General Medical Council and Dr Jane Barton
Report on Mr Lesley Pittock (Patient A)

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Consultant Physician

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General Medical Council and Dr Jane Barton
Report on Patient A

1. This report is provided at the instruction of Field Fisher Waterhouse solicitors. I have been asked to prepare a report on the medical care of the above patient and comment upon the care and treatment carried out by Dr Barton in relation to this patient to assist the GMC panel in determining whether Dr Barton has fallen short what is reasonably expected from a medical practitioner in the circumstances that she was practicing. I note the allegations presented to the panel that Dr Barton prescribed diamorphine, oramorphine, and midazolam in too wide a dose range that created a situation whereby drugs could be administered to Patient A excessive to his needs; that the prescriptions of diamorphine were excessive to Patient A's needs; that the prescriptions of nozinan in combination with other drugs were excessive to his needs; and that Dr Barton's prescribing was inappropriate, potentially hazardous and not in the best interests of Patient A.

2. I am the Jacobson Chair of Clinical Pharmacology at Newcastle University and a consultant physician at the Newcastle upon Tyne Hospitals Foundation Trust. I am a Doctor of Medicine and am trained and accredited on the specialist register in Geriatric Medicine, Clinical Pharmacology and Therapeutics in General and Internal Medicine. I was previously Clinical Head of the Freeman Hospital Care of the Elderly Service I undertook research into the effects of drugs in older people, I am current editor of the book Drugs in the Older Population and in 2000 I was awarded the William B. Abrams Award for Outstanding Contributions to Charity and Clinical Pharmacology by the American Society of Clinical Pharmacology and Therapeutics. I am a fellow of the Royal College of Physicians and practiced as consultant physician for 16 years. My curriculum vitae is separately attached.

3. This report should be read in the context of the general report I have provided on the Principles of Medical Care and Matters Specific to Gosport War Memorial Hospital.

4. This report is based on my review of the following documents; medical records of Patient A; statement of Dr Jane Barton re Patient A; witness statements of Lynda Wiles, Dr Jane Tandy, Tina Douglas, Dr Victoria Banks, Freda Shaw, Lynn Barrett, Gillian Hamblin, Dr Althea Lord, Fiona Walker; statement made by Dr Barton in relation to Patient A, interview of Dr Barton dated 23 March 2005.

5. Course of events.

5.1 Patient A was 82 years of age when he was admitted to Dryad ward for continuing long-term care on the 5 January 1996 (p 152) and died on 24 January 1996. His past medical history was notable for recurrent depression which had been treated with electro convulsive therapy 1992. He was admitted under the care of Dr Banks consultant psychiatrist in 1995 with depression he was noted to have a shuffling gait and mobility difficulties. He was discharged to a rest home on the 24 October 1995.

5.2 Patient A was admitted under Dr Banks' care again on the 13 December 1995 to Mulberry Ward. The notes at this time (p 63) record he was verbally aggressive, not mobilising, not eating well and felt hopeless and suicidal. On 22 December the notes

record he had developed diarrhoea and left basal crepitations (crackles, audible in the lungs) and was thought to have a chest infection. This was treated with antibiotics. On the 27 December the notes record (p66) a ward round by Dr Banks and that Patient A was *"chesty, poorly, abusive, not himself at all'*. He was commenced on another antibiotic. He had been catheterised for urinary retention. A Chest x-ray was obtained which showed no evidence of focal lung disease. An abdominal x-ray recorded gaseous extension of the large bowel consistent with pseudo obstruction; a condition when the bowel stops moving which can be due to a number of different underlying medical conditions and is seen in frail older people who are acutely unwell.

5.3 On 2 January a referral was made by Dr Bank's team to Dr Lord consultant geriatrician (page 67) states *'his mobility initially deteriorated dramatically and then developed a chest infection which is now clearing but he remains bed bound expressing the wish to just die'*. The referral says *"this may well be secondary to his depression but we will be grateful for any suggestions as to how to improve his physical health".*

5.4 On the 3 January on a ward round by Dr Banks the notes record that Patient A *"needs more time to convalesce"* and that he would probably need a nursing home. On the 4 January the notes record Patient A was seen by Dr Lord (page 68). Dr Lord noted the issue of quite recent depression, that he was completely dependent, had a urinary catheter in place which was bypassing, had ulceration of the left buttock and hip and hypoproteinaemia (low blood protein). She suggested high protein drinks, bladder wash-outs, dressing to buttock ulcers with padding. She indicated she would transfer him to a long-stay bed at Gosport War Memorial Hospital and suggested that his residential home place be given up as he was unlikely to return to his residential home. In a letter summarising her assessment (page 188) Dr Lord states that his prognosis is poor and that she understood Patient A's wife was aware of the poor prognosis. The nursing records at psychiatry ward (page 152) record that Patient A would transfer to Dryad ward for continuing long-term care.

