P

RED TOP CORRESPONDENCE

STANDARDS AND FITNESS TO PRACTISE DIRECTORATE

Assignee: Neil Marshall / Julian Graves

Section: (CPT) IAT.

Date: 10-02-09

DO Reference:	2009-78	
DO SR:	SR1-239765499.	
OPCE Reference:	276307	
Complaint Reference(s):	Lee Delaw	
Correspondent's Name:	Peter Walsh, AVMA	**UID:**
Doctor(s) concerned:	Dr Jane Barton	**UID:** 1587920
Subject:	- Request for minutes / transcript from IOP hearing of Dr Barton - Concerns over reasons why IOP took place in July '08 when GMC were aware of concerns previously	

Action Required: **Deadline:** 18-02-09

- ☐ **Acknowledge**
- ☑ **Reply direct**
- ☐ **Draft reply for:**
  - ☐ **AD / HoS**
  - ☐ **Director - Paul Philip**
  - ☐ **Chief Executive - Finlay Scott**
  - ☐ **President - Graeme Catto**
- ☐ **Provide Case Summary**

Notes:

Open cases Call CPT - with Code A:

2002/1345/01
2000/2047/02
2002/0941/01

(Closed: 2002/0553/01, 2003/1509/01, 2000/2047/03, 2000/2047/01)

Hearings:

H1-197783948 - IOP July '08
H1-202863465 - IOP Review Dec '08
H1-232476772 - IOP Review May '09
55-900722 - FTP Panel June '09

CC: NM to reply, with PP's approval. IAT to deal with FOI ~~Redacted~~ part + do in 1 response / 2. tbc.

17/02 - Reply sent NM - incorporating info from IAT too.

Code A

From: Code A
Sent: 10 February 2009 14:21
To: Paul Philip Code A
Cc: Christine Couchman Code A ; Sheila Bennett Code A Code A ; Julian Graves Code A
Subject: 00276307 Code A

Attachments: 00276307.pdf

00276307.pdf (36 KB)

Paul

Peter Walsh, AvMA, has sent the attached letter requesting the minutes / transcript from the IOP hearing of Dr Jane Barton on 11 July 2008. He is also seeking information on why the panel only considered it necessary to make interim conditions on Dr Barton in July 2008 to protect the public when concerns regarding Dr Barton where known to the GMC previously.

For FtP.

Thank you.

Code A

Code A
General Medical Council

Code A

avma
action *against* medical accidents

for patient safety and justice

Mr Finlay Scott
Chief Executive
General Medical Council
350 Euston Road
London NW1 3JN

RECEIVED 09 FEB 2009

6 February 2009

Dear Finlay

Dr Jane Barton
No: 1587920

AvMA is providing advice and support to a number of families who lost relatives in the 1990's at Gosport War Memorial Hospital. Some are involved in a forthcoming inquest. Some have lodged concerns with the GMC about the above doctor.

I note that on 11th July 2008 an Interim Orders Panel imposed conditions on Dr Barton's practice in order to protect the public. I would be grateful if you could provide a copy of any minutes or transcript of this meeting of the panel that might exist.

The families and AvMA would like to understand the reasons why it was only considered necessary to consider and make interim conditions in order to protect the public in July 2008, when the concerns about Dr Barton were known to the GMC years previously. Any help you can provide to help us understand this and assure us and the wider public that patients were not put at unnecessary risk in the years between the GMC knowing of the concerns and when it finally decided to make restrictions on Dr Barton's practice would be greatly appreciated.

I would appreciate you giving this your urgent attention.

Yours sincerely

Code A

Peter Walsh
Chief Executive

44 High Street, Croydon, CRo 1YB. | Tel: 020 8688 9555 | Fax: 020 8667 9065 | DX 144267 Croydon 24
Email: admin@avma.org.uk | Web: www.avma.org.uk

Code A

From: Code A
Sent: 10 February 2009 15:56
To: Neil Marshall Code A Julian Graves Code A
Cc: Paul Philip Code A Christine Couchman Code A Peter Swain Code A Code A
Subject: FW: 00276307 Code A

Attachments: 00276307.pdf

Hi Neil / Julian

Please see the attached letter from Peter Walsh of AvMA.

Neil – I've allocated this to you on Siebel: DO SR1-239765499. Please can you draft a reply to go in your name but with Paul's approval before it goes out?

Julian – please can I ask you to deal with the FOI request regarding the minutes / transcripts from the IOP hearing of Dr Barton.

Julian, as we discussed earlier I will speak to Neil to see if he has any preference on whether a joint response is sent or individual ones, and I will inform you accordingly.

Thanks,

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For FtP.

Thank you.

Code A
General Medical Council

Code A

Code A

From: Code A
Sent: 12 February 2009 10:41
To: Neil Marshall Code A ; Julian Graves Code A
Subject: FW: 00276307 Code A

Thanks Neil.

Code A - for your info.

Code A

-----Original Message-----
From: Neil Marshall Code A
Sent: 12 February 2009 10:30
To: Code A
Subject: Re: 00276307 Code A

Code A

I think a single response would be best. I'll put one together over the next few days and will speak to Julian if necessary.

Thanks, Neil

----- Original Message -----
From: Code A
To: Neil Marshall Code A
Sent: Thu Feb 12 10:12:46 2009
Subject: FW: 00276307 Code A

Hi Neil

I was going to have a quick word with you today about this but I see you're in Manchester for the rest of the week.

Would you prefer to send one joint response or two individual responses to Peter Walsh?

Thanks,

Code A

From: Code A
Sent: 10 February 2009 15:56
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Cc: Paul Philip Code A Christine Couchman Code A ; Peter Swain Code A
Code A
Subject: FW: 00276307 Code A

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For FtP.

Thank you.

Code A
General Medical Council
Code A

General
Medical
Council

Regent's Place
350 Euston Road
London NW1 3JN

Telephone: 0845 357 8001
Facsimile: 020 7189 5001
Email: gmc@gmc-uk.org
www.gmc-uk.org

17 February 2009

Mr Peter Walsh
Chief Executive
AvMA
44 High Street
Croydon
CRO 1YB

Dear Peter

Thank you for your letter of 6 February 2009, addressed to Finlay Scott, about the case of Dr Jane Barton. Finlay has asked me to reply on his behalf as the Assistant Director with responsibility for our investigation function. You may recall that we met several times recently at the CHRE's offices, as part of their working group establishing the audit of cases closed before a hearing?

As you may know, GMC Interim Orders Panel (IOP) hearings are held in private, as set down in our statutory rules, unless the doctor requests that their particular hearing is held in public. Dr Barton made no such request and so the hearing was held in private and, accordingly, the transcript and minutes are not publicly available.

Nonetheless, I have looked at your request for a copy of the IOP transcript and minutes relating to this case in accordance with the provisions of the Freedom of Information Act 2000 (FOIA). I consider, however, that an exemption set out in the FOIA applies to the information that you have requested. In accordance with the FOIA this letter acts as a refusal notice in respect of the information you have requested.

The exemption that applies, in my view, is set out at Section 40(2) of the FOIA. This relates to information requested which is about a third party, and the disclosure of which would be in breach of the Principles of the Data Protection Act 1998 (DPA). In this instance we believe that the disclosure of this type of information would breach the First Principle, which requires that the processing of data is fair and lawful.

This exemption is absolute which means that it is not subject to a public interest test (in order to assess if the public interest is greater served by disclosing the information than maintaining the exemption).

You have the right of appeal against this decision. If you wish to appeal please set out in writing your grounds of appeal, and send it to Julian Graves, Information Access Manager, GMC, 5th Floor, St James's Building, 79 Oxford Street, Manchester M1 6FQ. You also have a further right of appeal to the Information Commissioner. If applicable, Mr Graves will provide you with the contact details of the Information Commissioner.

I am sorry to write back in such formal terms, but you will understand that we wished to treat this as an FOIA request and ensure that we provided you with an answer which complies with the requirements of that legislation.

In broader terms, I can understand the questions that the families and AvMA may have about the GMC's decision to restrict Dr Barton's registration only relatively recently (from July 2008), when we have known about the case since July 2000. As you are likely aware, this case has been put to the Interim Orders Committee (IOC), as it was, on a number of occasions before July 2008. In fact, the case went to IOC in July 2000, June 2001, March 2002, September 2002 and October 2004, before being heard by IOP last July. On each of those previous occasions, as you know, no Order was made against the doctor.

Of course, the IOC's decisions were matters for the IOC and I could not go behind those decisions. Discussion of the case will have taken place in camera, amongst the Committee members, with the support of the Legal Assessor. Those discussions will, quite properly, remain confidential. The determinations of the Committee, although open to scrutiny by both the GMC representatives and the doctor's side, remain confidential (as explained above). It is therefore impossible for me to attempt to give detailed reasons for those decisions.

