GMC100648-0001

FFW/MR/148/06.

2000/2047

MEDICAL RECORDS FOR

1. GLADYS RICHARDS

2. ARTHUR CUNN... HAM

3. ALICE WILKIE

4. ROBERT WIL...

5. EVA PAGE

ESSELTE

Dr Barton

IOC 21 June 2001

Dr Barton : The Committee has carefully considered all the evidence before it today.

The Committee has determined that it is not satisfied it is necessary for the protection of members of the public, in the public interest or in your own interests that an order under Section 41A of the Medical Act 1983 should be made in relation to your registration.

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GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

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Thursday, 21 June, 2001

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Chairman: Professor MacKay

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Case of:

BARTON, Jane Ann

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Dr. J.A. Barton was present and was represented by MR A. JENKINS of Counsel, instructed by Solicitors to the Medical Defence Union.

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MISS L. GRIFFIN, of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council.

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A MISS GRIFFIN: Sir, this case comes before you under the Conduct procedures. The nature of the case is set out at the beginning of your bundle as, in summary, one of unlawful killing. A police investigation is continuing and has not come to a determination as yet, in relation to whether or not any charges will be brought against Dr Barton.

The papers before you relate to a patient by the name of Gladys Richards, who was
B treated at the Gosport War Memorial Hospital in August 1998, where she died. Mrs Richards was born on 13 April 1907. There is a short summary of her medical condition at page 57 from the Royal Hospital Haslar, Gosport, Hants, dated 10 August 1998, written by Sergeant Staff Nurse Curran.

The Committee can see that Mrs Richards had sustained a right fractured neck of her femur on 30 July 1998 whilst in the Glenheathers Nursing Home. She was admitted
C to the ward and had a right cemented hemi-artheroplasty, and was now fully weight-bearing, walking with the aid of two nurses and a Zimmerframe.

Her past medical history is set out in summary. She was deaf in both ears. She had had cataract operations to both eyes. She had a recent history of falls and was suffering from Alzheimer's, which condition had deteriorated over the previous six months. She had had a hysterectomy in 1955. Her allergies were set out and the
D drugs that she was currently taking.

The Committee can then see certain details set out as to her day-to-day living.

Straddling that document is a letter from Dr Reid at pages 56 and 58, dated 5 August 1998. Again, in summary it gives the Committee some information as to Mrs Richards' standard of health shortly before her death in 1998.

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Sir, the complaint about Dr Barton is brought on the basis of the two statements at the beginning of your bundle. The first is from Mrs Leslie Lack, and the second is from Mrs Gillian MacKenzie, the daughters of the late Mrs Richards. I ask the Committee to pay attention to those careful, considered and detailed statements in coming to their conclusions today. Those ladies were extremely concerned about the standard of care and attention that was being paid to their mother while she was
F under the care of the hospital, and in particular Dr Barton. They speak about concerns as to the standards of the care assistants and their attitude towards their mother, and also the standard of care afforded tot heir mother by the nurses at the hospital and their level of communication. They also complained of the level of nourishment and hydration provided to their mother, particularly in the last days of her life.

G It was the wish in particular of Mrs Lack that her mother be transferred back to the Haslar Hospital, from where she had been transferred to the Gosport War Memorial Hospital. It transpires that that hospital was willing to accept her, but that Dr Barton was reluctant to send her back. What was explained to the ladies shortly before their mother's death was that she had developed a haematoma after the successful manipulation of her hip after it had become dislocated. The suggestion was made at that stage that as she was in so much pain and had been receiving significant pain
H relief, that she should have some Diamorphine. The reaction of her relative was to

A say that that was tantamount to a suggestion of euthanasia, and that was denied by the doctors.

The daughters repeated their request that their mother should be transferred. Dr Barton said that that would not be appropriate because their mother had suffered too much trauma for one day already, and that the hospital would seek to keep her pain-free that night.

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The next morning, on return to the hospital, Mrs Richards' daughter was told that in effect nothing more could be done for their mother. They were told that the appropriate action would be a syringe driver with morphine to ensure that she had a pain-free death.

Their first information to that effect did not come from Dr Barton. However, they C did speak to Dr Barton about it. Her attitude was that it was going to be "the kindest way" and that they were to expect as the next thing a chest infection. Certainly Mrs Lack and Mrs MacKenzie found that that latter comment was extremely insensitive.

It is suggested within the papers and within the medical notes that the daughters accepted the course of action of a syringe driver with the morphine. However, they D maintain that it was something in effect that they submitted to and there was no question of their accepting that course in the knowledge that it would lead to their mother's death. What they wished was for her pain to be relieved. They believed her to be strong and to be fighting to recover.

It would appear that subsequently the syringe driver was put in place, that their mother received no nourishment in her final days, or indeed hydration. They did not E see a doctor in the days immediately preceding their mother's death, and certainly at the point of her death there was no doctor present.

I understand that the death certificate refers only to bronchopneumonia and does not refer to the haematoma of which they had been told a couple of days previously.

It was Mrs MacKenzie's opinion that their mother had not been given a proper F chance to make a recovery.

The medical notes begin at page 56. There are nursing notes that are copied on a number of occasions, but it is most convenient to turn to page 239 which shows a nursing care plan for 13 August 1998 through to 19 August 1998. That contains entries in relation to the drugs administered to Mrs Richards.

G On page 240 there is a contact record, which begins with 18 August 1998. It sets out contact with the family. At one stage Mrs Richards' daughter is noted as being "quite upset and angry". On the morning of 19 August the Committee will see that the daughters were seen. The note reads: "Unhappy with various aspects of care. Complaint to be handled officially." On 21 August there is a note: "Patient's overall condition deteriorating. Medication keeping her comfortable. Daughters visited during morning." At the top of page 241: "Condition poor. Pronounced dead at H 21.20 hours." The earlier part of that contact record is at pages 242-243.

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Sir, in relation to pain relief there is a note on page 243 that on 18 August 1998 the patient was reviewed by Dr Barton for pain control by a syringe driver, and her treatment was discussed with both daughters. "They agreed to use of syringe driver to control pain and allow nursing care to be given."

Dr Barton's notes are copied at pages 222-223. The Committee may find some of them difficult to read. We have the benefit of a police statement by Dr Barton, however, in which she sets out the substance of some of those notes in typewritten form. The Committee will note in particular the note in the form of a rhetorical question: "Is this lady well enough for another surgical procedure?" That was made on 14 August 1998. Turning the page, the Committee will see on 18 August the first note, "still in great pain" continuing, "I will see daughters today; please make comfortable". On 21 August: "Much more peaceful" or "restful" and there is a reference to a drug being given for her chest. The pronouncement of death is recorded again at the bottom of that page.

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The doctor's statement provided by the Hampshire police is at the back of the document. The Committee will have regard to that in coming to their conclusions. In essence, Dr Barton refutes any allegation of wrongdoing in her care of Mrs Richards in the days leading up to her death.

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Sir, it may be suggested that there has been significant delay in this matter coming before you. The statements of Mrs Flack and Mrs MacKenzie that were provided to us by the police were not forthcoming until 6 June 2001, as can be seen from page 6. This matter comes before the Committee at the first possible opportunity subsequent to the information being provided to the General Medical Council.

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It is my submission that in this case it would not be appropriate to consider conditions on the doctor's registration; that in essence the facts in the papers raise such a significant concern about this doctor that this Committee ought to consider suspending her registration on an interim basis.

THE LEGAL ASSESSOR: The events took place in August 1998. Do we have any information about when the inquiry commenced?