5.5 On the 5 January (page 196) an entry by Dr Barton in the medical notes at Gosport War Memorial Hospital states *'Transfer to Dryad ward from Mulberry. Present problems immobility, depression, broken sacrum, small superficial areas on right buttock. Ankle dry lesion L ankle, both heels suspect. Catheterised. Transfers with hoist. May help to feed himself, long standing depression on lithium and sertraline'.* The next entry in the medical notes is on the 9 January by Dr Barton and states *'Painful R hand, held in flexion. Try arthrotec. Also increasing anxiety and agitation ? sufficient diazepam ? needs opiates.'*

5.6 On Friday 10 January an entry by Dr Tandy states *dementia, catheterised, superficial ulcers, Barthel 0, will eat and drink. Transfer from Mulberry. For TLC. d/w wife – agrees ……(illegible)……. TLC'*. The next entry in the medical notes on 18th January 1996 is By Dr Barton and states 'F*urther deterioration, sc analgesia continues, ……(illegible)…… symptoms try nozinan*.

5.7 The next entry in the medical notes is dated 20 January (p198) and is unsigned but as it refers to a verbal order is likely to be by a member of nursing staff. *Has been unsettled on haloperidol in syringe drive diamorphine (illegible) to higher dose (illegible words), nozinan 50mg to 100m in 24 hrs (verbal order).* There is an entry

the following day dated 21 January 1996 (signature unclear) *'much more settled, quiet breathing, respiratory rate 6 / minute, not distressed continue'*. There is an entry in the notes on 24 January 1996 confirming death at 1.45 am. The recorded cause of death was bronchopneumonia.

5.8 Nursing assessment on the 5 January at Gosport on Dryad ward record Patient A had a poor physical condition with broken pressure areas to his buttocks and hip, and broken skin on scrotum. He was weight bearing to a very minimal degree, was low in mood but settled in behaviour (page 195). His fluid and diet intake was noted to be poor but that he was drinking supplement drinks (Fortisips).

5.9 An entry in the nursing notes on the 10 January states *'condition remains poor. Seen by Dr Tandy and Dr Barton. To commence on oramorph4 hourly this evening'*. A nursing entry on the 15 January states *'Seen by Dr Barton has commenced syringe driver at 08.25 diamorphine 80mg, midazolam 60mg + hyoscine 400ug'*. A second entry that day states his daughter was informed of Patient A's deterioration during the afternoon, and that he was now unresponsive and unable to take fluids and diet. On the 16 January the nursing notes record *'Condition remains very poor, some agitation was noticed when being attended to. Seen by Dr Barton haloperidol 5-10mg to be added to the driver'*.

5.10 An entry later that day at 1300h states *'previous driver dose discarded. Driver recharged with diamorphine 80mg, midazolam 60mg, hyoscine 400ug, and haloperidol 5mg given at a rate of 52mls hourly'*. There was a note to nurse him on his back and left side only. An entry in the nursing note on 17 January indicates Patient A was seen by Dr Barton and that his medication was increased as he remained *'tense and agitated, chest very "bubbly"'*. On the same day at 14:30h the nursing notes records Patient A was again seen by Dr Barton (page 210) his medication reviewed and altered, and that his syringe driver renewed at 15:30 with two drivers. Further deterioration is noted at 2030h. On the 17 January he appears more settled.

5.11 An entry on the 18 January in the nursing notes record that he appears comfortable. On 19 January *'marked deterioration in already poor condition'* is reported. Over the next 3 days the notes record he is settled and that an infusion of diamorphine, midazolam, nozinan, haloperidol and hyoscine was continuing.