This, I think, does raise a number of issues. What I can tell you is that, on five separate occasions, the GMC's lawyers attempted to persuade the IOC that an Order against Dr Barton was necessary. On none of those occasions was the IOC convinced of the case for an Order to be made. The GMC's investigation function has no right of appeal in such cases. This may change with the advent of the Office of the Healthcare Professions Adjudicator (OHPA) which will take the adjudication function away from the GMC and place it with an independent body (the current Department of Health timetable suggests OHPA will be operational by April 2011, at the earliest).

Whether the IOP (either in current or future form) should be more accountable – for example, by making its determinations public – is an interesting question. As the legislation stands, the reasons for IOP decisions (as expressed in their determinations) are not made public, though any actions taken against a doctor's registration are publicly available. This reflects the fact that the IOP make, exactly, interim decisions. They do not make findings of fact and yet they can take fairly radical action against a doctor (preventing them from practising or from practising unrestricted) assuming that there is cogent reason to *suspect* that a doctor's fitness to practise may be impaired. Clearly, in these circumstances, the IOP's powers – although necessary to ensure public safety - are not to be exercised lightly. Where they do consider a case, there has to be some protection for the doctor (who may, after all, turn out to be entirely innocent of the charges being made against him or her). I believe that this explains why the legislation is as it is and why, for example, the IOP meets in private. There is clearly a very delicate balancing act here between the rights of the doctor and the interests of accountability and openness.

The final point that I would make is that this case appears to have been characterised by additional information becoming available as investigations have proceeded and by a changing picture in terms of the other investigations being carried out outside the GMC. You will be aware of the Police involvement. One of the circumstances which did change

just before we took the case to IOP in July 2008 was that it became apparent that there was to be an Inquest into the deaths of several of the patients. Of course, the formal reasons for the decision to hold an Inquest also became apparent at that time. In addition, I believe it also became clear to us before July 2008 that there were further patients whose deaths were to be investigated. All of which gave us good cause to take the case back to the IOP in order that they could consider making an Order.

I hope that this at least begins to clarify the picture from the GMC's point of view Code A. I would be more than happy to discuss these issues with you in more detail. If you think a meeting might be useful, please let me know. Alternatively, I am available on the direct line number given below if you would prefer to call me to discuss.

Yours sincerely

Code A

Neil Marshall
Assistant Director – Fitness to Practise
Fitness to Practise Directorate
Code A

GENERAL MEDICAL COUNCIL

INTERIM ORDERS PANEL
(Re-referral)

Friday 11 July 2008

Regents Place,
Euston Road,
London NW1 3JN.

Chairman: Mr Manny Devaux

Case of:

BARTON, Jane Ann

Transcript of the shorthand notes of T A Reed & Co
Tel No: 01992 465900

T A REED & CO

GENERAL MEDICAL COUNCIL

INTERIM ORDERS PANEL
(Re-referral)

Friday 11 July 2008

Chairman: Mr Manny Devaux

Panel Members: Dr Eve Miller
Mr John Walsh

Legal Assessor: Mr Nigel Seed QC

CASE OF:

BARTON, Jane Ann

MR STEPHEN BRASSINGTON of counsel, instructed by the GMC Legal Team, appeared on behalf of the Council.

MR TIMOTHY LANGDALE QC of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton who was present.

(Transcript of the shorthand notes of TA Reed & Co
Tel No: 01992 465900)

T A REED & CO

INDEX

THE CHAIRMAN: Good morning Dr Barton and Mr Langdale. This is the Interim Orders Panel sitting on Friday 11 July 2008. Dr Jane Barton is present and is represented by Mr Timothy Langdale QC, instructed by the MDU. Mr Brassington of counsel, instructed by the GMC Legal Team, represents the GMC.

Mrs Barton, I thought your husband was coming. Is he waiting outside? Does he wish to come in?

DR BARTON: That would be lovely.

THE CHAIRMAN: It is your husband and it is your hearing and if you think it would be nice for you I have no problem with that. Mr Brassington, there is no objection?

MR BRASSINGTON: I have no problem with that.

THE CHAIRMAN: Please ask him to come in. He can sit at the back. (Mr Barton entered the room)

Dr Barton, can you confirm for the Panel your full name and your GMC number?

DR BARTON: Dr Jane Ann Barton and my GMC number is 1587920.

THE CHAIRMAN: Thank you very much. I know you have been to the Interim Orders Committee before and I think you probably remember me sitting on one of the Panels, but I will introduce you to this hearing today. This is the Interim Orders Panel – the previous panel was the Interim Orders Committee, which goes back to a little while ago. I am Manny Devaux, the Chairman of the Panel – a lay person. To my right is Nigel Seed QC, who is our Legal Assessor. Mr Seed gives independent legal advice to the Panel. To my left is Christine Challis who is Secretary to the Panel today. The Panel members are, to my right is Dr Eve Miller, who is a medical member, and to my left is John Walsh, who is a lay person. Mr Brassington, for the General Medical Council sits right opposite you and next to him at the far end is the shorthand writer.

In terms of our procedure today I will invite Mr Brassington to address the Panel on the matters that we have to consider, bearing in mind that this is an Interim Orders Panel. Thereafter there might be questions for him for clarification. Then we will move on to Mr Langdale, who will address the Panel on your behalf as obviously he is here to represent you today. If there is a matter you wish to raise for him quietly you can either write it down for him or his solicitor; and again we might have questions for him at the end of his presentation. Then we will go into private session following the advice of the Legal Assessor and then we will call you back.

To make sure we have the same papers, Mr Langdale and Mr Brassington. We have the bundle and then there is one addendum which is an employer details form and also a letter from Dr Barton saying that she will be here today.

MR BRASSINGTON: That is all the papers that we have.

THE CHAIRMAN: In that case we can move on. Can I make it clear before we start that we have had this bundle for a little while; we have read all the papers in advance and I know something of the background of the case because I was involved before a little while ago. Having said that, this is a new hearing but we have read all the papers.

MR BRASSINGTON: Sir, this is a re-referral of Dr Barton's case to the Interim Orders Panel and it is the first time she has appeared before it but has previously appeared before the Interim Orders Committee, as you say, on four previous occasions. Firstly, on 21 June 2001 when no order was made; on 21 March 2002 when no order was made; 19 September 2002, again no order; and 7 October 2004 is the most recent appearance – again no order was made.

Either the transcripts or partial transcripts are available in the bundle that you have, which I know that you have read and in due course I will make reference to them if I may.

The matter has been referred to the Interim Orders Panel because there is fresh material, say the GMC, available to you that was unavailable to previous Committees who considered the imposition of an interim order. It being the first appearance before the IOP and there being a slightly different test to that which was applied in the IOC can I begin, for the benefit of the doctor, by reading out the test that we say applies to your deliberations today. It is this: that if you are satisfied in all the circumstances that there may be impairment of the doctor's fitness to practise which poses a real risk to members of the public, or which may adversely affect the public interest or indeed the interests of the doctor; and that after balancing the interests of the doctor as against the interests of the public if you consider that an interim order is necessary to guard against any risk that you have identified, then you will move on to make the appropriate and proportionate interim order in all the circumstances of the case.

The bundles contain, as I say, the transcripts and that will give you an understanding of the material that was previously available to the Interim Orders Committee.

On 27 July 2000 the Hampshire Constabulary wrote to the GMC in a letter which you see at page 1 of your bundle, indicating that they were conducting an investigation into the death of a patient, GR, at the Gosport War Memorial Hospital, in August 2998. Dr Barton at that stage was thought to have been the doctor responsible primarily for the care of Patient GR.

Pausing there for a moment, I should have mentioned at the outset that my learned friend Mr Langdale has invited me to allow him during the course of my opening to draw your attention to any part of a document that I have not drawn to your attention in the course of my opening, to save time; and I am quite content that that be done as we go along. So if Mr Langdale speaks it is with the consent of all the parties.

MR LANGDALE: Sir, I am grateful for that. I think it may save time so that the Panel does not have to hear the facts twice.

THE CHAIRMAN: If that is the procedure I am happy with that. As I say, it is an Interim Orders Panel and not a full fitness to practise hearing.

MR BRASSINGTON: At that time in 1998 Dr Barton was a general practitioner practising in Gosport. She was additionally engaged as a visiting clinical assistant at the Gosport Hospital, employed by the Portsmouth Healthcare NHS Trust.

(1) As I say, on 21 June 2001 Dr Barton was referred to the Interim Orders Committee and at that time the only case before the Panel was that of the investigation into the alleged unlawful death of GR. The transcript for that hearing appears in your bundle at pages 4 through to 10. It was made clear to that Committee that there had already been one police investigation into the death of GR, which had concluded with the Gosport CID submitting their evidence to the Crown Prosecution Service who had decided that no criminal proceedings should follow. NO ORDER

Subsequently a complaint was made by the family of GR as to the quality of the original police investigation and following that complaint a decision was taken to reinvestigate.