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MISS GRIFFIN: I understand that there was an initial investigation by the police which was concluded, and no action was taken at that time, on the advice of the Crown Prosecution Service. I know not the basis for that advice. Subsequently a complaint was made about the conduct of that investigation by Mrs Richards' daughters, and the matter has subsequently been re-investigated.

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THE LEGAL ASSESSOR: Is it the second investigation that is being referred to in the letters at pages 4 and 5?

MISS GRIFFIN: Yes.

THE LEGAL ASSESSOR: The statements were taken in January and March 2000 by the police. The letter of 27 July on page 4 indicates that the investigation is ongoing and no charge is preferred. The letter at page 5, dated 20 September, says

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that the investigation is ongoing and that a file will be submitted to the Crown Prosecution Service as soon as possible. The outcome was estimated to be unknown for three or four months. We are now a considerable distance ahead of that period. Are you aware whether a file has been submitted to the Crown Prosecution Service?

MISS GRIFFIN: I understand that it is within their remit, but no decision has been taken.

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THE LEGAL ASSESSOR: Do you know whether or not, in the course of their investigation, the police have sought and obtained independent medical evidence to determine whether their case can be substantiated?

MISS GRIFFIN: Sir, we have provided the Committee with the evidence that was before the screener, and that is the only evidence that I have had sight of.

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MR JENKINS: Can I deal with those queries now, because I have some information. You have been told that the daughters complained. They did complain; they complained about almost everybody. I put the facts baldly and try not to put any gloss upon it. You will see that they complained about the nursing home where their mother was, long before she came under Dr Barton's care. They complained about the first hospital. I do not think all the members of staff were complained about, but some of them were. They complained about this hospital where Dr Barton had charge of this patient.

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The allegation appears to be a conspiracy to murder. It appears that everyone has put their heads together in looking after this elderly lady and agreed not to feed her and to give her a grossly excessive course of treatment. The sisters complained to the police and the police conducted an investigation, and that resulted in no action being taken. They then complained about the police who had conducted an investigation, and a second investigation has commenced. We do not have a result of that investigation. Those instructing me act for Dr Barton in the criminal investigation, and we therefore know that within the next few weeks there is to be a meeting between the police and the prosecution service and Treasury counsel instructed to advise the CPS, at which time we are told a decision will be taken. We know that expert opinion has been sought by those who investigate this matter. We have not seen a copy of the expert opinion, nor do we know what that opinion contains. We are certainly concerned at a very considerable delay. That is the background.

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The first point I make on Dr Barton's behalf is that, plainly, there is no conceivable basis here for suggesting that the drugs that were prescribed and administered to this lady were inappropriate. There is no basis at all for saying that the level of drug prescribed was excessive for this patient. There was no basis for arguing that the Diamorphine that was prescribed and administered caused the death. Similarly, in relation to the hydration and the other aspects of care provided to this patient, there is no basis for saying that what was provided was inappropriate. There is no medical opinion, and there is no argument either that any failure to hydrate this lady caused her death. The sisters suggest that it was their understanding that the haematoma could have caused death.

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A I do not mean to criticise the daughters at all. Plainly, they were extremely fond of their mother and they were anxious to do everything that could possibly be done for her. It may well be the case – as I know Dr Barton would say – that they were unable to accept that their mother was terminally ill, and they did not accept it. They believed that their mother would remain alive and continue to live. It would seem that they blamed those around their mother for failing to maintain her and keep her alive.

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It is clear from the medical records that this lady was in poor shape and was deteriorating. There has been no conspiracy by medical staff or the nursing staff, the charge nurse, or those others who were responsible. There is no conceivable basis for saying here that there is a *prima facie* case and that those responsible on a day-to-day basis caused this lady's death, or brought it about.

C This case may have been brought here prematurely. We suggest that it should not have been brought here at all. There may be, at some stage in the future, if there is an opinion of an expert in palliative care or terminal care, an argument that there were failures in Dr Barton's care of this patient, but on the evidence you have seen there is no basis for such a proposition at all.

Page 266 is Dr Barton's statement, which was provided by her when she was spoken

D to by the police. She was one of quite a number of people who were spoken to by the police and she was in no different position from the other people responsible for this lady's care. You will see Dr Barton's position, qualifications and experience. She qualified in 1972. She became a partner in her present practice in 1980. In 1988 she took up the additional post of clinical assistant in elderly medicine on a part-time sessional basis. She was working at the Gosport War Memorial Hospital. She retired from that position last year. Obviously, this statement dates from 2000.

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Her present situation is stated in paragraph 3. She is also the present Chair of the Gosport Primary Care Group.

She was carrying out five clinical assistant sessions at the Gosport Hospital. As you will see from paragraph 4, she would attend the hospital every weekday morning at an early hour and engage in two formal ward rounds with the consultant geriatrician.

F She would do that before she went to treat her patients in her general practice. She did not have constant attendance at hospital. She was not in a position to review at short notice this lady's condition. It is a misunderstanding on the part of the sisters to the extent that they suggest that Dr Barton was there and able to assist and deal with matters as and when they arose.

As far as the doctor's present position is concerned regarding opiates, she does not

G continue to work as a clinical assistant at this hospital. She has not prescribed Diamorphine for over a year. The last time she prescribed an opiate of any kind in palliative care was Fentanyl, and that was for a patient who was being nursed intensively. She does prescribe morphine sulphate tablets for her own patients, but obviously only when it is appropriate.

There is no basis here for saying that the prescription of an opiate for this lady was

H excessive or inappropriate.

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Page 21 is the statement of the sister who was herself a Registered General Nurse.

> "I have had sight of a report prepared by Dr Lord and dated 22 December 1998, which has attached to it a Hampshire Constabulary exhibit label ... "

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She goes on to say a few things about the report and, if I can use this phrase, she tries to pooh-pooh it. She says that the report appears to have been prepared by reference some time after the event to information, notes and documents supplied by colleagues with whom she worked on a regular basis. Can I show you this report, because this was the consultant under whose care this lady was admitted? It provides a commentary on two aspects of the case with which you may be concerned: (1) the use of a syringe driver and the prescription of Diamorphine; (2) the provision of fluids for this lady. (Same handed to members of the Committee)

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Sir, you and your colleagues will have seen the suggestion that one of the sisters believed the use of Diamorphine was merely to accelerate the death, that Diamorphine was to be used for euthanasia. They raised that proposition, it would seem.

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> "My sister asked the ward manager: 'Are we talking about euthanasia? It is illegal in this country, you know.' The ward manager replied: 'Goodness, no, of course not.'"

Diamorphine has a perfectly proper use and is used very commonly in terminal care.

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The second proposition raised by the daughters is that the use of a syringe driver for Diamorphine was foisted on them and they were unhappy with it. There were discussions. One would hope that there will be discussions between the nursing and medical staff and the relatives, so that agreement can be obtained as to a proper and therapeutic approach. It is clear from the documentation to which you have been referred that there were such discussions. It is regrettable that the daughters were later to say that they did not really agree, but you have been given the references at page 243.

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The true situation is that, clearly, there were discussions with the daughters and they were perfectly proper discussions. There is no basis for saying that this drug should not have been given or given at that level.

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In relation to fluids, you have the opinion of the consultant. You have Dr Barton's position stated at some length in the statement at the end of the bundle, which I know you will have read. The decision that was taken in this case, I suggest, was an entirely proper one. There is no basis here for suggesting that it was gravely improper or that it departed from proper medical practice. It is perhaps unfortunate that the sisters did not understand, or were later to say that they did not understand or agree with the decision, but it is clear from the records that there were regular discussions between those nursing this lady and the medical staff as to how she should be treated.