5.12 The drug charts indicate on the 5 January that Patient A was prescribed the drugs he had been receiving prior to his transfer which were sertraline, lithium, diazepam and thyroxine (p195). There is an undated prescription by Dr Barton (p200) for subcutaneous infusions of diamorphine 40-80mg/24 hours, hyoscine 200-400ug/24 hours, and midazolam 20-40mg/ 24 hours which were not administered. It is unclear to me if these drugs were prescribed by Dr Barton on the 5 January 1996. Regular oramorph (5mg 5 times a day) was prescribed on 10 January. Two doses were given at 2200h 10 January and 0600h on 11 January. On the 11 January the prescription is changed to 2ml (4mg) 4 hourly with 5ml (10mg) at 2000 at this dose regimen of morphine is given until the morning of 15 January 1996 with a last dose administered at 0600h with Patient A receiving a total of 26mg morphine daily (page 202).

5.13 On 11 January Dr Barton prescribed diamorphine 80-120mg subcutaneous 24 hours, hysoscine 200-400ug subcutaneous 24 hours, midazolam 40-80mg subcutaneous 24 hours , 80 mg of diamorphine, hyoscine 400ug, midazolam 60mg are then administered over 24 hour periods during the 15, 16 and 17 January (page 201).

5.14 On 16 January, haloperidol 5-10mg/24hr was prescribed. Haloperidol was administered on the 16 January (5mg/24hr) and 17 January (10mg/24hr). On the 17 January the dosage of all drugs were increased by Dr Barton to diamorphine 120mg/24hr, midazolam 80mg/24hr, hyoscine 1200ucg/24hr, haloperidol 20mg 24 hours and these were administered from 17 January onwards, until Patient A's death with the exception of haloperidol which was stopped on 20 January. On 18 January nozinan 50mg was prescribed by Dr Barton and 2 doses administered (dates unclear) this was then increased to 100mg on 20 January and this appears to be administered subcutaneously each 24 hours over the following 3 days. An entry in the nursing notes on 20 January (page 211) states *'verbal order taken to double nozinan and omit halopeirdol'.*

5.15 There is a prescription for diamorphine 120mg and hyoscine 600ug over 24 hours dated 18 January although the nursing entries on the drug chart suggest these were administered on 17 January. I cannot find the drug charts for the period 18-24 January in the copies of the medical records provided to me.

Drug therapy received at Gosport War Memorial Hospital

6. Pages 189-191 and 199-204
All prescriptions written by Dr Barton unless otherwise marked.

Regular Prescrptions

Sertaline 50mg bd	5 Jan - 11 Jan (discontinued)
Lithium carbonate 40mg od	5 Jan - 11 Jan (discontinued)
Diazepam 2mg tds	5 Jan -15 Jan (not administered after 0800h 15 Jan)
Thyroxine 50ucg od	5 Jan – 15 Jan (dose not administered after 15 Jan)
Illegible prescription	*tick mark 7 Jan*
Arthrotec one tab bd	8 Jan – 10 Jan (discontinued after 0900 10 Jan)

Oramorph (10mg/5ml) 5mg nocte	10 Jan	5mg nocte
Oramorph (10mg/5ml) 5mg qds	11 Jan	Four 5mg doses
Oramoprh (10mg/5ml) 10 mg nocte	11 Jan	10mg nocte
	12 Jan	Four 5 mg doses
	12 Jan	10mg nocte
	13 Jan	Four 5mg doses
	13 Jan	10mg nocte
	14 Jan	Four 5 mg doses
	14 Jan	10mg nocte
	15 Jan	one 5mg dose then discontinued

Diamorphine subcut via syringe driver 120mg/24hr Prescribed 18 Jan	17 Jan	120 mg/24hr
Hyoscine subcut via syringe driver	17 Jan	600ucg/24hr