On 14 August 2001 – we see at page 14 of the bundle – Hampshire Police wrote to inform the GMC that whilst a decision had been taken that there was insufficient evidence to support a viable prosecution against Dr Barton in respect of GR there had been concerns expressed by other families of patients who had died at Gosport, and preliminary inquiries were being made as to whether a more intensive police investigation should commence into the care given by Dr Barton to patients at that hospital.

On 6 February 2002 the GMC were told in a letter at page 16 that expert advice had been sought regarding the deaths of four further patients at the Gosport Hospital, but following review of that information no further police investigation at that stage was thought appropriate. However, the reports did raise, said the police, serious concerns over the standard of clinical care of patients, particularly given by Dr Barton, which raised concern as to her professional conduct. There was disclosure by the police of the reports that had been prepared.

(2) On 21 March 2002 following receipt of that letter and that information, the GMC referred the case again to the Interim Orders Committee on the basis of the new material that had been provided. You have in your bundle only a partial transcript of the hearing that took place in March 2002 and indeed that was submitted by the doctor as part of her response to the appearance of her case before the Preliminary Proceedings Committee. Nevertheless, you do have evidence give by Dr Barton on that occasion and it runs from page 32 through to page 50. It covers her evidence and the submissions made by my learned friend Mr Jenkins, who appeared on her behalf on that occasion.

Again, on the basis of the material presented to the Committee they were not satisfied that it was necessary in the circumstances to impose an order and no order was made. 11

On 11 July 2002 Dr Barton was notified by the General Medical Council that they had determined to refer her case to the Preliminary Proceedings Committee to determine

whether or not the case should be referred onwards to the Professional Conduct Committee, and you see a copy of the letter notifying her of that at page 19 of your bundle. The matters referred to the PPC were the five patients that had been identified and investigated at that stage by the Hampshire Constabulary. The allegations relate to Patient EP, Patient AW, Patient GR, Patient AC and Patient RW. The patients were all inpatients at the Gosport Hospital between February 1998 and October 1998, and without taking you through the allegations in any detail they assert, amongst other things, inappropriate and unprofessional prescribing of opiates and other sedative drugs by Dr Barton, in the knowledge that the amounts and combinations of drugs prescribed were excessive and potentially hazardous, and the doctor's management of the patients was unprofessional in that she paid insufficient regard to their rehabilitation needs.

As I said, Dr Barton provided fairly detailed written representations to the PPC in a letter that appears in your bundle at pages 23 to 31, together with a transcript of her evidence and the submissions of Mr Jenkins. In essence, what the doctor was asserting at that stage was that she was overworked and under-supported; that she was covering many patients without appropriate consultant cover, but that she was doing so within a well established nursing team with whom she had a good working relationship. For reasons of expediency she neglected her note taking, stretched as she was. Similarly, she adopted a policy of proactively prescribing – giving nurses in effect a degree of discretion in administering opiates and sedatives within a range of doses of medication.

The doctor moved on in her letter to give more detailed comments on each of the five patients that had been referred to the PPC, but I do not propose, unless invited, to take you through each of those patients and the comments that she made; I am satisfied that you have read this bundle carefully.

On 29 August 2002 you will see at page 51 of your bundle that the PPC determined, having heard evidence or considered the written evidence in the case, that a charge should be formulated against the doctor on the basis of the information that had been provided. They set out in that letter at page 51, dated 12 September 2002, the reasons why they determined it was appropriate to formulate a charge for referral, which were, amongst other things, that there was evidence of an apparently reckless and inappropriate prescribing of the drugs by Dr Barton, appearing to precipitate if not cause death and that patients were being commenced too rapidly on to terminal care drug regimes or being rapidly prescribed excessive doses of those drugs.

As a result of the referral by the PPC to the PCC the matter was again re-referred to the Interim Orders Committee. A transcript of that hearing appears in your bundle at page 53 through to 70, Ms Horlick appearing on behalf of the General Medical Council and Mr Jenkins appearing on behalf of Dr Barton. At that hearing of the Interim Orders Committee it was argued by Mr Jenkins that there was in truth no new material before the Interim Orders Committee which would entitle it to reconsider the necessity for an order. The only possible change that was alluded to by Ms Horlick was that the Crown Prosecution Service were reconsidering the decision to take no further action, and she makes reference to that at page 54 paragraph F.

(3)

19/9/02

A It was observed later by the Chairperson of the Panel, Mrs Macpherson, that there was in fact no material before the Panel which spoke to that suggestion that the CPS may be considering the position, and that is dealt with at page 66 of your bundle at paragraph C.

The Panel considered, having heard from Mr Jenkins and Ms Horlick, that there was indeed no new material available to it and accordingly did not go on to consider
B whether it was necessary to make an order in the case.

On 30 September 2004 Detective Chief Superintendent Watts, who was the head of the Hampshire CID, wrote a statement setting out the history of what is described as Operation Rochester, and that appears in your bundle at page 71 onwards. It reviews the progress and evolution of the criminal investigation and at pages 73 to 75 sets out
C that an expert team, comprising various different healthcare experts, was engaged to conduct reviews and to categorise some 88 patients from Gosport who had been administered opiates prescribed or authorised by Dr Barton. There was categorisation into three different categories, set out at pages 73 and 74 and I do not need to take you through it – you have read it.

The police at that stage were unwilling – for good reason, you might think – to
D disclose the entirety of the material that they held in relation to Operation Rochester for fear of prejudicing their inquiry, and the statement of the Chief Superintendant goes into some detail as to the reasons why not all of the available material was being provided to the GMC, and that is dealt with at page 76 of the bundle. However, the Chief Superintendant was cognisant of the primacy of public protection and made reference to a voluntary agreement that had been entered into between the doctor and the Fareham and Gosport Heath Care Trust, from apparently October 2002, and
E reference is made to that at page 78 of the bundle.

The doctor had undertaken not to prescribe benzodiazepines or opiate analgesics from 1 October 2002:

> "All patients ongoing requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their care would not be compromised.
>
> F
>
> Dr Barton will not accept any house visits if there is a possible need for such drugs to be prescribed. Problems may arise with her work for Health-call as a prescription may be required for a 14-day supply of benzodiazepines for bereavement. Dr Barton also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patient's notes."

G There is some reference then to the prescription by Dr Barton of diazepam to relatives of deceased patients.

There is then an update provided by the Chief Superintendant as to the five cases that were of particular concern to the GMC and that had been previously considered by the Interim Orders Committee in September 2002. AC had been assessed as a category 3 case and was being investigated accordingly – category 3 being the most serious in
H

terms of the case against Dr Barton, as was Patient RW. GR, the original complaint, was assessed as a category 2 case by the clinical team:

> "This assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004."

Patient AW, no further police action was to be taken in respect of this particular patient, the medical records not being sufficient to enable an assessment. The Chief Superintendant then makes emphasis on two key points:

> "There is no admissible evidence at this time of criminal culpability in respect of any individual."

And that the information adduced by the investigation and the findings so far justifies the ongoing operation and its use of resources.

(4) The matter in consequence of that statement being received was referred back to the Interim Orders Committee for the fourth time, which sat on 7 October 2004. The reasons obviously are clear. It had come to the GMC's attention that there was a much more wide-ranging investigation being conducted by the Hampshire Constabulary into many more patients than had previously been considered by the General Medical Council.

The Interim Orders Committee on 7 October 2004 – the transcript is at page 80 – considered those five patients that had previously been considered in September. There appears in the transcript to be passing reference – and I emphasises the "passing reference" to six further patients. Passing reference because Mr Henderson, Queen's Counsel, who appeared for the General Medical Council on that occasion, at page 105 of your bundle, introduces those patients and says that in truth little weight should be attached to the reports and the material surrounding them, some of the material having been received recently and some of its provenance being uncertain; and he invited the Committee to have little regard to that evidence.

So when the Interim Orders Committee sat in October 2004 in truth what they were looking at was pretty much the same picture as that which they looked at in September 2002. The expert reports in relation to the other patients were not relied upon to any great extent and the export reports dealt mainly with the five original patients.

That position is borne out by the submissions made by my learned friend Code A on that occasion who appeared for Dr Barton, because in his submissions he said that there was nothing new before the Interim Orders Committee over and beyond that which they had considered in September 2002. Beyond the fact that there was an ongoing police investigation which had been prayed in aid by my learned friend Mr Henderson and Code A said of that, "That amounts to nothing new, there has been a longstanding ongoing police investigation of this case in any event."

A The determination of the Interim Orders Committee, which is set out in your bundle at page 118 was that there was no need for an interim order; the Panel were not satisfied that it was necessary in all the circumstances of the case.