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A As to the decision not to transfer this elderly and demented lady back for a third transfer to the Haslar Hospital in a very few days, there is no basis for saying that that was a wrong decision or one that did not have her best interests at heart – it plainly did. The report of the consultant clearly bears out the approach that Dr Barton took.

B There is no conceivable basis for alleging that any actions by Dr Barton in prescribing or causing to be administered the Diamorphine, caused the death. There is no basis for saying that anything she did reduced the quality of life of this lady or shortened her life. There is no basis for saying in this case that there should be a suspension. I do not deal with the question of conditions. Clearly, conditions have not been asked for. In any event, Dr Barton no longer works in this unit, and I have given you her present situation as far as opiates are concerned.

C DR BHANUMATHI: I notice that Diamorphine was given in the dosage of 40 mg and the patient was on 45 mg of Morphine prior to that. I know that pain control was not too good, but the day the 40 mg of Diamorphine was started it was equivalent to 120 mg of Morphine, which was three times the dosage. What was the dosage that she was on, on the 21st?

MR JENKINS: I think it was the same. There is a record within this bundle.

D DR BHANUMATHI: There is no mention of dosages anywhere, as to whether it was increased or decreased from 14 August.

MR JENKINS: It was not decreased. There is a record here. There is a prescription sheet, but I do not have a page number. That shows the administration.

E DR SAYEED: Who had the ultimate legal responsibility in Gosport Memorial Hospital? Is there a consultant involved?

MR JENKINS: They are consultant beds.

DR SAYEED: How often does the consultant do a round?

F MR JENKINS: I think the position may have changed since 1998, but Dr Barton's statement says that there were two consultant ward rounds a week.

DR SAYEED: We are talking about 1998. Who carried the ultimate clinical responsibility of those beds?

G DR BARTON: Dr Lord, whose statement you have just read, had responsibility for the patient. She was on study leave for the last three days of Gladys Richards' life but she carried out weekly war rounds prior to that.

DR SAYEED: The clinical assistance sheet shows that it is two sessions weekly.

MR JENKINS: It is page 266. It was five clinical assistant sessions.

H DR SAYEED: Was any junior doctor involved?

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Dr Barton: There are no junior doctors. It is just me.

DR BHANUMATHI: Going back to what I was saying, now that I have had a chance to read it properly, the Diamorphine was 40 to 200 mg (page 254), which is a very big jump of medication. Who authorised it and how was that done?

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DR BARTON: The dosage was reviewed every morning, and if an increase was necessary, it would be put up – obviously not straight from 40 to 200 mg but in 20 mg steps until the patient was comfortable. As it turned out, it was not necessary. Gladys needed no increase from the 40 mg initially put.

DR BHANUMATHI: The nurses were not left to increase the dosage; it was by au of the doctor.

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DR BARTON: Yes.

THE LEGAL ASSESSOR: Sir, the Committee can only act if they are satisfied either that it is necessary for protection of the members of the public, or otherwise in the public interest, or in the interests of the practitioner that an order be made under section 41(A)(i) of the Medical Act 1983. Before you, the Committee, can be so satisfied in any case, it is necessary to find that the evidence before you amounts to a *prima facie* case supporting interim action on one or more of the grounds that I have just referred to. In this particular case, I simply draw to your attention the absence of any independent specialist medical expert opinion indicating fault of any kind on the part of Dr Barton, which is obviously something you will have to take into account in considering the question of whether or not there is a *prima facie* case here suggesting fault. If you find that you are so satisfied in respect of any one or more of those grounds, then you must decide whether to make an order attaching conditions to the registration or suspending that registration in either case for a period not exceeding 18 months.

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MR JENKINS: Might I add one point, which I should have raised? Those instructing me did make inquiries of the GMC about this case. I know that the screener, when he or she looked at the papers in this case, did not have Dr Barton's statement to look at. It was provided by the police at a date after the screener had looked at these papers, so all the screener saw was the statements of the two sisters and the medical records.

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MISS GRIFFIN: My understanding is that the police statement at page 266 came in with the fax header sheet that was received dated 12 June this year (page 265) and that is the date after which the screener screened the matter. My understanding and my instructions are that the screener did have the statement of Dr Barton.

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THE CHAIRMAN: We are dealing with all the documents before us, which include Dr Barton's statement. We will give due weight to all the documentation we have.

MR JENKINS: We have received a letter from the Fitness to Practise Directorate dated 19 June. Of course, I will check with my learned friend, but we have raised in correspondence the question of whether the screener saw Dr Barton's statement, and

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we were told that the screener, in reaching his decision, considered the documentation that was supplied to us by the police on 6 June 2001 and which was served on Dr Barton. Dr Barton's statement was received at a later time than that.

THE LEGAL ASSESSOR: In any event, as the Chairman has made clear, this Committee considers all the material matters before it and is not in any way bound by the fact that the screener has decided to refer the case to the Committee.

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MR JENKINS: I raise it for the sake of completeness, for no other reason.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE COMMITTEE DELIBERATED IN CAMERA

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DECISION

THE CHAIRMAN: Dr Barton, the Committee have carefully considered all the evidence before it today.

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The Committee have determined that they are not satisfied it is necessary for the protection of members of the public, in the public interest or in your own interests that an order under section 41(A) of the Medical Act 1983 should be made in relation to your registration.

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GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

Thursday 21 March 2002

PROFESSOR NORMAN MACKAY in the Chair

Case of
BARTON, Jane Ann

DR BARTON was present and was represented by MR A JENKINS of counsel, instructed by the Medical Defence Union.

MR J LLOYD of counsel, instructed by Field Fisher Waterhouse, the Council's Solicitors, appeared in order to present the facts to the Committee.

[The Chairman introduced those present to Dr Barton and her legal representatives.]

MR LLOYD: Dr Barton was previously before this Committee in June of last year, when she was subject to police investigation into the death of an elderly lady by the name of Gladys Richards at Gosport War Memorial Hospital in 1998. The only evidence before the Committee in June of last year were statements taken by police from her two daughters, the medical notes of Mrs Richards and exculpatory statements by Dr Barton herself, and by Dr Lord, the consultant geriatrician of the ward to which Mrs Richards was admitted. Those documents appear at pages 7 to 278 of the Committee's bundle. There was at that time no independent medical expert opinion indicating any fault on the part of Dr Barton and, in those circumstances, the Committee found no grounds on which to make an order concerning her registration. The transcript of the proceedings is at pages 280 to 289 of the bundle.

As I say, at the time of that hearing the police investigation was still continuing, not only into the death of Mrs Richards but into the deaths of four other patients as well. The police subsequently received three experts' reports on these five cases: the report of Professor Livesley, which is at pages 294 to 327 of the bundle, into the case of Mrs Richards only; the report of Dr Mundy, which is at pages 328 to 334 of the bundle, which relates to the other four patients; and the report of Professor Ford, at pages 335 to 373 of the bundle, which deals with all five cases.

Having received advice from counsel, the police decided not to prefer criminal charges against the doctor, but the reports were forwarded to the Fitness to Practise Directorate in the light of very serious concerns raised about the standard of care given by Dr Barton and, in the light of those matters, it has been referred back to this Committee.

At the relevant time Dr Barton was working as a clinical assistant in elderly medicine at Gosport War Memorial Hospital. Can I deal with the reports, first of all insofar as they relate to Gladys Richards? Mrs Richards was a 91-year-old patient who was operated on for a fractured femur on 28 July 1998 and transferred to Daedalus ward at the hospital on 11 August 1998. She was further operated on on 14 August 1998 and returned to the ward on 17 August.

