40089212

2038

Draft response – Gillian Mackenzie

Our ref: F11/3516/JM

Dear Ms Mackenzie

I refer to your email of 24 March 2011 copied below.

Your request has now been considered in accordance with the Data Protection Act 1998 (DPA).

I am aware that you were notified that the GMC's Preliminary Proceedings Committee decided to refer Dr Barton to the Professional Conduct Committee in September 2002.

At this time the GMC was in possession of papers relating to your mother, Gladys Richards, received from Hampshire Police. These papers specifically included a witness statement from Dr Barton in connection with your mother which was supplied by the police in June 2001.

I hope this clarification is useful to you.

Yours sincerely

Code A
Information Access Officer
Code A

General Medical Council
3 Hardman Street
Manchester
M3 3AW

From: Gillian Mackenzie Code A
Sent: 24 March 2011 08:16
To: Code A
Subject: Jane Barton GMC Investigatoon

Dear Code A
I acknowledge receipt of your e mail of 22 March 2011.
I am not asking for sight of papers - I would just like specific confirmation that when I received confirmation from the GMC in 2002 that there would be a hearing into the death of my mother Gladys Richards you had the relevant papers from Hampshire police and presumably this included a statement from Dr. Jane Barton – I can see no reference to it in the transcript of the GMC hearing nor can I see reference to the statements from the Haslar staff regarding my mother's discharge from Haslar on the 11August 1998 and 17 August 1998 to the Gosport Memorial Hospital. Verbally Haslar staff have stated that my mother was nowhere near death on both occasions. I am aware that at least one statements exists from Field Fisher Waterhouse even if it does not appear in the transcript. From the medical file records I can see that neither the police nor the GMC picked up the fact that the letter from Jane Barton to my mother's GP at Lee on Solent reporting the death gave the date of setting up the syringe driver as

the 20 August 1998 and death on the 21 August 1998. That report would not have raised a query about the length of time between setting up the syringe driver and death whereas a syringe driver set up with the doses of diamorphine etc on the 17 and death on the 21 would – or at least all my contacts in the field of palliative care and hospice settings seem to think it would have raised alarm bells – as would my experience with dying cancer patients. May I have specific answers to my specific questions. Gillian M Mackenzie