What has passed since that Interim Orders Committee in 2004? A great deal and you are not provided with all of the material which is in the possession of the General Medical Council in relation to the proposed fitness to practise hearing, which was B listed for September of this year. Can I take you through some of the documentation that is in your bundle? You have at page 119 what is termed an investigation overview between 1998 and 2006, a document which has been prepared by a Detective Superintendant Williams from the Hampshire Constabulary. It is a useful document; it gives a helpful guide to the history of the case and goes into a little more detail than I have done in rehearsing the history. It develops the categorisation of the different cases which occurred during the investigation, and on page 125 it tells you C that in fact 92 cases were investigated, and at the foot of page 125 records that 78 of those cases failed to meet the threshold of negligence required to conduct a full criminal investigation, and accordingly were referred to the General Medical Council and the Nursing & Midwifery Council for their information and attention.

Fourteen category three cases – the most serious – were therefore referred for further investigation by the police.

D

> "Of those 14 cases four presented as matters that although potentially negligent in terms of standard of care were causes where the cause of death was assessed as entirely natural. Under the circumstances the essential element of causation could never be proven to sustain a criminal prosecution for homicide.
>
> E Notwithstanding that the four cases could not be prosecuted through the criminal court they were reviewed from an evidential perspective by an expert consultant geriatrician Professor Black, who confirmed that the patients were in terminal end stage of life and that in his opinion death was through natural causes.
>
> Accordingly the four cases were released from the police investigation in F 2006."

Those were patients CH, TJ, EC and NW.

> "The final ten cases were subjected to full criminal investigation upon the basis that they had been assessed by the key clinical team as cases of 'negligent care that is today outside the bounds of acceptable clinical practice, G and cause of death unclear.'"

You are then given some indication of who it is that looked at the particular cases. On page 127 you learn that Dr Barton was interviewed under caution in respect of those allegations and the interviews were conducted in two phases – at the initial phase designed, it says, to obtain an account from Dr Barton in respect of care delivered to individual patients.

H

> "Dr Barton responded during these interviews through provision of prepared statements and exercising her right of silence in respect of questions asked.
>
> During the second interview challenge phase (following the provision of expert witness reports to the investigation team) Dr Barton exercised her right of silence and declined to answer questions."

The ten category three cases that were investigated by the police are set out on page 128 to page 129.

Page 130 records:

> "There was however little consensus between the two principal experts Doctors Black and Wilcock as to whether the category 3 patients were in irreversible end stage terminal decline, and little consensus as to whether negligence more than minimally contributed towards the patient death."

The opinion of Treasury Counsel was sought and that opinion was considered by the Crown Prosecution Service and in December 2006, having regard to the overall expert evidence, it was determined that it could not be proved that doctors were negligent to the criminal standard.

> "Whilst the medical evidence obtained by police was detailed and complex it did not prove that drugs contributed substantially towards death.
>
> Even if causation could be proved there was not sufficient evidence to prove that the conduct of doctors was so bad as to be a crime and there was no realistic prospect of conviction."

That summary from Mr Williams is dated 16 January 2007.

Nevertheless the General Medical Council then commenced or continued its investigation into the professional misconduct alleged against Dr Barton and in March 2008 the General Medical Council served its draft notice of hearing, which you will find at page 133. Accompanying that draft notice of hearing were the expert reports that had been prepared by the now Professor Black in relation to each of the individual patients.

The allegations run from page 133 through to page 146. There is an additional set of allegations relating to a further patient which appear in the bundle at page 265, Patient L, and it is much in the same form as those that appear at page 133. Again, I hope not inappropriately, I summarise what the allegations amount to, and it is this: inappropriate and potentially hazardous prescribing by Dr Barton of opium and sedatives together with poor record keeping by her of those prescriptions and of the clinical care offered to those 12 patients.

The expert reports prepared by Professor Black, which appear in an unsigned form in your bundle, but of which I have received signed copies – and my learned friend is aware of that – begin in your bundle at page 147 and individual reports are provided for each of the different patients that are the subject of the notice of hearing. I do not

propose to take you in any great detail through those reports – I am sure that you have read them carefully – and I remind myself that this is not a fact finding Panel.

The opinions of Professor Black are set out at the end of those reports. You will see from having read them that there is a table within each which describes the medication that was dispensed or prescribed for these patients, and Dr Barton is the principal prescriber of the opiates and sedatives that were administered to these 12 patients. Professor Black has engaged in an exercise of looking at whether the standard of care afforded to the patient in the days leading up to their deaths was in keeping with the acceptable standard of the day, and if the care was found to be sub-optimal what treatment should normally have been preferred in that case.

Of particular importance for your consideration today, you might think, are the opinions expressed. Can I take you to the first of those opinions at page 154? There is a short rehearsal by Professor Black of the patient's history and then he indicates where it is appropriate in his judgment that there were significant failings in the medical care provided to each patient. In relation to the first, Mr P:

> "The failure to undertake a physical examination of the patient on admission to the medical ward at Gosport, or if it was undertaken a failure to record it in the notes.
>
> The prescription of a high dose of diamorphine, 40 to 80 milligrams by Dr Barton on the PRN part of the drug chart on admission, without explanation.
>
> The failure to document a detailed assessment of his pain and distress in the notes prior to starting regular opioid treatment.
>
> The use of approximately three times the usual expected daily does of diamorphine when starting the syringe driver, together with a dose of 60 milligrams of Midazolam, without any explanation in the notes, in my view negligent clinical practice."

He goes on then to describe deficiencies in the use of the drug chart at the Gosport War Memorial Hospital, over the page. So it follows in each of the reports that you have a similar pattern.

Can I invite you when you retire to consider each of those opinions, unless the Panel wish me to read through each of them now? I am in your hands. It would seem a laborious exercise for me to undertake. Can I, if that finds favour, invite you to go to page 219, which is the report provided in relation to the patient RW. The drugs prescribed and administered are set out in tabular form at page 224 of the bundle and over the page to 225. It records at 4.6 that:

> "He is transferred on 14 October for ongoing assessment, possible rehabilitation and decisions about long-term care arrangements. No examination has been recorded on admission by the medical staff. Not even a basic clinical examination has been undertaken or, if it has, was not recorded."

A Over the page at 4.8:

> "The decision to give morphine on 14 and then the regular morphine, at this dose, on 15 October is crucial to the understanding of this case."

This was a patient who had a long history of alcohol abuse.

B

> "'The effects of hepatitis or cirrhosis on drug deposition range from impaired to increased drug clearance in an unpredictable fashion ... the oral availability for high first class drugs such as morphine ... is almost double in patients with cirrhosis compared to those with normal liver function. Therefore the size of the oral dose of such drugs should be reduced in this setting.'"

Professor Black says:

C

> "In my view the decision to give the significant doses of morphine on 14 then the regular high oral doses of strong opiates on 15 was negligent. The appropriate use of weaker analgesics had not been used, though these had apparently controlled his symptoms the previous week in the Queen Alexandra Hospital as he had not received strong opioid analgesia after 5 October. The dose of morphine used, particularly in the presence of severe liver disease, was very likely to have serious implications."

D

There is criticism in 4.9 of a failure by Dr Barton to seek senior medical opinion in relation to this patient when seen on 15 October.

On the afternoon of 16 Patient RW was started on a syringe driver. Although prescribed by Dr Barton there is nothing in the notes to document that the decision to start is a medical or nursing decision.

E

4.11:

> "In my view the regular prescription and dosage of Oramorphine was unnecessary and inappropriate on 14 and 15 October and in a patient with serious hepatocellular dysfunction was likely the major cause of the deterioration, in particular in mental stage, on 15 and 16 October. In my view it is beyond reasonable doubt that these actions more than minimally contributed to the death of RW."

F

Then the opinions of Professor Black are expressed at paragraph 5.1, 5.2 and 5.3.

Can I take you to the summary of conclusions in relation to Patient ES, which begins at page 231? Again you will see that there are prescriptions given by Dr Barton on page 234, set out for you in tabular form.

G

Paragraph 4.4:

> "The problem documented in Gosport on the point of admission is continued pain, this is difficult to reconcile with the one page summary ..."

H

– from the hospital from which the patient was transferred:

> "... which says that Mrs S is purely on intermittent Paracetamol."

From intermittent Paracetamol you can see the range of opiates and sedatives that were prescribed to her by Dr Barton, all on page 234.

Paragraph 2.12 on page 237:

> "In my view the dose of diamorphine used on 11th was inappropriately high. However, I cannot satisfy myself to the standard of 'beyond reasonable doubt' that this had the definite effect of shortening her life in more than a minor fashion of a few hours. I understand the cause of death on the death certificate was Cerebrovascular Accident. There is nothing in the medical notes to substantiate this diagnosis which is misleading and probably inaccurate."