Professor Livesley's opinion is at pages 307 to 311 of the Committee's bundle. Perhaps I can summarise the opinions which I appear in those pages, I hope accurately. It says first of all that, despite recording that Mrs Richards was not in pain on 11 August 1998, she was prescribed wide dosage ranges of opiate and sedative drugs to which Mrs Richards was known to be sensitive. Secondly, when she returned to the ward on 17 August 1998 in pain, but not suffering any life-threatening condition, she was not given oral pain relief but continuous subcutaneous administration of diamorphine, haloperidol and midazolam from 19 August until her death on the 21st. During that time at no time did Dr Barton appropriately review Mrs Richards' condition. Also, thirdly, during this period there is no record of Mrs Richards being given fluids as food in an appropriate manner.

So far as Dr Ford's report is concerned, he deals with this case at pages 341 to 347 of the Committee's bundle. I would ask the Committee to refer to the paragraphs at 345-6, "Evaluation of drugs prescribed and the administration regimens". I shall not read out passages from those paragraphs but I shall, if I may, refer to the summary conclusions at page 347, in which the doctor says,

> "During her two admissions to Daedalus ward there was inappropriate prescribing of opiates and sedative drugs by Dr Barton. These drugs in combination are highly likely to have produced respiratory depression and/or the development of bronchopneumonia that led to her death".

Perhaps I can move on to the second patient, Arthur Cunningham. He was aged 79 when he was admitted to the hospital on 21 September 1998, to attempt to heal and control pain from a sacral ulcer. His case is dealt with by Doctors Mundy and Ford. Dr Mundy's comments are at pages 330 to 331 of the bundle. Perhaps I can summarise his criticisms. He said, "Morphine was started without any attempts to control the pain with less potent drugs"; the use of a syringe driver was started without clear reason, and the dose of diamorphine increased without clear indication.

So far as Dr Ford is concerned, his report into the case of Mr Cunningham is at pages 348 to 354 of the bundle. Again, may I refer the Committee, without reading it, to the passage which is headed "Evaluation of drugs prescribed" at pages 350, and the summary at page 354, which I will read if I may.

> "The initial prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton was in my view reckless. The dose increases undertaken by nursing staff were inappropriate if not undertaken after medical assessment and review of Mr Cunningham. I consider it highly likely that Mr Cunningham experienced respiratory depression and profound depression of conscious level due to the infusion of diamorphine and midazolam. I consider the doses of these drugs prescribed and administered were inappropriate and that these drugs most likely contributed to his death through pneumonia and/or respiratory depression."

Moving on to the case of Alice Wilkie, she was an 81-year-old lady who was admitted to Gosport on 6 August 1998 with urinary tract infection, complaining of pain, and she was prescribed diamorphine. Dr Mundy deals with this patient at page 331 of the Committee's bundle and his comments are these:

> "There was no clear indication for an opioid analgesic to be prescribed and no simple analgesics were given, and there was no documented attempt to establish the nature of her pain. In my view the dose of diamorphine that was prescribed...initially was excessive and there is no evidence that the dose was reviewed prior to her death".

Dr Ford deals with this at pages 355 to 358. His conclusion at 358 is this:

> "In my opinion the prescription of subcutaneous diamorphine and midazolam was inappropriate and probably resulted in depressed conscious level and respiratory depression, which may have hastened her death".

The case of Robert Wilson, aged 75. He was admitted to Gosport on 14 October 1998, having suffered a fractured arm. He was also known to suffer with alcohol abuse, gastritis, hyperthyroidism and heart failure.

Dr Mundy deals with that at pages 331 to 332. He has no significant criticism of Dr Barton.

Dr Ford is more critical at pages 359 to 363. Again I would refer the Committee to the "Evaluation of drugs prescribed and the administration regimens", and perhaps I can read some extracts from those paragraphs.

> "The initial prescription and administration of oramorph to Mr Wilson following his transfer to Dryad ward was in my opinion inappropriate."

At paragraph 5.12,

> "The administration of diamorphine and hyoscine by subcutaneous infusion as a treatment for the diagnosis of a silent myocardial infarction was in my opinion inappropriate".

Paragraph 5.13,

> "The increase in diamorphine dose...is not appropriate...and potentially very hazardous. Similarly the addition of midazolam...was...highly inappropriate and would be expected to carry a high risk of producing profound depression of conscious level and respiratory drive".

Finally, the case of Eva Page. She was an 87-year-old lady who was admitted to Gosport on 27 February 1998 for palliative care, having been diagnosed with possible lung cancer. Dr Mundy deals with her case at pages 332 to 333 of the bundle. He says that, in the absence of any symptoms relevant to the cancer and of any pain, she was inappropriately started on opioid analgesia.

Dr Ford deals with the matter at pages 364 to 368 of the Committee's bundle. Again, I ask the Committee to refer to his evaluation and to the summary at page 368. He says,

> "In general I consider the medical and nursing care she received was appropriate and of adequate quality. However I cannot identify a reason for the prescription of subcutaneous diamorphine, midazolam and hyoscine by Dr Barton on 3 March. In my view this was an inappropriate, potentially hazardous prescription".

That deals with the reports of those three experts.

The most recent developments in relation to the doctor's practice insofar as they relate to her hospital practice are revealed in letters from the NHS Trust, which are at pages 378 to 380 of the bundle. I would ask the Committee to have regard to those. They are both dated 13 February 2002.

It is clear that Dr Barton has entered an arrangement with the Trust, and we can see at page 380 that it has been agreed that she "would cease to provide medical care both in and out of hours for adult patients at Gosport War Memorial Hospital" and that she "would voluntarily stop prescribing opiates and benzodiazepines with immediate effect". It would appear from page 378 that the arrangements that have been come to with her would be reviewed subsequent to this hearing.

So far as any conditions upon this doctor's registration are concerned, clearly the Committee will have regard to the issues of protection of the public and public confidence in the profession. It is our submission that it would not be appropriate that this doctor's registration should remain unrestricted, and that the voluntary arrangement into which she has entered should be formalised by conditions, perhaps along the lines of those imposed by the NHS Trust.

I know not whether the doctor has any private practice outside of her NHS practice, but it may be that the Committee would wish to consider imposing a condition which restricts her to NHS practice, for the purpose of her ongoing supervision. Those are my submissions on behalf of the Council.

THE CHAIRMAN: There may be questions from members of the panel.

MR WARDELL: Is your last point that you certainly are not seeking for the Committee to consider suspending this doctor? I wanted to clarify that.

MR LLOYD: It is a matter of course for the Committee, but I have taken instructions on it this morning to clarify the position. The position is as I have set it out.

MR WARDELL: There is another matter, and it may be that Mr Jenkins wants to develop this. I have no idea what is in his mind, but I wanted to seek clarification as to whether the Committee is entitled to know what is Dr Lord's role in this matter, as is set out in the Hampshire Constabulary letter which is in front of us at page 292. There is implicit criticism there of the consultant in charge. Are we entitled to know whether that particular consultant has been referred to the Council, or whether the police are continuing their investigations into him, or whatever? It may be that could be relevant to the part that this doctor has played relative to the consultant.

MR LLOYD: I can certainly say that, so far as any police investigations are concerned, they are concluded, and there are no police investigations ongoing into Dr Lord. I wonder if I may take instructions on the other matter? [*Having taken instructions*] I have no instructions on any other action taken against Dr Lord.

