WITNESS STATEMENT

STATEMENT OF: DR ALTHEA LORD

AGE: OVER 18

This statement consisting of page(s) signed by me is true to the best of my knowledge and belief and I make it knowing that if it is tendered in evidence I shall be liable to prosecution if I have willfully stated in it anything which I know to be false or do not believe to be true.

DATED this 29th day of March 2009

Signed ......Code A.....

I am Dr Althea Everesta Geradette Lord of Code A New Zealand. I am a Medical Practitioner, and qualified at the Faculty of Medicine, University of Sri Lanka in Colombo with the degrees MBBS in 1978. I hold the further qualifications of MD (Sri Lanka) 1983, and FRCP (UK) 1997.

Following qualification I was appointed as House Officer in Obstetrics & Gynecology at the Castle Street Hospital for Woman in Colombo from March to September 1978, after which I became the House Officer in General Medicine at the General Hospital in Colombo until June 1979. I then became a Medical Officer for out-patients at the Base Hospital, Chilaw until October 1979, before returning to the General Hospital in Colombo as an SHO in Thoracic Surgery. I held this appointment from November 1979 through to September 1980, before taking up the post of SHO in Surgical Intensive Care at the same hospital until June 1981. My next appointment was again at the General Hospital in Colombo, this time as an SHO in General Medicine until December 1982. I then became a Registrar in General Medicine at the General Hospital, a post that I held until May 1984.

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I then moved to the United Kingdom, taking up the position of Registrar in Nephrology at St. Mary's Hospital, Portsmouth, from May 1984 through to October 1985. I was then appointed as a local registrar in Geriatric Medicine at St. Mary's & Queen Alexandra Hospitals, Portsmouth for three months, before taking up the substantive post in January 1986 through September 1988.

From October 1988 until March 1992 I was then Senior Registrar in Geriatric Medicine on a rotation between Southampton and Portsmouth Hospitals. From March 1992 until June 2004 I was then employed as a Consultant Geriatrician for the Department of Medicine for Older People in Portsmouth, during which time I worked at the Queen Alexandra, St. Mary's and Gosport War Memorial Hospitals. In June 2004 I became a Consultant Community Geriatrician for the Fareham & Gosport PCT. I held this post until August 2006 when I then moved to New Zealand. I am now Consultant Geriatrician with the Hutt Valley District Health Board.

I make this statement about matters which relate to the proceedings at the General Medical Council concerning Dr Jane Barton, formerly a part time Clinical Assistant in Geriatrics at the Gosport War Memorial Hospital.

The Gosport War Memorial Hospital is a Community or Cottage type hospital. Originally my involvement there related to care of patients in long term care beds on the male and female wards at the Redclyffe Annex of the hospital. However, re-building took place at the hospital in about 1994 or so, with the construction of new facilities including Daedalus and Dryad wards at the hospital. I then became the Consultant responsible for the patients on Daedalus and Dryad wards and would carry out a ward round on each ward every other week. I also had a weekly session at the Dolphin Day Hospital. I also had an out patient clinic on alternate weeks at Gosport War Memorial Hospital and St Mary's Hospital. At some point – I cannot now remember when – the long term care beds became slow stream general rehabilitation and stroke rehabilitation beds.

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In addition to these responsibilities at the Gosport War Memorial Hospital, I had responsibilities for in-patients at the Queen Alexandra Hospital, and the Kingsclere Rehabilitation ward at St. Mary's Hospital. Given the significant demands on my time from these other commitments, my time in seeing patients on Daedalus and Dryad Wards at Gosport was essentially limited to the fortnightly ward round. I was however contactable by telephone throughout the week, should it have been necessary.

If I was unavailable to carry out the ward round, through being on leave, then my ward round would not take place for a further two weeks, but there was consultant cover, from the team of Consultant Geriatricians.

I found that I would frequently work late on the days that I was in Gosport. My demands elsewhere were such that I could not spend more time at Gosport. Initially, I was responsible for both Daedalus and Dryad Wards, carrying out a fortnightly ward round on each ward. However, in due course, Dr Tandy then took over as the Consultant responsible for the patients on Dryad Ward, I think as a recognition of the increase in demands generally on consultant time.

Initially, the patients admitted to Daedalus ward were long stay or continuing care patients. Following admission, they might be discharged, or might require a degree of rehabilitation. However, in the course of the mid-1990's, the Royal Hospital at Haslar started to take trauma patients. In addition, St Mary's Hospital in Portsmouth had limited capacity for rehabilitation, with only about 20 beds for the whole of Portsmouth being available. Travelling distance for relatives to visit patients in hospital in Portsmouth was also an issue which produced an increase in the numbers of more frail and complex patients being admitted to the wards at the Gosport War Memorial Hospital, including Daedalus Ward. Once a patient was stable we would offer a transfer to a bed to the Gosport War Memorial Hospital. Over a period of time, this activity gradually increased, and we became busier at the War Memorial Hospital. Bed occupancy and turnover increased, and the nature of the patients changed to a

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degree, with more slow stream rehabilitation patients being admitted rather than patients for longer term care. The patients may have deteriorated after the initial assessment and could be quite unwell upon arrival at the Gosport War Memorial.

I would estimate that the change in activity took place from the mid 1990s onwards, with each year the dependency of the patients becoming greater. By 2006, Daedalus and Dryad Wards were not receiving any continuing care patients.

Given the greater frailty and dependency of the patients, the greater bed occupancy and turnover, there was in consequence a gradual increase in the amount of work, and all the staff, medical and nursing, had to work harder. Inevitably the demands on the staff changed, with more to be done as the medical needs of the patients became greater and more complex.