The doctor does not face any allegations in relation to the final part of that paragraph but she does in relation to the inappropriate use of diamorphine. I am bound to read that paragraph out to you to illustrate that the judgment of Professor Black was that he could not be satisfied beyond a reasonable doubt, and no doubt that is the type of opinion evidence that has influenced the decision by the police not to prosecute this matter criminally; but it does not preclude the General Medical Council, we say, from having regard to the inappropriateness of the high doses of morphine and diamorphine that were being prescribed to this patient in particular and to others.

THE LEGAL ASSESSOR: It might give rise, though, at the substantive hearing to an abuse argument, might it not, that the police conclusion came shortly before the standard of proof was changed by the General Medical Council; it is now different, of course, since April of this year. Mr Langdale will no doubt be keeping his powder dry, but I would have thought there is a ready made abuse argument here.

MR BRASSINGTON: I will not ask him to develop it today and it may be that it is not something that is contentious – I know not. The reason that I raise it is that it is one thing to say, "I cannot be satisfied beyond a reasonable doubt that it hastened death", which is entirely different from him saying it was inappropriately high; and that is the distinction I am drawing between the criminal allegations and what the General Medical Council are going to be examining. The General Medical Council are not going to be litigating whether or not this amounted to negligent manslaughter because that matter has been determined elsewhere.

THE LEGAL ASSESSOR: The Panel today has to bear in mind that they are not adjudicating on facts and finding facts proved, but they obviously will bear in mind that there presumably will be expert evidence to the contrary at the trial of this matter, and they must not today form any conclusions about Professor Black's opinion.

MR BRASSINGTON: I quite agree and I was not seeking to do that; I was just simply seeking to draw the distinction between what are criminal charges and what are matters of professional regulation, and I think that that paragraph well illustrates it and that is why I draw your attention to it.

A The opinion of Professor Black in relation to ES is set out at paragraph 5.2 and third amongst those points is the prescription on admission without explanation of strong opioid analgesia, when apparently the patient had only needed Paracetamol at the previous hospital. There is again failure to document the reason for starting the syringe failure; failure to explain in the notes the decision to start with 80 mgs of diamorphine; and the failure to explain the decision to increase the dose of Midazolam at the same time as the diamorphine was reduced on 12 April.

B The next summary of conclusions to which I invite your attention is that for Patient GP, which begins on page 240 of your bundle, sir. Again, it is in very similar form; there is a table on pages 243 and 244. Page 245 at 4.8:

> "Despite this there is an important decision to be made on 26 August. Whatever the cause, Dr Barton identifies that the patient is seriously ill and the
C acute problems, whether a G.I. bleed or a myocardial infarction would not be appropriately managed in a community hospital.
>
> Dr Barton makes the decision that the patient is too ill for transfer and should be managed symptomatically only at Gosport. In my view this is a complex and serious decision that should be discussed with the consultant in charge of the case as well as with the patient and their family if possible. I can find no
D evidence of such a discussion in the notes. It is my view, however, that in view of his other problems it is within the bounds of a reasonable clinical decision to provide symptomatic care only at this stage. The chances of surviving any level of treatment, including intensive care unit and surgery were very small indeed.
>
> Mr P deteriorates further in the evening and is prescribed a single dose of
E diamorphine as a result of a verbal request."

And reference is made to the drug chart and identification of the prescriptions therein.

There is again reference to the misleading and inaccurate death certificate.

F Opinion at 5.2:

> "The failure of Dr Barton on 26 August to undertake investigation to exclude the first diagnosis made and the failure to review the investigation that was undertaken, the full blood count."

G The failure, on page 248, to ask senior medical opinion at the time of a complex and serious medical decision on 26 August; the failure to document any reason for both starting regular opioid medication and possible high starting dose of Oramorphine on 27 August; the failure to document any reason to start the syringe driver on 30 August and whether that was a medical or nursing decision. There is then reference to deficiencies in relation to the drug chart, with which I need not trouble you.

Unless invited to by either my learned friend or by you I am not going to go, as I say, through the rest of the opinions; I am sure that you will read them carefully.
H

Those expert reports are before an Interim Orders Panel or Committee for the first time, and we say that it is new material which is significant, and to which you, in determining whether it is necessary to make an order today, should have particular regard, together with the fact that there are now no longer simply five patients being considered by the General Medical Council but 12, which you have read about in the notice of allegations provided.

This case has a long history. It was due to be heard before a Fitness to Practise Panel applying the PCC Rules in September of this year. However, matters were effectively taken out of the GMC's hands when on 28 April 2008 David Horsley, Her Majesty's Coroner for Portsmouth and South East Hampshire, wrote to Field Fisher Waterhouse, the external solicitors dealing with this case, to indicate that it was the intention of the coroner to hold an inquest into the deaths of ten people who died at the Gosport War Memorial Hospital. This is at page 261, sir. Eight of the patients that are being considered by the coroner overlap with the patients being considered by the GMC, and in those circumstances you may well think that it was appropriate, as happened, for the General Medical Council to postpone the hearing of the Fitness to Practise Panel for it was said that the likely timing of any inquest would be in autumn of this year and so potentially would have overlapped with the Fitness to Practise Panel hearing.

On 20 June 2008 the GMC wrote to Dr Barton's solicitors indicating postponement of the PCC hearing, which had been scheduled for 8 September. Dr Barton in subsequent correspondence accepted that this postponement was inevitable and necessary because of the overlap of issues. I should have said to you as well, sir, that the report from Professor Black in relation to the final patient that is the subject of allegations is at page 267 of your bundle.

So that is where matters rest currently. There is now no fixed date for a fitness to practise hearing to take place in relation to these allegations and the coroner's inquest is due to take place at some time this autumn.

The submission that I make on behalf of the General Medical Council is that in accordance with Section 41A of the Medical Act 1983, as amended, for protection of patients, in the public interest and in the doctor's own interests an interim order of conditions should be imposed upon the doctor's registration. You can be satisfied, we say, that there may be an impairment of the doctor's fitness to practise which poses a real risk to members of the public, which may adversely affect the public interest or indeed the interests of the doctor herself.

Any response to material such as this, if there is to be a response, must be a proportionate one and when considering whether the imposition of conditions would be a proportionate response I am bound to observe that Dr Barton appears, at some stage in 2002, to have entered into a voluntarily arrangement with her Primary Care Trust that she not prescribe opiates or benzodiazepines, and you will recall reference being made to that in the statement of the police officer Williams.

It appears that, having entered into such a voluntarily arrangement, the doctor was well able to continue practising her trade. It did not place such restriction upon her

A that she was not able to continue in practice, and that is important, in my respectful submission.

I pose this question rhetorically to the Panel: in the circumstances of this case, given that there are 12 patients to be considered by a Fitness to Practise Panel about whom there are serious concerns as to the appropriateness of the prescribing of this doctor of opiates and sedatives; that there is a coroner's inquest scheduled to take place in
B relation to ten patients surrounding their care and the reasons for their death, I ask rhetorically what confidence can the public have in the medical profession or indeed in the body that is tasked to regulate it, that if knowing that those proceedings are ongoing she is permitted to continue prescribing such drugs? The answer, I respectfully suggest, would be none. Confidence and trust in the profession would be undermined and the credibility of the regulatory body would be in question,
C particularly when the public understand that this is a neutral act and that this neutral act would not prevent the doctor practising medicine, as the voluntarily undertakings previously did not. In truth there would be no hardship placed upon Dr Barton, but there would be protection of patients; there would be maintenance of confidence in the profession, and in those circumstances, sir, despite the passage of time, despite the failure of any criminal allegations to crystallise, these are serious matters and these grave allegations require action from the GMC to prevent an undermining of the justified faith and trust the public place in its profession and its regulator.

D

Unless I can assist you further, sir, those are the submissions that I make.

THE CHAIRMAN: Thank you, Mr Brassington. I now ask Panel members whether they have any questions for you for clarification. Mr John Walsh is a member of the Panel.

E MR WALSH: It may be that we will be told this in due course but are you aware of the current status of those undertakings with the hospital?

MR BRASSINGTON: No.

MR LANGDALE: I will be able to assist.

F THE CHAIRMAN: Dr Eve Miller is a medical member of the Panel.

DR MILLER: Just for clarification, were all the patients you have asked us to consider inpatients at this particular hospital?

MR BRASSINGTON: To the best of my understanding yes, but if I am wrong I welcome correction.

G

MR LANGDALE: They were.

DR MILLER: Does the GMC have any other complaints about the rest of Dr Barton's practice?

H

MR BRASSINGTON: As I understand it the matters that are to be heard by a Fitness to Practise Panel are those that have been reduced into the draft notice of hearing and its addenda.

THE CHAIRMAN: Mr Brassington, you suggest that the Panel needs to consider the issue of conditions. Do you have any instructions as to what those conditions should be? It is obviously for the Panel to decide but do you have any instructions?

