the 18th January 1996 she noted 'difficulty controlling symptoms, try nozinan' (levomepromazine). Which symptoms were difficult to control are not specified but Dr Barton believes that it was for Code A agitation. Haloperidol was increased to 20mg and levomepromazine 50mg was added to the syringe driver. Increasing the dose of antipsychotic medication for terminal agitation is reasonable but Dr Barton should be asked to explain why the levomepromazine was given in addition to the haloperidol rather than substituted for it. It remains unclear if Dr Barton undertook an assessment o Code A agitation.

Point 36

Dr Barton states that the nursing notes record that Code A appeared comfortable in between attentions. She infers from this that he had adequate relief from symptoms but would experience pain, distress and agitation when receiving care. Dr Barton should be asked to clarify why if this was the case the syringe driver not modified again; why smaller doses of the diamorphine, midazolam, levomepromazine or haloperidol and hyoscine hydrobromide were not prescribed 'as required' to be administered prior to turning Mr Code A; and if, given that the symptoms were difficult to control, whether she sought advice?

Points 38, 39 and 40

Dr Barton states that 'Dr Briggs would have been advised of Mr Code A's condition and the drug regimen. The only modification was in the antipsychotic medication (levomepromazine), it would seem that Dr Briggs did not consider the general regimen to be inappropriate.....'. Dr Briggs should be asked for his view of this.

4. CONCLUSION

Dr Barton admits to poor note keeping and proactive prescribing due to time pressures in 1996. Even with significant episodes in Mr Code A's care however, no entry was made. Having read Dr Barton's statement regarding Code A, I believe that the main issues raised in my report (BJC 71), dated 24th April 2005, remain valid and have not yet been satisfactorily addressed due to a lack of clarity regarding:

- the nature of Code A pain and its possible cause(s)
- the justification for the proactive prescribing of a syringe driver containing diamorphine, hyoscine and midazolam 'just in case he needed it'
- the lack of use of 'as required' doses of the above drugs instead of, or subsequently, alongside the syringe driver
- the basis for Dr Barton's use of diamorphine specifically for the relief of agitation
- the lack of assessment of the possible cause(s) of Code A agitation
- how the dose of diamorphine Code A ultimately received (80mg) was calculated in a way that can be clearly related to his existing dose of opioid
- given the difficulty of controlling the symptoms, whether Dr Barton sought advice.

As some of the above points relate directly to Dr Barton's knowledge of the management of pain and other symptoms in a palliative care setting it would be helpful if she could state what specific training she had received in relation to

this. In particular, where she obtained her understanding from with regards to the indications for the use of morphine/diamorphine, the phenomenon of tolerance to opioids, the methods of determining an appropriate dose of diamorphine given a patients oral morphine dose and what prescribing guidelines she was aware of and/or followed.

Specific implications of the statement of Dr Barton regarding Mr Code A *regarding my report (BJC 71), dated 24th April 2005*

Dr Barton's statement clarifies that the 'arthrotec' (and not 'hot water') was prescribed for Mr Code A's painful right hand held in flexion. This relates to specific issue ii (pages 23 and 28) in my report.