600ucg/24hr Prescribed 18 Jan		
Haloperidol subcut via syringe driver 5-10mg/24hr Prescribed 16 Jan	16 Jan 17 Jan	5mg/24hr 10 mg/24hr
Diamorphine subcut via syringe driver 120mg/24hr Prescribed 18 Jan	17 Jan 18 Jan 19 Jan 20 Jan 21 Jan 22 Jan 23 Jan	120 mg/24hr 120 mg/24hr 120 mg/24hr 120 mg/24hr 120 mg/24hr 120 mg/24hr 120 mg/24hr
Midazolam subcut via syringe driver 80mg/24hr Prescribed 18 Jan	17 Jan 18 Jan 19 Jan 20 Jan 21 Jan 22 Jan 23 Jan	80 mg/24hr 80 mg/24hr 80 mg/24hr 80 mg/24hr 80 mg/24hr 80 mg/24hr 80 mg/24hr
Hyoscine subcut via syringe driver 1200ucg/24hr Prescribed ? Jan	17 Jan 18 Jan 19 Jan 20 Jan 21 Jan 22 Jan 23 Jan	1200ucg/24hr 1200ucg/24hr 1200ucg/24hr 1200ucg/24hr 1200ucg/24hr 1200ucg/24hr 1200ucg/24hr
Haloperidol subcut via syringe driver 20mg/24hr Prescribed 16 Jan	17 Jan 18 Jan 19 Jan 20 Jan	20 mg/24hr 20 mg/24hr 20mg /24hr 20 mg/24hr discontinued
Nozinan subcut 100mg/24hr Prescribed 22 Jan	23 Jan	100mg/24hr

As required prescriptions

Diamorphine subcut via syringe driver 80-120mg/24hr Prescribed 11 Jan	15 Jan 16 Jan 17 Jan	80mg/24hr 80mg/24hr 80mg/24hr
Hysoscine subcut via syringe driver 200-400 ucg/24hr Prescribed 11 Jan	15 Jan 16 Jan 17 Jan	400 ucg/24hr 400 ucg/24hr 400 ucg/24hr
Midazolam subcut via syringe driver 40-80mg/24hr	15 Jan 16 Jan	60mg/24hr 60mg/24hr

Prescribed 11 Jan	17 Jan	60 mg/24hr
	18 Jan	80 mg/24hr
Midazolam subcut via syringe driver 80mg/24hr Prescribed 16 Jan	None administered	
Nozinan subcut via syringe driver 50mg/24hr Prescribed 18 Jan	18 Jan	50mg/24hr
	19 Jan	50mg/24hr
Nozinan subcut via syringe driver 100mg/24hr Prescribed Dr Brigg	20 Jan	100mg/24hr
	21 Jan	100mg/24hr
	?	100mg/24hr

Opinion on Patient A's management

7. Patient A had a long standing history of depression which was severe and appears to be the most likely cause for his decline leading to his admission to a residential home in 1995. Immediately prior to his admission to Dryad ward he had developed when an inpatient in a psychiatry ward, a chest infection and pseudo obstruction and had become immobile with malnutrition and bedsores. Dr Lord's assessment indicates he was very ill and would possibly not survive to leave hospital. Dr Lord appears to have decided that at that stage it was not appropriate to consider finding a nursing home for Patient A, presumably because he was at this stage very medically unwell. The decision to transfer him to a long-stay ward suggests she had considered his medical condition was severe and unstable enough that he should continue to be managed in a continuing care bed.

8. There are limited entries in the medical notes during Patient A's time on Dryad ward where he spent 18 days prior to his death although the nursing records indicate Patient A was seen by Dr Barton at regular intervals during this period. On admission Dr Barton summarised Patient A's problems but there is no evidence in the medical notes that she undertook a physical examination. The notes do not record what history, if any she obtained from Patient A of his current symptoms and problems. Subsequent entries in the medical records are brief and I consider the medical records at Dryad are inadequate and not consistent with good medical practice. It is not clear from the admitting notes whether Dr Barton considered Patient A was for palliative care only.

9. The previous assessment by Dr Lord and nursing records describe a clear picture of a frail, older man who was deteriorating rapidly and highly likely to die in the next few weeks or months. Overall responsibility for the care of Patient A following his admission to Dryad ward lay with Dr Tandy as the responsible consultant. Day to day medical care was the responsibility of Dr Barton and during out of hours the on call doctors.

10. Despite the limited medical documentation the decision of Dr Barton to prescribe 5mg of oramorph 4 hourly on 10 January was in my view reasonable given that Patient A was likely to be in significant discomfort and pain from his pressure sores. It would be difficult to determine whether restlessness and agitation in Patient A were due to pain or his depression. A decision had been made that day that Patient A was for "TLC" (tender loving care). This indicates Dr Tandy considered Patient A was likely to die within days or weeks and the focus of treatment at this stage was towards palliating any

symptoms he might have rather than initiation of other medical interventions to treat or prevent active ongoing problems. Given Patient A's general condition this decision appears reasonable and was appropriately discussed with his relatives.

