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IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

B E T W E E N:

THE GENERAL MEDICAL COUNCIL

Claimant

-and-

DR JANE BARTON

Defendant

WITNESS STATEMENT OF LUCY SMITH

I, Lucy Smith, Solicitor to the General Medical Council, 5th Floor St James' Buildings, 79 Oxford Street, Manchester, M1 6FQ, and a Solicitor of the Supreme Court, will say as follows:

1. I am authorised by the General Medical Council ('the Claimant') to make this statement on behalf of the Claimant in support of its application for an extension of the interim order of conditions imposed by its Interim Orders Panel ('IOP') on 7 June 2007.

2. The Defendant, Dr Jane Barton, is a medical practitioner registered with the Claimant.

Statutory Scheme

3. The Claimant is responsible for, amongst other things, supervising and regulating the fitness to practise of practitioners registered with it under the

Medical Act 1983 (as amended) (hereinafter 'MA 1983'). For this purpose, section 1 MA 1983 provides that the Claimant shall have (amongst other Committees) an Interim Orders Panel ("IOP"). The duties and powers of this Panel are further described in the amended Part V and amended Schedules 1 and 4 MA 1983.

4. The procedure which the IOP follows is set out in the General Medical Council (Fitness to Practise) Rules Order of Council 2004 which came into force on 1 November 2004 and is contained in Statutory Instrument 2004 No. 2608 ('the 2004 Rules').

5. The IOP can, where it considers that it is necessary for the protection of members of the public or is otherwise in the public interest or the medical practitioner's own interest, make an order under the amended section 41A MA 1983 for the medical practitioner's registration to be suspended or restricted by way of conditions pending the outcome of the Claimant's investigation into the doctor's fitness to practise.

6. Under the amended section 41A of the MA 1983, if the IOP is satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or is in the interest of the practitioner that an Order be made, the IOP should decide whether to impose specified conditions on, or suspend, the practitioner's registration. The IOP must have in either case specify the period, not exceeding 18 months, during which the Order is to remain in force.

7. Section 41A(2) MA 1983 provides that where the IOP has made an Interim Order, it should be reviewed within 6 months of the date on which the Order was made and thereafter every 6 months.

8. Part 7 of the 2004 rules sets out the procedure for review hearings.

Background

9. The Claimant was first made aware of concerns in relation to Dr Barton, a General Practitioner, by way of a letter from Mr R Burt, Acting Detective Superintendent for Hampshire Constabulary (the 'Constabulary'), dated 27 July 2000. Mr Burt advised that an allegation had been made by the family of a woman, GR, to the effect that she had been unlawfully killed as a result of treatment received at the Gosport War Memorial Hospital ('GWMH') during the period 17 – 21 August 1998. Dr Barton had been the doctor responsible for GR's care at the time.

10. The Claimant was informed that an investigation was currently being conducted into the allegations against Dr Barton, and the investigation was completed on 30 March 2001.

11. The Interim Orders Committee ('IOC', precursor to the Interim Orders Panel 'IOP') first considered Dr Barton's case on 21 June 2001. The Committee heard that a complaint had been made by GR's daughters, who raised concerns regarding the standard of care and attention that had been paid to their mother whilst at the GWMH, in particular by Dr Barton, who they alleged had:

- Refused to transfer GR to the Haslar Hospital, against their wishes.

- Shortly before GR's death, suggested that she be given diamorphine after developing a haematoma, in order to provide pain relief.

- Administered a syringe driver with morphine, advising that this would be the 'kindest way'.

- Did not ensure that GR was hydrated or nourished, or visit her in the days preceding her death.

12. On that occasion, the Committee determined that it was not satisfied that it was necessary for an order to be made in relation to Dr Barton's registration.

13. On 14 August 2001, the Constabulary informed the Claimant that, based on the papers submitted to the Crown Prosecution Service ('CPS'), there was insufficient evidence to support a viable prosecution against Dr Barton with regard to the death of GR and, consequently, no further action would be taken. The Constabulary did, however, state that it was conducting further preliminary enquiries as several members of the public had expressed concerns regarding the death of their relatives at GWMH, following the publicity generated by the original enquiry.

14. By way of a letter dated 6 February 2002, the Constabulary informed the Claimant that it had commissioned expert reports in respect of four other patient deaths, and had also carried out a further review of the death of GR. Although the reports criticised Dr Barton and raised concerns regarding her professional conduct, it had been decided that no further police investigations were currently appropriate, although this was subject to review should further substantial evidence become available.

15. The IOC reviewed Dr Barton's case on 21 March 2002, when it again made no order.

16. On 11 July 2002 the Claimant wrote to Dr Barton in accordance with Rule 6(3) of the General Medical Council Preliminary Proceedings Committee ('PPC') and Professional Conduct Committee (Procedure) Rules 1988, stating that the allegations against her would be referred to the PPC. It was alleged that Dr Barton had inappropriately prescribed drugs – including diamorphine - to five patients: EP, AW, GR, AC and RW.