Over this period from the mid 1990s onwards through to 2000, I am not aware that there was any increase in the number of nursing staff on Daedalus and Dryad Wards. Similarly, there was no additional provision of medical staff over this period, until Dr Barton resigned as Clinical Assistant. With hindsight the numbers of nursing staff were probably satisfactory, but the staff training was limited so that they could not cope with the demands. The skill mix needed to be different.

Dr Barton was already in post when I became a Consultant at Gosport War Memorial. My understanding of Dr Barton's working pattern was that she would attend at the Hospital at about 7: 30a.m. each week day morning in order to see patients, and in particular anyone who needed to be seen. She would then go to her GP Surgery, and following a morning session she might then return to the Hospital if there were any particular concerns about specific patients. She would also pop in to the Hospital in the early afternoon in order to clerk patients in. In addition, Dr Barton would attend on my fortnightly ward round. In my view, Dr Barton put in a lot of time although in hindsight I

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appreciate that we needed more in terms of the amount of medical time available, and the nursing skill mix. We required more medical, nursing and therapy time available, including senior nursing time, given the increase in demands in relation to patient care which took place during the 1990s.

I am aware that Dr Barton wrote on a couple of occasions about the demands on her time and the difficulties which resulted, specifically to Peter King of the Human Resources Department. I think this may have been in about 1999 or 2000.

Of Dr Barton I would say that she was kind, hard working, with a dry sense of humour. She was happy to push for her patients. To those who did not know her, her manner might appear abrupt on occasion, but in fact she was sympathetic to older people and worked really hard at the Hospital. She was a natural with older people and got on well with all the staff. Her clinical skills were of a high order. She was a good doctor.

Looking back in hindsight, clearly the documentation in patient records could have been better. I have to say however that I have no recollection of anyone saying anything to Dr Barton about the quality of her records, and I am not aware of any official complaints about her in any regard prior to 1998. With everyone working hard on the Wards, it is easy to understand how pressures might arise which meant that it was simply not possible to do everything.

It is now clear that the nurses were also making limited notes, a position which I did not fully appreciate until I went back to review notes in relation to the patients following the expression of concerns about their care.

Although the quality of record-keeping on the part of the staff was in hindsight inadequate, I never felt that the quality of care delivered was sub-optimal. For example, it is not possible to review the nursing and medical notes to see the true picture of the way in which a given patient's condition deteriorated for example.

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With things becoming busier, I was conscious that Dr Barton was concerned, for example, about the ability to look after patients over a weekend. It was difficult for her partners, who would be on duty from time to time over weekends, to deal with patients with whom they were unfamiliar. In part in consequence of this, a practice was evolved whereby patients could be prescribed on an 'as required' basis with a dose range to enable medication to be given for patients who were, for example, in pain, so that there was a degree of flexibility about the amount of medication which could be delivered and an ability to increase the medication when necessary. In consequence, opiates, including Diamorphine together with sedatives might be prescribed in a dose range if the patient was, for example, in pain and/or was agitated and/or terminally ill. If it was anticipated the patient might reach the point when such medication might be required then similarly a prescription could be made on these bases. Our concern was that patients should not suffer through an inability to deliver medication to relieve pain, anxiety and distress, particularly in circumstances in which they might, for example, be terminally ill.

At the time, I was not unhappy that prescribing was being carried out in this way. In my view it seemed to work well and the patients I saw who were terminally ill were comfortable, and most of the relatives were happy with the position which had been reached.

In relation to the patients in whose care I was involved, I did not see any situations in which there were any errors or any situations in which a patient was actually put at risk through the administration of medication which was not appropriate for their condition.

Ordinarily, nurses would have discussed the patient's condition with Dr Barton and some agreement was reached about the commencement or increase of medication which would take place in any particular case.

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I was aware that the expectation was that the Nursing Staff would commence medication at the lower end of the dose range and gradually increase if that became necessary, and in my experience this was what actually took place. The Nursing Staff knew not to start medication prescribed in this way at an inappropriately high dose and there was contact with Dr Barton to confirm that.

I would accept that it is possible the effects of opiates were not always adequately communicated to relatives, but I think we all gradually learned in that regard, and we became more explicit as to the effect.

Where patients were close to death there was a policy that enabled Nurses to confirm death so that they did not need to call out a doctor specifically to certify death immediately. In this way, the body did not then need to stay on the Ward. This was hospital policy at that time.

Following Dr Barton's resignation she was replaced with a Staff Grade, who was a member of the Royal College of Physicians, and therefore had postgraduate qualifications and was a full time appointment. At the time that I left, Gosport War Memorial employed one associate specialist and three Senior House Officers, although these clinicians also cover the day hospital. There were, in addition, four consultants, with each ward having two consultants. That was a significant increase in the medical input.

Looking back on things, the difficulty from the pressures of the workload resulted in us falling down in relation to documentation, and the lesson to be learned is that, together with the need to ensure that appropriate information is then fed up the line to management.

At the time, we coped with the increased demand, so that in order for Haslar to take more patients, we had to move the patients out to other clinical settings, and Gosport bore the brunt of that. It was not therefore the average community hospital at the time, but had greater demands through the need to cope with trauma patients, and so consequently was in need of greater resources.

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In order to maintain the throughput of patients at Haslar, with hindsight we were taking on patients at Gosport who were too complex. Whilst unsatisfactory, this was, in reality the best that we could achieve in the circumstances as they were. Our intentions were good, but in hindsight the resources were simply not adequate.

All junior doctors in Gosport subsequently got regular supervision and appraisals, but this was not done at the time when Dr Barton was a clinical assistant. I did not think it was necessary to supervise Dr Barton as a junior doctor given her seniority. This may have left her more vulnerable to criticism.

I would have taken steps to deal with any situation where I felt that a patient was at risk, but in fact, I never felt that on any occasion Dr Barton's treatment was inadequate or unsafe.

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