11. I consider the discontinuation of sertaline and lithium carbonate on 12 January was reasonable as Patient A was deteriorating, although the medical records should have recorded the rationale for this. When patients are rapidly deteriorating it is common practice to withdraw routine drugs and it would be unlikely the withdrawal of these drugs would lead to any major effects on Patient A's mood and general level of functioning when he was deteriorating.

12. The change on 15 January from regular oral doses of morphine to syringe driver subcutaneous infusion of a much higher dose of opioid (80mg diamorphine/24hr) in addition of midazolam 60mg/24hr is in my opinion is not justified by any information recorded in the medical notes. The nursing notes suggest Patient A was agitated at times but there is no record that he was in pain.

13. The diamorphine dose prescribed was not justified and was excessively high. Patient A was receiving 30mg oral morphine/24 hour on 14 January. The equivalent dose of subcutaneous diamorphine would have been 15-20mg/24hr. The prescription of diamorphine 80-120mg/24hr was at least a four-fold increase in the equivalent opioid dose he had been receiving. An appropriate dose to commence with if a diamorphine infusion had been justified would have been 15-20mg/24hr and up to 30mg/hr if Patient A was showing signs of still being in pain. The prescribed dose of midazolam of 40-80mg/24hr was excessively high and the notes contain no entry from Dr Barton justifying such a high starting dose. An appropriate starting dose in a frail older man if a subcutaneous infusion had been indicated would have been 10mg/24hr particularly when a diamorphine infusion was also being administered. The prescription of diamorphine at an infusion rate of 80mg/24hr with midazolam at an infusion rate of 60 mg/24hr on 15 January carried a very high risk of producing respiratory depression and/or coma.

14. It would have been appropriate for Dr Barton to perform a clinical assessment at this stage but there is no evidence in the notes that this took place. Dr Barton does not appear to have considered the possibility that Patient A's agitation might be secondary to or exacerbated by the morphine he had received. As Patient A was deteriorating and expected to die in the near future I do not think Dr Barton need necessarily have discussed Patient A's problems with the consultant Dr Tandy but she should have examined patient A, documented her findings in the medical notes and explained her rationale for prescribing subcutaneous infusions of diamorphine, midazolam, haloperidol and nozinan. The medical notes contain no justification for the commencement of haloperidol and then nozinan, a more sedating neuroleptic drug. However the prescription of haloperidol would have been reasonable if agitation was a continuing problem in Patient A.

15. The prescription of nozinan on 18 January was not justified by any information presented in the nursing or medical records as at this point as Patient A was reported to be comfortable. The combination of diamorphine midazolam, haloperidol and nozinan very likely shortened Patient A's life although he would not have been expected to live more than a few week following his admission to Dryad ward.

16. In my opinion the infusions of diamorphine, midazolam and haloperidol and then nozinan, very likely led to respiratory depression and shortened Patient A's life span although he would have been expected to die in the near future even if he had not received these drugs.

Summary of Conclusions

17. Patient A was a frail, dependent man with a long history of severe depression who was deteriorating prior to his admission to Dryad Ward who was expected to die within a few weeks. The initial prescription of oral morphine was appropriate. The medical and nursing notes are limited but document he had persistent symptoms of agitation which merited treatment with a sedative such as diazepam or antipsychotic drug such as haloperidol. However there was inadequate assessment of Patient A by Dr Barton as the doctor responsible for the day to day care of the patient with no clinical findings or other information recorded to justify the prescription of subcutaneous infusions of diamorphine and midazolam. The prescriptions of both these drugs in the wide dose ranges used were not justified and highly risky because of the risk of respiratory depression. There was no justification in the medical or nursing notes for the prescription of nozinan by Dr Barton. However the very poor quality of the medical and nursing notes make it difficult for me to be certain that these drugs were not justified given Patient A's clinical condition and reported pain and agitation.

18. In my opinion Dr Barton in her care of Patient A failed to meet the requirements of good medical practice:
    - to provide a adequate assessment of a patient's condition based on the history and clinical findings and including where necessary an appropriate examination;
    - to keep clear, accurate contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatments prescribed;
    - to prescribe only the treatment, drugs or appliances that serve patients' needs.

19. I understand my duties as an expert, as set out at paragraph 57 of my Generic Report.

I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct.

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GARY A FORD