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The INDEPENDENT

A continuing risk to patients, yet Gosport doctor allowed to practise

Outraged families will ask the High Court to rule on the General Medical Council's refusal to strike off Dr Jane Barton

BY NINA LAKHANI SUNDAY 31 JANUARY 2010

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The General Medical Council's decision to allow a doctor found guilty of serious professional misconduct to continue to practise is likely to be challenged. A health watchdog, prompted by anger among the relatives of 12 of the doctor's patients who died while under her care in the infamous Gosport War Memorial Hospital case, is now expected to take the matter to the High Court.

The saga of Dr Jane Barton, found guilty of multiple counts of misconduct last week, has outraged relatives, MPs, lawyers and patients groups alike. Several medical experts described the decision not to strike her off as "illogical and inconsistent".

The Council for Healthcare Regulatory Excellence is examining transcripts from the hearing, which began last June. The GMC's imposition of 11 sanctions on Dr Barton did little to curb the widespread concern.

The GMC's five-person panel said: "There have been instances when Dr Barton's acts and omissions have put patients at increased risk of premature death... the panel was unable to accept that she no longer posed any risk to patients." However, the panel decided that she had proven her safety in the past 10 years during which she continued working as a GP

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while several police investigations, an inquest and NHS report were carried out.

Relatives of the deceased were particularly angry at the credence given to the 187 testimonials gathered from some of her patients and colleagues, which led the panel to conclude that "preserving Dr Barton's services as a GP is in the public interest".

She prescribed high doses of powerful drugs delivered through an intra-muscular syringe driver without properly assessing or investigating the patients. The panel concluded that she showed a "worrying lack of insight". Dr Barton worked as a part-time clinical assistant at the community hospital between 1989 and 2000.

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Few of the 92 families who complained to Hampshire Police and triggered a massive investigation were permitted to give an opinion at the hearing. These families pointed out that the Shipman inquiry, into the deaths of elderly patients at the hands of their GP Harold Shipman, found that he too had been popular with his victims and their families.

Many of the 108 recommendations made in 2005 by Lady Janet Smith to tighten the system to prevent other murders have still to be fully implemented. A senior medical legal source admitted last night it is "universally accepted" that the current system of death certification and regulation "is a mess" and would not prevent another Shipman.

Ten years after the conviction of Shipman, the eminent toxicologist involved in his prosecution warns that a similarly murderous doctor could still escape detection for years.

Robert Forrest, professor of forensic chemistry at Sheffield University and one of Britain's foremost experts on murders committed by healthcare professionals, has told The Independent on Sunday that a "Dr Shipman who is careful and who used drugs not readily available could probably still get away with it for a considerable length of time."

He added: "Dr Barton and others who have sailed close to the harsh wind of the law of homicide no doubt have had in mind the rule of dual-effect that gives a doctor an exemption from the general law of murder. This, in effect, gives a practitioner the option to prescribe what they know to be life-shortening doses of pain and anxiety-relieving medicines if their primary intention is not to shorten life, even if they know that is likely. To deliberately prescribe such doses with the intention of ending life is, of course, murder, provided the CPS prosecutes and a jury convicts.

"The cases of [nurse] Beverley Allitt and Harold Shipman have removed any vestiges of disbelief investigators may have had that doctors and nurses can deliberately kill patients in large numbers and get away with it for, sometimes, many years."

The IoS has learnt that the Nursing Midwifery Council is likely to face an unprecedented second investigation in the space of two years amid allegations of failing properly to investigate the nurses who worked with Dr Barton. The new chief executive last night promised to start investigations immediately, but it is

outcome being that the patient died. The drug was always being administered via 'syringe drivers'. It is fair to say that this member of staff was speaking on behalf of a group of her colleagues."

In 1999 Hampshire Police asked Professor Brian Livesley, an expert on medical care for the elderly, to look into the death of 91-year-old Gladys Richards in 1998. He concluded:

"Doctor Jane Barton prescribed the drugs diamorphine, haloperidol, midazolam and hyoscine for Mrs Gladys Richards in a manner as to cause her death.

"Mr Phillip James Beed, Ms Margaret Couchman and Ms Christine Joice were also knowingly responsible for the administration of these drugs.