THE CHAIRMAN: The working relationship between Dr Lord and Dr Barton might be explored through Mr Jenkins.

In the absence of further questions, Mr Jenkins, would you like to begin?

MR JENKINS: Sir, what I propose to do is ask Dr Barton to give evidence before you.

JANE ANN BARTON, Sworn
Examined by MR JENKINS

Q Dr Barton, I want briefly to go through your *curriculum vitae*. The Committee will see from the front page of their blue papers that you qualified with the degree MB BCh 1970 in Oxford and that your home address is in Gosport. If we turn to page 266 of the bundle, we can see a statement produced by you to the police at a stage some months ago. I want to go through it with you, if we may.

You say in the second paragraph there that you joined your present GP practice, initially as an assistant, then as a partner and, in 1988, you took up the additional post of clinical assistant in elderly medicine on a part-time session basis. You say the post originally covered three sites but, in due course, was centred at Gosport War Memorial Hospital. You retired from that position this year. I think you retired in the spring 2000, is that right?
A Yes, that is right.

Q How many sessions were you doing at the War Memorial Hospital? I think we have the answer at paragraph 4, but I will just ask you about it. Tell us how many sessions you were doing.
A The health care trust allocated me five clinical assistant sessions, of which one and a half were given to my partners in the practice to cover the out-of-hours aspect of the job; so that I remained with three and a half clinical assistant sessions in order to look after 48 long-stay geriatric beds. I would visit each of the wards at 7.30 each morning, getting to my surgery at nine. Towards the end of the time doing the job, I was back very nearly every lunchtime to admit patients or to write up charts or to see relatives. Quite often, especially if I was duty doctor and finished my surgery at about seven in the evening, I would go back to the hospital in order particularly to see relatives who were not available during the day because they were working. That became a very important time commitment in the job.

Dryad ward had no consultant cover for the 10 months that you are considering these cases. Dr Lord was trying to cover both wards as well as her commitments on the acute side and the other hospital in the group, and found it very difficult to be there very often.

Q I will break it up and take it in stages, if I may. You would be there from 7.30 to nine o'clock each weekday morning, is that right?
A Yes.

Q You have mentioned two wards. One was Daedalus; the other was Dryad ward.
A Yes.

Q Were you in charge of both of the wards?
A Yes.

Q How many beds were there?
A Forty-eight in total.

Q Over the period with which this Committee is concerned, what was the level of occupancy typically of those 48 beds?
A We were running at about 80 per cent occupancy, but of course that was not enough for the health care trust towards the end of my time there. They attempted to increase it up to 90 per cent, which is running a unit very hot, when you have one part-time jobbing general practitioner and no increase in resources of nursing staff, support staff, OT and physio, and no support from social services.
Q How many other doctors would be there throughout the day to treat these 48 patients if all the beds were full?
A None.

Q So yours was the medical input?
A Mine was the medical input.

Q Between half-past seven in the morning and nine o'clock each weekday morning.
A Time to see each patient, to actually look at each patient, but not time to write anything very substantial about very many of them.

Q If you wanted to see relatives, were you able to see relatives at those early hours in the morning?
A No, except for that one particular case where they spent the night in her single room with her, with their notebooks. Generally, relatives preferred to see me either at lunchtime or in the evening. I would see them in the morning if it was that urgent, but it was generally not appropriate.

Q When you first started this job in 1988, what was the level of dependency typically of patients who were under your care?
A This was continuing care. This was people who – now, because their Bartell or dependency score is less than four, are a problem – went to long-stay beds and stayed there for the rest of their natural lives. So I had people that I looked after for five years, for 10 years, in these beds. The sort of people that I was given to look after in these beds generally were low dependency; they did not have major medical needs, but were just nearing the end of their lives. The analogy now, I suppose, would be a nursing home.

Q Did that position change as time went on?
A That position changed.
Q Tell us how.

A Continuing care as a concept disappeared. The National Health Service was no longer going to look after people who were as dependent as that. It was going to go into the private sector. I cannot give you an exact year, but it happened in the 1990s. At the same time, social services found that, with their budget constraints, they had difficulty placing people with a Bartell of less than four. So there was constant conflict between what we were supposed to be looking after and doing with the patients and what the private sector was going to take from us.

Q Just explain to us, what does a Bartell of less than four mean? What is the range of the Bartell scores?
A You or I have hopefully a Bartell of 20. That means we are able to take care of ourselves; do all the activities of daily living; cut up your food and eat it; go to the loo; change your clothes; walk about. Most of these people in the places mentioned have a Bartell of zero; I think one chap had one of four. So these were very dependent people.

Q That is an indication of the requirements made of nursing staff?
A Nursing requirements. They could not do anything for themselves, basically.

Q What you have told us is that, over time, the level of dependence of the patients increased.
A It escalated enormously: to the point where I began to be saying to my employers, "I can't manage this level of care for this number of patients on the commitment I have". But there was not anybody else to do it. During 1998, when the consultant on Dryad went on Sensitive leave, they made the decision not to employ a regular locum, so that I did not even have full consultant cover on that ward and so that Althea was left to attempt to help me with both, although she was not officially in charge.

Q Althea is...?
A Dr Lord, the other consultant.

Q Did she have other clinical commitments outside the two wards with which we are concerned?
A She had her acute wards up on the Queen Alexandra site; she had a day hospital and outpatients to run down at the St Mary's site in Portsmouth – so she was a very busy lady.

Q How often was she able to undertake a ward round on the two wards with which you were concerned?
A She did not ward rounds on Dryad ward. She came to Daedalus on the Monday to do a continuing care round. Towards the end of my job she designated six of her beds as slow stream stroke rehab' beds, and she did a Thursday ward round – which I could not always make because it was my antenatal day. She was in the hospital and doing outpatients on Thursday as well, so she was in my hospital twice a week – but available on the end of a phone if I had a problem.

Q You have told us that over a 10-month period there was no consultant cover at all.
A Yes.

Q That is 10 months during 1998, which is the period essentially within which the cases that this Committee have been asked to consider fall?
A Yes.

Q Were your partners in your GP practice able to help at all?
A My partners provided the out-of-hours cover – those who were not using Healthcall. They would admit patients who arrived from the district general hospital and see that they had arrived safely. They were in general unwilling to write up pro-active opiate prescribing or any prescribing for patients because they felt that I was the expert and it should be left to me to do it. I think they felt it was not part of their remit, providing cover for me, to prescribe for the patients.

Q So if anyone was to prescribe opiates or other forms of strong analgesic to patients, would it always be you?
A It was generally me.

Q We know that your time at the War Memorial Hospital was limited to the mornings, lunch times and evenings, when you told us you would see relatives. If you were not in a position to prescribe for the patient and the patient was experiencing pain, what provision was there for another doctor to write up a prescription?
A They would have to either ask the duty doctor to come in or they would have to ask the duty Healthcall doctor to come in. That is why, in one of the cases, you see somebody has written up "For major tranquillisers" on one occasion, because that duty doctor obviously either felt it inappropriate or was unwilling to use an opiate and he wrote up major tranquillisers instead.

The other alternative was, of course, that they would ring me at home. If I was at home – and I am only at the end of the road in the village – I would go in and write something up for them, outside the contracted hours.

Q You have said that your partners regarded you as the knowledgeable one about opiates and palliative care.
A Yes.