MR BRASSINGTON: The instructions that I have in relation to this are that the conditions should mirror those which the doctor previously gave as undertakings. Of course there would be the necessity for other notification conditions in relation to her practice familiar to this Panel and drawn from the Conditions Bank, upon which I do not need to address you. Really the substance of it comes from the statement provided by the Chief Superintendant at page 78..

THE CHAIRMAN: We have no further questions for you, thank you. Mr Langdale, over to you.

MR LANGDALE: Sir, I do not mean to in any sense sound flippant, but Dr Barton could be forgiven for saying to herself, "Here we go again." It is remarkable – I hope I am not putting it too highly – that when exactly the same issues are brought before this Panel – as it now is, as opposed to the Committee – that no reason has been given as to why any change of circumstances should make the slightest difference to what the Interim Orders Committee found in 2004, in other words that there was no need to impose any kind of order with any kind of conditions.

All that is now being said is that there is a difference between the situation that pertained in October 2004 and the situation that pertains now in 2008, the difference being, in effect, there are now more allegations in the sense that there are now more patients, and that there is a further expert's report. My submission to the Panel is that when one looks at everything that has been presented in this case, and the history, that there is no reason supplied as to why that technical difference – an increase in the number of patients and a further expert's report – should have any bearing whatsoever on Dr Barton's fitness to practise in the interim period before the hearing. It is all very well to assert that the numbers are different, but it will not do to simply suggest that without giving any reason as to why that affects the position, bearing in mind that this Panel will not make a judgment about this case which is in any way different to the Interim Orders Committee, unless there is some real significant evidence of a change in circumstances which goes to the issue in this case as to whether any conditions should be imposed. In brief – although I shall say a little bit more, I hope at not too great length – in essence the reality is that the real change, compared to what the situation was in October 2004, is that there are no longer any criminal allegations hanging over Dr Barton's head. The police investigation, having been carried out over a long period of time, has found that there is no basis for bringing criminal allegations – that is something that is different and, if I may put it this way, in the doctor's favour compared to the situation in October 2004.

Secondly, another real and meaningful change from what the position was in 2004 is that Dr Barton has had a further four years of practice without blemish or criticism. That is a real change and a real difference and, in my respectful submission,

reinforces the fact that there is no proper basis for this Panel seeking to impose any conditions after four previous referral hearings and the distance of time, the lapse of time that has occurred since the last allegation or criticism that is made relates to 1999. It is now getting on for ten years since there has been any criticism of any of the conduct of Dr Barton.

That is why I say that this is an unusual referral.

In terms of the expert evidence there is absolutely no difference – leave aside wording and particular features which may be slightly different – with regard to the opinion of Professor Black to the opinions expressed one way or the other by five experts whose evidence was in existence and available to the Interim Orders Committee in October 2004. Professor Black is not saying anything different to what was the allegation against Dr Barton in terms of expert criticism in relation to the five patients who form the original – if I use the word "collection" I do not mean that disrespectfully – collection of patients considered by the Interim Orders Committee in October 2004. If any confirmation of that is needed this Panel need only refer to the transcript detail of the hearing in October 2004 when Mr Roger Henderson, appearing for the General Medical Council, set out in detail what the medical opinions were of various experts – it was not just one – with regard to those five patients. One can take it that my point is a proper one and it has some force because my learned friend, Mr Brassington, has not sought to suggest to you – quite properly – that Professor Black is saying anything essentially different by way of criticism about Dr Barton than what had already been said by way of criticism with regard to the initial five patients.

Furthermore, if one looks at the nature of the charges that were proposed to be brought in respect of the initial five patients, which are in your bundle at page 19, if you look at those it is immediately apparent that the essence of the nature of those charges is exactly – and when I say "exactly the same" not word for word but for material purposes – the same as the nature of the charges which are to be brought against Dr Barton in the forthcoming hearing. So there is not actually any difference, save for an increase in numbers and the fact that there is a different expert being called in to assist the General Medical Council at the hearing.

Again, if I can stress this – and I am sorry if I am repeating myself but it does seem to be rather important – not one word has been said as to why these differences, the extra number of patients and the fact that there is a different medical expert being used – make any difference to Dr Barton's position with regard to whether any conditions should be imposed upon her. There would have to be, I suppose, both in logic and in fairness some different reason applying after October 2004 for this referral to make any sense at all. As I say, we have not heard one thing advanced as to why it makes any difference and the Committee in October 2004 considered the matter in considerable detail, it is evident from the transcripts; and it is evident from all the background material that has been cited to you by my learned friend. They considered it in great detail – all the allegations were the same. When my learned friend Mr Henderson appeared for the Council he was saying that conditions should be imposed because a voluntarily arrangement was not going to be binding. Exactly the same arguments were applied as to why that should be required. He did not – and this is not a criticism really, but I cannot resist saying it – resort to rhetorical flourishes in terms of asking rhetorically what the public think if this, that and the

A other was the case. The Committee in October 2004 made it very clear what they thought; they did not feel that public confidence would be damaged with regard to its view of the profession by the fact that there was no need to impose any kind of conditions.

The Panel will obviously be looking at the history – and I am not going to repeat it because it has been gone into in some detail and you have it all before you. I would B like to stress this – because the situation has to be looked at very much in tandem with what was before the Committee in October 2004 – that the Committee in 2004 was well aware that there were question marks or concerns about a very large number of patients additional to the five who at that stage formed the basis for the charges. There were 88 cases that the police had been looking into.

It is also worthwhile pointing out that mention was made more than once by counsel C appearing on behalf of the Council to the scope of matters relating to what had happened at the Gosport War Memorial Hospital. Just by way of illustration can I draw your attention to the bundle page 81? This is just to illustrate the point. If you look on page 81 at C – just between C and D Mr Henderson said – referring to the state of Detective Chief Superintendant Watts:

> D "The statement shows the scale of the police concern on top of the reference which has already been made to the Preliminary Proceedings Committee to the Professional Conduct Committee of the Council for enquiry into certain matters ..."

So the Committee then were well aware that it might well not just be five cases that were involved in this case. The critical thing perhaps to bear in mind is that when the Committee was then considering should they impose any conditions or not they were E well aware that it was not just five people about whom concerns were raised. It is now being suggested that this Panel should impose conditions because a further, comparatively speaking, handful of patients have now formed the subject of charges against Dr Barton – it is now 12 not five.

Similarly, if you look briefly at page 101 of the bundle at B:

> F "An investigation surrounding the deaths of 88 patients occurring principally during the late 1990s at Gosport War Memorial Hospital. This investigation followed allegations that during the 1990s elderly pats at Gosport War Memorial received suboptimal or substandard care, in particular with regard to inappropriate drug regimes and as a result their deaths were hastened."

At page 105 of the same bundle Mr Henderson made reference, at C, to the piles of G documents that concerned the cases. So all of that goes to show – and any other detail which this Panel may find relevant – is that the Committee in 2004 was not looking at the case as if the only concerns expressed by anybody related to five patients; yet it is now being suggested that a different view should be taken by this Panel because there are a further seven patients about whom allegations are made, as I repeat – but I do so to stress it – of no significantly different character in relation to the allegations and of no consequence or relevance with regard to what the position should be in the year H 2008 with regard to Dr Barton.

It is worth bearing in mind that all of these allegations embrace a particular timeframe – 1996 to 1999; one patient in 1996 and three in 1999 – a limited timeframe. And this Panel will no doubt have very much in mind the points made to the Committee in October 2004 with regard to the particular working conditions which pertained when Dr Barton had these concerns raised about her professional conduct. It was in conditions far removed, radically different this Panel may think to the situation that pertains to her normal GP practice, which has been going on without blemish, without complaint ever since 1999. You will be aware, of course, that she resigned from the hospital in the year 2000 – her decision.

I do not think it is right to suggest that in some way the October 2004 hearing was just a rehearing of previous matters; it certainly was not the position adopted by counsel for the General Medical Council. Mr Henderson was not suggesting that that was simply a repeat of what had gone before; he was suggesting that there were differences. The Committee found that whatever those differences were they did not justify the imposition of conditions.

I think I shall probably be repeating myself if I go over any of the other material which I suggest thoroughly supports what I am submitting to this Panel. I have made the points; I think they can justifiably be kept pretty brief because it is our contention that looked at in the reality this is raising exactly the same issues – an increase in number and a different expert does not make any difference at all to what it is that this Panel has to consider as compared to what the Committee had to consider nearly four years ago.

May I just assist finally with regard to the position that Dr Barton is in with regard to the PCT and so on in Hampshire? There was a voluntarily arrangement entered into; it worked then perfectly well, it has worked since perfectly well. I think I need to make one thing clear. You will have observed from the transcript of the hearing in October 2004 that there seemed to be a sort of suggestion that maybe Dr Barton had not been adhering to the agreement. That suggestion was not pursued and indeed the Committee heard in quite some detail about prescribing, how the fact of the matter was that Dr Barton was, for example, not prescribing diamorphine and any prescriptions which might have been issued which might look as if they had been prescribed by her were not, and it was never suggested by counsel appearing on behalf of the General Medical Council that there had been any breach by her of the voluntarily undertaking.