"As a result of being given these drugs, Mrs Richards was unlawfully killed."

A meeting took place between senior police officers, the CPS, Treasury Counsel and Professor Livesley. During that meeting, Treasury Counsel came to the view that his assertions were "flawed in respect of his analysis of the law".

In August 2001 the CPS advised that there was insufficient evidence for a successful prosecution.

From first suspicions to a verdict

1991 Night shift nurses raise concerns with the Royal College of Nursing about numbers of elderly patients given diamorphine at Gosport. The matter is dealt with internally at the Hampshire hospital.

August 1998 Gillian Mackenzie reports the death of her mother, Gladys Richards, to Hampshire Police, which launches an investigation. Two complaints are upheld by the Police Complaints Commission. No charges are brought.

1999 Another police investigation is launched into five deaths. Dr Jane Barton is interviewed. No charges.

April 2000 Dr Barton leaves the hospital, but continues as a GP. She agrees to stop prescribing opiates such as morphine. She says she raised concerns about her high workload.

July 2002 The Commission for Health Inspection finds systemic failings in the monitoring and prescribing of medication for elderly patients at Gosport. The NHS Trust doesn't issue an action plan until November.

September 2002 The chief medical officer orders an independent audit into the deaths. This report has never been made public. A nurse reveals complaints dating back to 1991. Police begin an investigation into 92 deaths at the hospital.

October 2007 Crown Prosecution Service concludes there is insufficient evidence to prosecute any health professionals. Police reports are passed to the Portsmouth coroner, David Horsley, in early 2008. His call for a public inquiry is dismissed by the Government.

March 2009 Inquests into 10 deaths begin. A jury decides that in the cases of Robert Wilson, 74, Geoffrey Packman, 66, and Elsa Devine, 88, the use of painkillers had been inappropriate for their conditions. In two other cases, Arthur Cunningham, 79, and Elsie Lavender, 83, the medication doses contributed to their deaths.

July 2009 GMC fitness-to-practise hearing begins eight years after Dr Barton was first referred. She tells the panel: "I was aiming to ensure the maximum comfort and dignity for my patients."

January 2010 Dr Barton is found guilty of multiple instances of serious professional misconduct but allowed to continue working under certain conditions. She says she is disappointed with the verdict. The Nursing & Midwifery Council promises to start investigations into nurses working alongside Dr Barton.

Richard Osley

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Richard Osley

Early Day Motion 691

Early Day Motion

EDM 691

Printable EDM.. | Signatures

DEATHS AT GOSPORT HOSPITAL

21.01.2010

Lamb, Norman

That this House supports the calls for a public inquiry made by the families of the more than 90 elderly patients who died in extraordinary and unexplained circumstances at Gosport War Memorial Hospital between 1990 and 2001; expresses its dismay that despite the fact that concerns were raised first in 1991, the issue still remains unresolved despite repeated investigations by the police, a highly critical report by the Commission for Health Improvement in 2002, 10 inquests and a disciplinary hearing by the General Medical Council; notes that serious questions have been raised by the families involved and in the media about the robustness of the inquiries by the police, General Medical Council and Nursing and Midwifery Council; further notes that the police refused to disclose evidence to the General Medical Council to facilitate consideration of whether steps should be taken to safeguard patients safety; calls on the Secretary of State for Health to work with the Secretary of State for Justice in convening an independent public inquiry, recognising that only a public examination with equivalent powers to the Shipman inquiry could satisfactorily consider the complex nature of the multiple deaths and satisfy the public interest in learning lessons about patient safety in such cases; believes that the establishment of an independent inquiry is consistent with the Government's commitment to putting the needs of victims and their relatives at the heart of the justice system; and further notes that the Portsmouth Coroner and relatives of the deceased have supported such a call.

Signatures(17)
Standard Order
Status
Open signatures

Lamb, Norman
Iddon, Brian
Hunter, Mark
Corbyn, Jeremy
Jones, Lynne
Sanders, Adrian
Simpson, Alan
Cryer, Ann
Hancock, Mike
Simpson, David
McCrea, Dr William
Campbell, Ronnie
Leech, John
Pelling, Andrew
Foster, Don
Russell, Bob
Hemming, John