Q Tell us what your experience may be in those areas.
A In 1998 I was asked to contribute to a document called the *Wessex Palliative Care Guide*, which was an enormous document that covered the management of all major types of cancer and also went into management of palliative care and grief and bereavement. Each month, another chapter would arrive through the post for you to make comments on, contribute your experience to and send it back. This document was published in 1998 as the *Wessex Palliative Care Guide* and we all carry the *Wessex Palliative Care Handbook* around with us, which contains a sort of----

Q Is that it?

A Which you carry in your coat pocket. [*indicates document*]

Q You contributed towards that?
A I contributed to the writing of that and I am acknowledged in the thanks in the major document. I attended postgraduate education sessions at the Countess Mountbatten and also at the other hospice locally, The Rowans.

Q Just remind us, where is the Countess Mountbatten?
A The Countess Mountbatten is part of Southampton University Hospitals and it is in Hedge End, which is about 10 miles from Gosport. The Rowans is a similar distance in the other direction. I am still in very close contact professionally with both the director and the deputy director of Countess Mountbatten. I still go to their postgraduate sessions and I still talk to them about palliative care problems. They are always very available and helpful, and of course they provide district nursing, home care nursing input into our community, which is enormously helpful in general practice.

Q Are you – perhaps I can use the expression – up to date in developments locally in primary care and matters of that nature?
A I was also, at the time of these allegations, chairman of the local primary care group which, on 1 April this year, becomes a primary care trust, so that I was very involved in the political development of our district. I knew only too well that the health care trust could not afford to put any more medical input than I was giving them, on the cheap as a clinical assistant, into our cottage hospital at that time. I knew what the stresses and strains were on the economy and I knew where the money needed to go.

I could have said to them, "I can't do this job any more. It's too difficult; it's becoming dangerous", but I felt that I was letting them down. I felt that I was letting down the nursing staff that I had worked with for 12 years, and I felt that I was letting patients down, a lot of whom were in my practice and part of my own community. So I hung onto the job until 2000. In the thank-you letter I got for my resignation letter they said that I "would consider, wouldn't I, the three quarters of a million they were looking for, to beef up community rehabilitation services in the district" – which included replacing my job with a full-time staff grade, nine-to-five, every weekday in Gosport.

Q We will come to some correspondence shortly. After you resigned, your job was taken over by another doctor?
A Yes, a single, full-time staff grade. I hear on the grapevine that the bid has gone in for two full-time staff grades to do that job now.

Q Is this to do the job that you were doing within three and a half clinical assistant sessions?
A In three and a half clinical assistant sessions. It is just a measure of the difference in the complexity and the workload that is being put into a cottage hospital.

Q Can I ask about your note-keeping? You had a significant number of patients; it was at 90 per cent occupancy. Clearly that is----

A Between 40 and 42 patients, yes.

Q What time would you have during your clinical session to make notes for each of the patients?
A You could either sit at the desk and write notes for each patient, or you could see the patients. You had that choice. I chose to see the patients, so my note-keeping was sparse.

Q You accept, I think, as a criticism that note-keeping should be full and detailed?
A I accept that, in an ideal world, it would be wonderful to write full and clear notes on every visit you pay to every patient every weekday morning.

Q But the constraints upon you were such, I think, that you were not able to do so?
A Yes.

Q Were the health authority aware of your concerns as to staffing levels and medical input?
A Yes.

Q Were they aware of your concerns over the increasing level of dependency that patients had who were transferred to your unit?
A Yes. In the dreadful winter of 1998, when the acute hospital admissions – admissions for acute surgery and even booked surgery – ground to a halt because all their beds were full of overflow medical and geriatric patients, my unit received a letter asking us to improve the throughput of patients that we had in the War Memorial Hospital, accompanied by a protocol for the sort of patients we should be looking after: how they should be medically stable and everything like that. I wrote back to the then acting clinical director and said, "I can't do any more. I can't really even look after the ones that I have got, because of their dependency and medical needs. Please don't give me any more". I got a bland reply, saying that we were all going to try to help out with this crisis in the acute sector.

Q We will look at the correspondence. Can I come to nursing staff, your relations with them, and the experience of the nursing staff? Clearly you started 12 years before you retired. Did the number of nurses increase over the period of time that we are talking about?
A Marginally.

Q What about the level of experience of the nursing staff? The impression that we have is, towards the end of the period, you are dealing with patients who had very high dependency. Was the experience of the nursing staff raised in order to meet that increase in need?
A By an large they were the same people and they learned in the same way that I did: by having to deal with these more difficult needs. I do not think I can comment on how much input the Trust put into improving their skills. I think that would be inappropriate for me to do.

Q Perhaps I can ask this. Was it apparent that the Trust were seeking to raise the level of experience and qualification of the nursing staff in the War Memorial Hospital? And the answer should go on the transcript.
A Does it?

Q Was it apparent?
A It was not apparent that they were making any great attempts to improve the cover, the experience and the training of some of the nurses.

Q Were the health authority aware of your concerns, both as regards nursing levels and levels of medical staff?
A Yes. I did not put anything in writing until 1998 – or was it 2000?

Q I think it was 2000.
A 2000 -- but I was in constant contact with the lower echelons of management. Any remarks you made about the difficulties you were having, the worries you had and the risk of the patients you were covering, would definitely fall on stony ground.

Q You chose to prescribe opiates. It is something which is criticised by the experts whose reports are before the Committee. You chose to prescribe over a range, and quite a wide range, for certain of the opiates that we have seen.
A A professor of geriatrics in a teaching hospital, or even a big district general hospital, will have a plethora of junior staff. There will be never any need for any opiate dose to be written up for more than 24 hours, because somebody will either be on the end of the bleep or be back on the ward. That was not the case in Gosport War Memorial. If there was a weekend, if I was on a course, if I was on sick leave, if I was on holiday, I have already explained that there was not the cover for someone else to write drugs for me, and therefore I wrote a range of doses. I implicitly trusted my nursing staff never to use any of those doses inappropriately or recklessly. You will see from each of the documents that there is no question that any of these people received enormous amounts of opiate or benzodiazepine.

Q If the nurses wished to move from one level of administration of opiate up tot he next stage, but within the range that you had already prescribed----
A They would speak to me.

Q How would that happen?
A Because I was in, if it was a weekday morning. I was on the end of the phone in surgery or, if I was at home and it was a weekend and they were worried, they would ring me at home. I did not have any objection to that.

Q Did you feel that your relationship with the nursing staff was such that such informal communication could take place?
A I trusted them implicitly. I had to.
Q What we see again and again in the comments of Professor Ford and others is that the expert can see no justification for raising the level of prescribing. The expert in each case will have looked at the notes. Was there always

recorded a justification for increasing the level of prescribing or the level of administration?
A Not always in my notes. I would hope that the nursing notes would be copious enough. In particular, interestingly, the night staff tend to make more of a full record of what the patient has been like through the night. It was quite often their feeling, night sister's feeling, that the patient was less comfortable or was beginning to bubble, or something like that, that would suggest to me that we needed to move up a step or in a step with the drugs we were using.

Q I will ask you to turn to page 370, which is the final couple of paragraphs of Professor Ford's report. Paragraph 7.5, two-thirds of the way down that paragraph, he says,

> "It would be important to examine levels of staffing in relation to patient need during this period, as the failure to keep adequate nursing records could have resulted from under-staffing of the ward".

What do you say about levels of nursing staff on the ward during the period with which we are concerned?
A He is absolutely right. These experienced, caring nurses had the choice between tending to patients, keeping them clean, feeding them and attending to their medical needs, or writing copious notes. They were in the same bind that I was in, only even more so. As you can see from the medical records you have had, the health care trust produces enormous numbers of forms, protocols and guidelines, and sister could spend her whole morning filling those out for each patient or she could nurse a patient.