It is not quite as closely defined as the original wording might seem to suggest. May I just pause for a moment? (Mr Langdale took instructions) Sir, I have been reminded – and if I can go back – about something which may be of significance. At the hearing in October 2004 counsel appearing on behalf of Dr Barton read out certain passages from an investigation report that had been carried out on behalf of the Commission for Health Improvement – I think it was known as the CHI report in the transcript – and I do not think that what he read out from that report appears in the transcript, so I had better just deal with it, if I may, briefly.

THE CHAIRMAN: Can you mention the report again for our purposes and also for the shorthand writer?

MR LANGDALE: Yes, it is the July 2002 CHI report relating to the Portsmouth Health Care NHS Trust at Gosport War Memorial Hospital, and it is headed *Investigation*, as you can see from the document I am holding up. These paragraphs, as I say, were put before the Committee, and the point of this is simply to show how the difficulties of the conditions under which Dr Barton was working at the time in relation to which complaint is made – conditions and so on – and obviously to highlight the fact that she has not been since 1999 or early 2000 in any similar situation since. The paragraph that was read out was paragraph 6.8:

> "The CHI is not aware of any Trust systems in place to monitor or appraise the performance of clinical assistance in 1998."

Dr Barton, of course, was a clinical assistant:

> "This lack of monitoring is still common practice within the NHS. A consultant submitting patients to Dryad and Daedalus Wards to whom the clinical assistant was accountable had no system for supervising the practice of the clinical assistant, including any review of prescribing. Staff interviewed commented on the long working hours of the clinical assistant in excess of the five contracted sessions."

Then paragraph 7.9, relating to what had been done subsequently:

> "Action was taken to develop and improve Trust policies around prescribing of pain management. In addition CHI learned that external clinical advice sought by the Portsmouth Health Care NHS Trust in September 1999 suggested that the prescribing of diamorphine with dose ranges from 20 to 200 mg a day was poor practice and could indeed lead to serious problems. This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20 to 40 mg per day."

Then reference to an agreed protocol.

> "Further correspondence in October 1999 indicated that a doctor working on the wards requested a Trust policy on the prescribing of opiates in community hospitals."

Then "Other Trust Lessons" paragraph 7.11:

> "Lessons around issues other than prescribing have been learned by the Trust."

A series of actions:

> "An increase in the frequency of consultant ward rounds on Daedalus from fortnightly to weekly; the appointment of a full time staff grade doctor in September 2000, which increased the medical cover, following the resignation of the clinical assistant."

That being of course Dr Barton:

A

> "On additional consultant session began in the year 2000 following a district-wide initiative with local PCGs around intermediate care."

As I say, I mention those because they were before the Committee in October 2004 and they do not appear in the transcript, but they simply highlight the point as to the situation that Dr Barton was in in the latter part of the 1990s, in particular the problems and difficulties. I do not seek to repeat it because it is described already in
B the transcript of that hearing and the fact that action was taken to remedy defects which were not in any sense Dr Barton's fault.

Coming back, if I may, to the question of what the situation is with regard to what Dr Barton can or cannot prescribe in relation to the agreement she has with the PCT. As this Panel will be aware, in relation to opioid analgesics they technically include a large number of medications; for example, that term of itself would embrace codeine.
C It has never been part of the voluntarily arrangement that Dr Barton was not allowed to prescribe some opioid analgesics, but there is a clear line to be drawn between things such as codeine and there are other named drugs which are referred to in meetings between the PCT and Dr Barton in connection with the voluntarily arrangement. The understanding is and the practice is that Dr Barton does not describe what I think – and I may have the term wrong – may be called schedule 2 drugs, the drugs of the category such as morphine, to use the blanket expression,
D pethidine and so on. I want to make that clear to the Panel that it is not absolutely technically exactly what the words might be taken to mean on the face of them. Similarly, in terms of the benzodiazepines there has been some prescription of those in particular cases but as the Panel will be aware from the history of the matter the undertaking is and the voluntary arrangement or agreement is that she does not prescribe outside the guidelines. I can go into more detail if necessary but what I am going to do, if I may, is to provide the Panel with a letter written by the Community
E Pharmacy Development Manager at the PCT, which sets out that Dr Barton has been in full compliance with the voluntarily arrangement. As I say, I can go into detail more necessary but I do not think it is. I will make sure that my friend has a copy of it.

THE CHAIRMAN: Has he seen it?

F MR LANGDALE: He will not have seen it yet. It is 9 July of this year. (Same distributed)

THE CHAIRMAN: That will be D1.

MR LANGDALE: Thank you. I will take you through it fairly quickly, if I may. I am going to the body of the letter.

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> "I have been closely monitoring Dr Barton's prescribing of benzodiazepines and opioid analgesics since 2002 following her voluntary agreement with the Fareham and Gosport Primary Care Trust to restrict her prescribing of diazepam and diamorphine. Any prescriptions for diazepam issued will be in line with BNF guidance with no prescribing of diamorphine. Prescribing data is available from April 2001 (prior to the voluntary agreement) through to

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A May 2008. The data is obtained from the NHS Business Services Agency, Prescription Pricing Division.

I have met with Dr Barton at regular intervals to discuss the data and when necessary have requested copies of prescriptions. The PPD data is recorded against the GP name printed in the bottom of the prescription not against the signature. The prescribing GP may be a partner in the practice other than the B named GP for the prescription. Dr Barton has asked patients requiring long-term treatment with opiates or benzodiazepines to see other partners within the practice. Copies of all diamorphine prescriptions issued by the practice since May 2006 have been requested from the PPD. None of the prescriptions were signed by Dr Barton.

Dr Barton has maintained her compliance with the voluntary agreement which C has been in place since October 2002."

That, I hope, deals with the matter clearly.

Sir, in conclusion it is respectfully submitted that this Panel should not, and indeed has no logical or proper basis for taking any different view to the view that the Committee took in October 2004. The only material changes from the situation that D was presented to the Committee in October 2004 are two things, which support the submission I am making to the Panel. One is that there is now no police investigation; secondly, Dr Barton has had a further four years of practice without blemish, fully – no doubt one can say properly – supporting the confidence that the Committee had in October 2004 that there was no need to impose conditions.

That is all I seek to say; thank you. E

THE CHAIRMAN: I will ask Panel members if they have any questions for you. Mr Walsh, lay member of the Panel.

MR WALSH: Coming to that undertaking on page 78, that is the only copy that we have, is it?

F MR LANGDALE: It is the only copy that I have available to me. I will check if I may, with those instructing me, to see whether there is anything else that we have. I do have file notes of meetings which took place where various matters were being discussed, but they none of them suggest that there was any breach of the undertaking. (Instructions taken) I am told that is right.

MR WALSH: Looking at it as a lay person, it is not qualified in the way that you G describe about, for example, the line on opiates that you described.

MR LANGDALE: This is not raised as a criticism by the General Medical Council and they are not suggesting that Dr Barton has not been abiding by the terms, but I thought it right to point out that it is not just as simple as it might appear from the original wording. One can see why the wording was employed but the understanding always was that it did not include every single conceivable opiate analgesic – for H example, I am taking the very bottom of the range, codeine.

MR WALSH: There is no term to that undertaking – it is open-ended.

MR LANGDALE: It is open-ended and it is obviously currently still in force.

DR MILLER: Just to carry on the point made by my colleague, in the letter that you have provided of 9 July from the Community Pharmacy Development Manager, it has come down now to restricting prescribing diazepams, just one benzodiazepine, and diamorphine just one opioid analgesic, is that correct?

MR LANGDALE: May I just check that? (Instructions taken) I am told that is right, that it therefore embraces anything coming under that description – obviously morphine, pethidine and so on. I can provide the detail of the prescribing if necessary.

DR MILLER: The only other point I have is what is Dr Barton doing now?

MR LANGDALE: She remains in practice as a GP. I am not quite sure what further detail I can usefully provide.

DR MILLER: But with no other clinical assistant position?

DR LANGDALE: As I understand it, no; and she confirms.

DR MILLER: Thank you for that. Does she come under the appraisal process of the PCT?

MR LANGDALE: She does.

DR MILLER: When was her last appraisal?

DR BARTON: January this year.

THE CHAIRMAN: There are no further questions from Panel members for you, Mr Langdale and I think you have completed your submission. We have heard very clearly what you say. Mr Brassington, there is nothing else to add, is there?

MR BRASSINGTON: Only this: that my learned friend has suggested that not one word has been said as to why there is now a difference, and if I have not made that plain in my submissions that is my fault, and you might want to hear from me what I say about that. It has effectively been rehearsed by my learned friend already. There are now a greater number of patients about whom there has been expressed grave concerns as to the clinical care offered by this doctor. The timeframe has increased significantly from being 1998 to being now 1996 to 1998, over which this is said to have taken place, and that suggests a longer pattern of inappropriate prescribing.