17. On 29 August 2002, the PPC determined that a charge should be formulated against Dr Barton on the basis of the information received from the Constabulary, and that an enquiry into the charge should be held by the Professional Conduct Committee ('PCC').

18. On 19 September 2002 and 7 October 2004, the IOC again determined that it was not necessary to make an order in relation to Dr Barton's registration.

19. The expert reports of Professor Black, which were prepared in 2008, in respect of 11 patients, demonstrated the alleged incompetencies of Dr Barton, which appear to form a consistent pattern in all cases, especially with regard to:

- over – prescribing, often to the point of overdosing;
- prescribing Controlled Drugs ("CDs") without due care;
- poor prescribing practices
- lack of clinical examinations, especially on admission
- no follow up on test results
- failure to document patient examinations or treatment plans
- no reasoning given for prescribing, especially with regard to syringe pumps
- failure to discuss cases or treatments with senior colleagues and consultants
- incorrect diagnoses on death certificates

20. The Police are not proceeding further with any of the cases. However, in a letter dated 28 April 2008, the Coroner directed that inquests be held into the deaths of 10 patients at GWMH.

21. The IOP first considered Dr Barton's case on 11 July 2008, when the Panel determined that it was necessary to impose an interim order of conditions on Dr Barton's registration for a period of 18 months. The order was reviewed and maintained by the IOP on 22 December 2008.

22. Dr Barton's substantive case was due to be heard before the Fitness to Practise Panel in September 2008. However, that hearing was postponed pending the outcome of the Coroner's inquest into the deaths of 10 patients at GWMH, eight of which formed the subject of the Fitness to Practise Hearing.

23. The inquest was listed for 18 March 2009, and the inquest verdict in relation to three of the 10 cases was that the medication administered was

inappropriate for the condition/symptoms and that its administration had contributed "...more than minimally or negligibly to the death of the deceased".

24. On 1 June 2009, the IOP reviewed and maintained the interim order of conditions upon Dr Barton's registration.

25. Dr Barton's case was considered by the Fitness to Practise Panel on 8 June – 21 August 2009, however, the hearing was adjourned due to insufficient time and will reconvene on 18 – 29 January 2010.

26. The Fitness to Practise Panel did make a determination on findings of fact and made multiple findings that Dr Barton's conduct had been inappropriate, potentially hazardous and/or not in the best interests of her patients. The Panel also concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.

27. At the IOP review hearing on 12 November 2009, the Panel was satisfied that it continued to be necessary for the doctor's registration to remain subject to the following unvaried conditions:-

1. You must notify the GMC promptly of any professional appointment you accept for which registration with the GMC is required and provide the contact details of your employer and the PCT on whose Medical Performers List you are included.

2. You must allow the GMC to exchange information with your employer or any organisation for which you provide medical services.

3. You must inform the GMC of any formal disciplinary proceedings taken against you, from the date of this determination.

4. You must inform the GMC if you apply for medical employment outside the UK.

5. You must not prescribe diamorphine and you must restrict your prescribing of diazepam in line with BNF guidance.

6. You must provide evidence of your compliance with condition number 5 to the GMC prior to any review hearing of this Panel.

7. You must inform the following parties that your registration is subject to the conditions, listed at (1) to (6), above:

- Any organisation or person employing or contracting with you to undertake medical work

- Any locum agency or out-of-hours service you are registered with or apply to be registered with (at the time of application)

- Any prospective employer (at the time of application)

- The PCT in whose Medical Performers List you are included, or seeking inclusion (at the time of application)

- Your Regional Director of Public Health.

28. Given that Dr Barton's Fitness to Practise hearing is due to reconvene on 18 January 2010, the Claimant requires an extension of the interim order of conditions for a period of 6 months to ensure that the order remains in place until the Fitness to Practise matters are resolved.

29. Conclusion

30. This application to extend the order imposed by the IOP that expires on 10 January 2010 is not one that the Claimant undertakes lightly.

31. On 11 July 2008, the IOP considered that it was necessary to impose an interim order of conditions upon Dr Barton's registration, determining that such an order was necessary for the protection of members of the public, in the public interest and in Dr Barton's own interests. On 22 December 2008, and 1 June 2009 those conditions were maintained.

32. At the IOP review hearing on 12 November 2009, the conditions were once again maintained and the Panel determined that an application should be made for an extension of the interim order under Section 41A(6) of the Medical Act 1983, as amended.

33. A period of 6 months is required in order that the public may remain protected during the time that it will take for Dr Barton's Fitness to Practise proceedings to be concluded.

34. The order sought is proportionate to the concerns raised in relation to Dr Barton's professional performance.

I believe the facts stated in this statement are true.

Signed: .....
Lucy Smith

Dated: .....

CO/ /2009

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