Q He goes on,

> "Similarly there may have been inadequate senior medical staff input into the wards, and it would be important to examine this in detail, both in terms of weekly patient contact and in time available to lead practice development on the wards".

Do you have a comment on that?
A I agree entirely. There was inadequate senior medical input.

Q During 10 months of 1998 was there any senior medical staff input?
A No.

Q It is not apparent that Professor Ford was aware that you were doing three and a half sessions----
A In a cottage hospital.

Q ...in the cottage hospital.
A No.
Q It may be that Professor Ford believed that you were permanent staff.
A Failed junior staff! His last comment in paragraph 7.5 – his review of Dr Lord's medical notes – is absolutely correct. She was caring and thoughtful and considerate, and with a considerable workload – probably more than she

should have been carrying. Therefore it is difficult to criticise. She did what she could, within the constraints that she had available to her.

Q I am not going to go through the individual cases. This is not a trial; this Committee is not here to find facts proved or not proved. But I think it fair to you to invite you to comment on Professor Ford's next paragraph. He says,

> "...the level of skills of nursing and non-consultant medical staff" – it was only you – "and particularly Dr Barton",

– the word "particularly" suggests he may have believed there were other medical staff –

> "were not adequate at the time these patients were admitted".

How do you respond to that?
A I find it very upsetting. I was only a clinical assistant. The definition of a clinical assistant is in fact that it is a training post, and the only training that I received was that I went to get for myself as a part of my postgraduate learning, and I did my best at that time. In my opinion they were probably adequate.

Q Can we turn to the last page of the bundle, page 380? This is a letter dated 13 February 2002 and sets out matters that were agreed between you and the acting chief executive, Dr Old. Yes?
A Yes.

Q Attention has already been drawn to this document, but is it right that you agreed to cease to provide medical care, both in and out of hours for adult patients at the Gosport War Memorial Hospital?
A Yes.

Q And you agreed voluntarily to stop prescribing opiates and benzodiazepines.
A I did.

Q Had you not agreed those, were you threatened with any action?
A Dr Old told me that, under the change in Government legislation on 14 December last year, he was entitled to suspend me from general practice; but he did not wish to do that and, provided we came to this voluntary agreement, he would wait to see what the GMC had to say on the matter.

Q This is the same health authority who had been putting through a significantly higher volume of patients to your cottage hospital and with much higher levels of dependency?
A This is the employers of the health care trust who had been putting through significant.... The health authority in fact purchase work from the health care trust and, theoretically, employ general practitioners. So this was my employer telling me that he could suspend me from the day job as well. So I agreed to the voluntary restrictions on my practice. At that time I had four patients in general practice on opiates and approximately 15 on any form of

benzodiazepine. I handed the four patients over to my partners and said I felt no longer able to treat them. I no longer sign any prescriptions for sleeping tablets in general practice; the other partners do that for me.

Q You have given us the figures. Do you describe yourself as a high prescriber of benzodiazepines?
A I was quite surprised at how few of my patients got benzodiazepines from me.

Q And of those prescribed opiates----
A One was for terminal care. She went into hospital a couple of days after I was suspended and died there. The other three are maintained by the partners for longstanding chronic pain.

Q Just to remind the Committee, in your statement at page 266 you say in paragraph 3,

> "As a general practitioner, I have a full-time position; I have approximately 1,500 patients on my list".

A Yes.

Q The Committee can see, of the 1,500 patients, precisely how many are prescribed benzodiazepines and/or opiates.
A Yes.

Q [*To the Committee*] Sir, we have a small bundle of correspondence. I am sorry that you have not been given it in advance.

THE CHAIRMAN: We will refer to it as D1. [*Same handed*]

MR JENKINS: Sir, we are giving you a number of letters. I am happy if they are collected in D1, or we can number them sequentially.

THE CHAIRMAN: I assume they have been circulated. Shall we put them in chronological order?

MR JENKINS: I would be happy with that. The first letter you should have is one dated 16 February. It is from the consultant physician, Dr Jarrett. He talks of a "bed crisis at Queen Alexandra Hospital continues unabated". "It has fallen on us", he says,

> "to try and utilise all our beds in elderly medicine as efficiently as possible. There has been some under-utilisation of continuing care beds. From 16 February I propose that we use vacant continuing care beds for post-acute patients. A policy offering guidance is enclosed".

You should see a document, enclosure 2, "Emergency use of community hospital beds". You will see it reads,

"Due to current crisis with the acute medical beds at Queen Alexandra Hospital and the detrimental effect on surgical waiting lists, the Department of Medicine for Elderly People is making some urgent changes to the management of beds in the small hospitals".

Can I break off and remind the Committee, this relates to the year 2000. The situation with which you are concerned for the five patients whose records you have were treated in 1998. So this is after, but we hand these documents to you to give you the continuing picture. You will see,

"Therefore patients referred to these beds for post-acute care should be:

1. Waiting for placement...
2. Medically stable with no need for regular medical monitoring...",

and the other matters that you see listed.

The next document is a letter from Dr Barton dated 22 February to Dr Jarrett. The letter reads,

"I was very disappointed and also quite concerned to be shown a letter from yourself dated 16 February on the subject of the bed crisis at Queen Alexandra and addressed to the various ward managers and sisters.

Less than a month after I wrote a letter to the clinical director expressing my concerns about the situation in our continuing care unit, I find that we are being asked to take on an even higher risk category of patient.

These post-acute patients have a right to expect a certain standard of medical care, appropriate levels of therapy and supervision, and appropriate out-of-hours cover during this period of time in hospital.

I find myself without a consultant or seamless locum consultant cover for a period of a further month on one of the wards, and the other consultant cannot be expected to provide anything other than firefighting support during this time.

As a result, I am unable to do the clinical assistant job to a safe and acceptable standard, which will inevitably lead to further serious and damaging complaints about the service given in my wards. In addition, my staff are subjected to ever-increasing pressures from patients and relatives, causing stress and sickness levels to rise.

I would also question the term 'under-utilisation' in a unit which is handling approximately 40 per cent of the continuing care done by Elderly Services at this time".

The next document in time is a letter from Dr Jarrett dated 7 March, by way of response. I do not need to read it to you, but you have heard Dr Barton suggest

that there was a request, effectively, for three quarters of a million pounds from the primary care group to go towards the local hospital. You may find a hint of that in the last paragraph of this letter.

The next document is the one with the fax strips down the centre of it. It is a letter from Dr Barton dated 28 April 2000, tendering her resignation. It is addressed to Peter King, personnel director, and it reads as follows:

> "Over recent months I have become increasingly concerned about the clinical cover provided to the continuing care beds at Gosport War Memorial Hospital. I have highlighted these worries on two occasions previously in the enclosed letters.
>
> I returned from my Easter leave this weekend to find that the situation has deteriorated even further. For example, on one of the wards I will only be having locum consultant cover until September. In addition, an increasing number of higher risk 'step down' patients continue to be transferred to the wards, where the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise for them.
>
> The situation has now reached the point that, with the agreement of my partners, I have no option but to tender my resignation".

You will see a reference to the original contract of employment in 1993.

The last letter, dated 19 May from Fiona Cameron, is one responding to the letter we have just read. The second paragraph reads as follows:

> "I am writing to offer my thanks for your commitment and support to Gosport War Memorial Hospital over the last seven years. There is little doubt that over this period both the client group and workload have changed and I fully acknowledge your contribution to the service whilst working under considerable pressure".