I am also bound to make reference to the fact of the coroner's inquest, and although my learned friend teases me – rightly probably – for the rhetoric he suggests I flourish before you, I say that that is not done flippantly. You are here to protect the public

interest and so it is proper that you ask yourself that question, as to what the public perception would be.

From the letter that has just been put before me may I please make a comment – I not having seen this before – that has perhaps already been made by Dr Miller in her question of Mr Langdale, that there appears, does there not, to have been now a voluntary relaxation of the condition that was entered into by the doctor in 2002, over which the General Medical Council has no control and no say, which again perhaps illustrates the points that I have been making. If my learned friend wishes to come back then of course he may, but I have nothing further to add beyond that, thank you.

MR LANGDALE: Yes, may I very briefly?

THE CHAIRMAN: Of course.

MR LANGDALE: It is my fault. I am not suggesting that my learned friend has not said what is different – he made it clear, extra number of patients, a different expert's report, coroner's inquest. My point is – and I am sorry if this was not clear – that those changes, those differences do not raise any issue or question, or cast any doubt upon the fact that it was perfectly proper for Dr Barton to continue in practice without there being conditions. My point is that not a word has been said as to why those changes make a difference to the view that anybody should take about Dr Barton not requiring conditions to be imposed – why it is not in the public or in her interest to have conditions imposed. There has to be something to say, "Actually these changes make a difference as to why conditions should be imposed." That is my point.

With regard to the last point that my friend made, there is no difference to the arrangement that was in place, it is that the wording – as it was presented initially, in the way that has been touched upon by Mr Walsh – needed to be clarified. It is not as if there has been a change in what has been agreed between the PCT and Dr Barton since the voluntary arrangement was entered into. There is no difference; it is not as if she is now being allowed to prescribe things which before she was not allowed to prescribe under the terms of the arrangement.

THE CHAIRMAN: Thank you for that clarification, Mr Langdale. There are no further points from Panel members. Can I turn to the Legal Assessor?

THE LEGAL ASSESSOR: You are operating under Section 41A of the Medical Act as amended, and I stress that that is for an interim order – you are not determining these proceedings. You have heard that there is an expert's report now which was not available at previous interim proceedings, but you are not making any findings about that. You have also heard that the prosecution is no longer contemplated – in fact a decision has been taken that there should be no criminal proceedings. Again, you are not making any findings of fact.

The test for you is whether you are satisfied that it is necessary for the protection of members of the public or is otherwise in the public interest or in the interests of the doctor to make either an order for suspension, which you are not invited to do in this case, or an order for conditions. I should add that "otherwise in the public interest"

includes preserving public confidence in a profession and maintaining good standards of conduct and performance.

I also stress that Section 41A is not mandatory; you may make an order if you are satisfied of those things. But any order you make must be proportionate and therefore you do bear in mind what has happened at previous hearings and you will also bear in mind that whilst there are now more patients being contemplated the last Committee was aware that there were more than the five before it; also when considering proportionality you must bear in mind that the last patient about whom there is any question for prescribing died in November 1999.

THE CHAIRMAN: Thank you, Mr Seed. We will now go into private session.

PARTIES THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

PARTIES HAVING BEEN READMITTED

THE CHAIRMAN: I am sorry to have kept you waiting but we have had to make sure that we have our determination correct. Dr Barton, I am going to read out your determination and afterwards you will be given a copy and a copy will be given to Mr Langdale as well.

This is the Panel's determination in the case of Dr Jane Ann Barton.

DETERMINATION

THE CHAIRMAN: Dr Barton, the Panel has carefully considered all the information before it today, including the submissions made by Mr Brassington on behalf of the General Medical Council (GMC), those made on your behalf by Mr Langdale, and the documentation provided. The Panel has noted that your case was previously considered by the former Interim Orders Committee on four occasions and no order was made. However, the Panel has considered your case in the light of the submissions and information presented to it today.

In accordance with Section 41A of the Medical Act 1983, as amended, the Interim Orders Panel has determined that it is necessary for the protection of members of the public, in the public interest and in your own interests to make an order imposing conditions on your registration for a period of 18 months as follows:

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:
   a. Any organisation or person employing or contracting with you to undertake medical work;
   b. Any locum agency or out-of-hours service you are registered with or apply to be registered with (at the time of application);
   c. Any prospective employer (at the time of application);
   d. The PCT in whose Medical Performers' List you are included, or seeking inclusion (at the time of application) ;
   e. Your Regional Director of Public Health.

In reaching its decision to place conditions on your registration, the Panel bore in mind that it is not its function to make findings of fact or to decide on the veracity of the allegations. The Panel has, however, given such weight as it considers appropriate to the allegations that you face.

In reaching this determination, the Panel has considered the information received initially from the Hampshire Constabulary concerning your alleged inappropriate prescribing for a number of patients at Gosport War Memorial Hospital and the investigations into their deaths. The Panel has noted from the overview of the police investigation contained in the statement of Detective Superintendent Williams dated 16 January 2007, that the Crown Prosecution Service has decided not to proceed with a criminal prosecution. However, the Panel has noted the criticisms in respect of your prescribing and record keeping contained in the report by Professor Black, an expert commissioned by the GMC.

The Panel has also taken account of the information that the GMC has referred your case for a hearing by the Fitness to Practise Panel into allegations that your prescribing in relation to 12 patients at Gosport War Memorial Hospital was inappropriate. The Panel has noted that the GMC has decided to postpone the Fitness to Practise hearing until the outcome of the Coroner's inquest into the deaths of ten patients at Gosport War Memorial Hospital, eight of which are the subject of the Fitness to Practise hearing. The Panel notes that the inquest is expected to take place in the autumn of 2008.

Mr Brassington submitted that in view of the serious concerns raised in relation to your prescribing, and the potential for risk to members of the public or the public interest it would be appropriate for the Panel to make an order imposing conditions on your registration. Mr Brassington submitted that the public interest includes the maintenance of public confidence in the profession.

The Panel also considered Mr Langdale's submission that there is no new information before the Panel today which justifies the imposition of an interim order.
Mr Langdale submitted that although the allegation formulated by the GMC now relates to 12 patients rather than the five patients who were the subject of the investigation when the Interim Orders Committee last considered your case in October 2004, the position has not altered.

Mr Langdale pointed out that you have continued to work as a general practitioner for the past four years and there have been no complaints about your practice.

The Panel had regard to the information that you entered voluntarily into an agreement with the Fareham and Gosport Healthcare Trust (the Trust) in which you gave an undertaking that you would not prescribe benzodiazepines or opiate analgesics with effect from 1 October 2002. The Panel has received a letter dated 9 July 2008 from Hazel Bagshaw, Community Pharmacy Development Manager at the Hampshire NHS Primary Care Trust (Hampshire PCT). Ms Bagshaw states that she has been closely monitoring your prescribing of benzodiazepines and opioid analgesics since your undertaking to restrict your prescribing of diazepam and diamorphine and confirms that you have maintained your compliance with the voluntary agreement which has been in place since October 2002.

While the Panel notes your compliance, it is concerned that the agreement is voluntary and that there are no formal arrangements in place to monitor your continued compliance. Given that this is not the first time that your prescribing has been queried and that there are to be inquests in respect of ten of the patients concerned, public confidence in the profession could be undermined if you were left in unrestricted practice in the meantime. The Panel considers that it is necessary for the maintenance of public confidence in the medical profession for the GMC to exercise control over your compliance with restrictions on your prescribing.

Taking all the information into account, the Panel is satisfied that there may be impairment of your fitness to practise which poses a real risk to members of the public and which may adversely affect the public interest and, after balancing your interests and the interests of the public, the Panel has determined to impose an interim order to guard against such a risk.

The Panel has taken account of the issue of proportionality and has balanced the need to protect members of the public, the public interest and your own interests against the consequences for you of the imposition of conditions on your registration. Whilst it notes that the above conditions restrict your ability to practise medicine, the Panel considers that the conditions are necessary to protect members of the public and the public interest whilst these matters are resolved. It is therefore satisfied that the

imposition of the above conditions on your registration is a proportionate response to the risks posed by your remaining in unrestricted practice.

In deciding on the period of 18 months, the Panel has taken into account the uncertainty of the time needed to resolve all the issues in this case.

The order will take effect today and will be reviewed within six months, or earlier if necessary.

Notification of this decision will be served upon you in accordance with the Medical Act 1983, as amended.

Dr Barton and Mr Langdale that concludes your case today. Thank you very much for coming to assist the Panel. Can I also thank your husband for coming here. I know it is not easy, it is not very good news but thank you for coming to support your wife today.