Sir, that is the evidence I seek to place before you. I have called Dr Barton and, if there are questions for her, the Committee or Mr Lloyd may wish to ask those questions now before I go on to sum up, if I can put it that way.

THE CHAIRMAN: Mr Lloyd, do you wish to ask questions?

THE LEGAL ASSESSOR: I have no questions, sir.

Questioned by the COMMITTEE

DR RANSON: Did you have consultant cover during 1998?

A I had a lady called Dr Jane Tandy, who became Sensitive who commenced her annual leave on 27 April 1998 and followed on with Sensitive leave from 1 June until 8 February 1999. So basically she was very pregnant, and then she was gone for the rest of the year.

Q And no replacement or locum cover?
A No.

Q So you were in fact on your own in a training grade post?
A Yes.

MR WARDELL: I would like to ask some questions in order to have a feel for the 48 beds you were looking after with regard to patients. You mentioned the Bartell Score, that I am not familiar with at all but I am pleased that I am at 20.
A On a good day!

Q Absolutely! You said that the bed occupancy rate was about 80 per cent when you were there. Perhaps you were looking after about 38, up to 40 patients?
A Yes.

Q With regard to your looking after those patients, could you give us a feel of what you did? You said you were there for an hour and a half in the morning. Can you run through fairly quickly the typical kind of week you would have at the hospital?
A I would arrive as they opened the front door of the hospital at 7.30 and I would go straight to Dryad ward first. I would walk round the ward with the nurse who had just taken the night report, so it was the most senior nurse on. We did not, fortunately, have these named nurses at that point. I would stop by every bed and I would ask, "Are they in pain? Have they had their bowels open? Do I need to see the family? Is there anything I should know?". So I got a report at the foot of each bed. That was Dryad.

Daedalus liked to do it slightly differently, in that I did the report with the person who had taken the hand-over in the office, and then was invited to look at any patients they had concerns about. They preferred to do it in front of their paperwork. But the concept was the same: you went through all the patients in your care each morning, and that took until just before nine.

Q How many days a week did you do that?
A That was five. That was each weekday morning.

Q Was that your total involvement with the hospital?
A That is when it started. Generally, with the rate at which we were running admissions in 1998, I think an average week would contain five admissions. I had to try to get them to bring them down to my hospital before four o'clock in the afternoon. Lunchtime was better, because (a) they get very cold and stressed if you carry them round the countryside and bring them in after dark and (b) it gave me time to clerk them and to check whether any further investigations, bloods or anything needed doing, and to get them settled into the ward. So I would go back most lunch times, unless I had a PCG or purchasing meeting or something like that. In those days I was only on duty once a fortnight, but I would quite often go back in the evening if I felt there was somebody I was particularly worried about – to talk tot he relative or to support the nursing staff.

Q Mr Jenkins put in front of us a number of documents, including the second one, which is "Emergency use of community hospital beds". In point 7 there, the second sentence reads, "...this placement does not entitle patient to NHS continuing care".
A There was no such thing in 2000. If your condition became medically stable and you could persuade social services to either fund you or agree to have you at all, then you would be moved on – even though your dependency score might be very low.

Q In that period, say 1998 to 2000, were you experiencing dilemmas whereby – and I use the word "conspiracy" advisedly, because I have the evidence from a report that I chaired during that period when I was in another post in the House of Commons – in evidence we had it said that there was a conspiracy between social services, doctors and management with regard to trying to push people who were entitled to have NHS care out of hospitals into nursing homes, where they would have to pay out of their own resources? Were you in that horrible dilemma?
A If you knew anything about Gosport, you would realise that (a) there is not much potential for private practice and (b) there were not vast numbers of patients who were self-funding. Self-funders were not the problem then. If they were stable and social services would agree that they could go to a nursing home at all, that was not the problem. I would never conspire with anyone in social services.

Q I was not levelling that at you. I was just thinking about the dilemma, that if you had patients in beds, such as the patients you were dealing with, then they would be covered in terms of the NHS system----
A They were not.

Q They were not?
A They were not. They were not entitled to stay in any of those beds. In order to keep them in those beds, you had to write in the notes, "Requires ongoing medical care". Despite a Bartell of zero, if they required no further medical input and their medical condition was stable, you then had to find them a nursing home. But the sort of people we are talking about here were not going to become stable.

MR WINTER: You refer to raising concerns in 1998 verbally with lower levels of management about your working situation. Would you be prepared to say a little more about what you actually did and whether you considered putting your concerns in writing at that point?
A I should have put my concerns in writing, because I was sitting on these strategic bodies. We were talking about how the health community was going to move forward, how we were going to improve step-down care, and how we were going to make available more beds for acute surgery so that the Trust achieved its waiting list targets and therefore its money from region. But I did not put anything in writing. I became increasingly concerned. I spoke to lower management, who probably did not even relay those concerns further up. I spoke to my clinical colleagues.

Dr Lord tried at that time to get more funding and was unsuccessful. The first time we got any extra funding was in 2000 when I resigned and we got an extra three-quarters of a million for St Christopher's and Gosport War Memorial to do more post-acute rehabilitation work. So they knew we were in trouble, but I did not go to print at that stage.

Q Could you say approximately how many times you raised these matters with people in lower management?
A Once every couple of months.

THE CHAIRMAN: I wonder if I might be allowed to ask a few questions, just so that I understand the situation? Am I correct in assuming that Gosport War Memorial Hospital is a stand-alone community hospital?
A It has no theatre facilities; it now has no A&E or minor injuries facility; it has a little X-ray department with basic, standard equipment in a Portacabin. It has a little outpatient department to which consultants come down from the centre to do peripheral clinics, and it has approximately 100 beds.

Q These are including the 48 long-term care beds?
A We have long-stay elderly medical patients; we have babies; we have a maternity unit and we have a small GP ward.

Q Can you tell me roughly what the average length of stay was in, say, 1989, about 10 years ago, and then in the later part of the 1990s? How had the average length of stay changed?
A I had patients I had had for five years. I had some very ill patients transferred from the Royal Hospital, Haslar, after orthopaedic surgery or transferred from the main unit because they lived in Gosport and their relatives lived in Gosport. But those were the minority. The majority of patients were long stay.

Q Was there a calculation of the average length of stay in the early 1990s?
A It would be difficult to do, because we also did shared care and respite care in those days. I was looking at the figures the other day. You would find it very difficult to get a feel for the average length of stay, but it was generally reckoned to be a good long time. Then in the late 1990s – I could not find any research on this subject, but there are two major risk times for these elderly transferred from a nursing home to an acute unit and then down to a long-stay unit. They may well die in the first two, three days – something to do with the shock of being moved really makes them quite poorly. If they survive that----

Q While you do not have a specific figure for average length of stay, you are quite convinced that the dependency level increased over the decade?
A Massively, yes.

Q We are aware of how the Gladys Richards case came to the surface. It is not clear to me from the papers how the other cases were identified. Can you help me with that? [*Dr Barton conferred with counsel*]

MR JENKINS: Sir, you will recall from what I said to an earlier constitution of this Committee that the relatives of Gladys Richards complained. What I said to an earlier Committee was that they complained about everybody, including the police officers who conducted the inquiry. They generated some publicity locally about their concerns, as a result of which relatives of other patients – and I think the four with which you are concerned – expressed concerns. I think that is how the police became involved in those other cases.

DR BARTON: The health care trust also decided to invoke CHI, the Commission for Health Improvement, and CHI produced a lot of local publicity saying, "If you have any concerns about your hospital, this is the phone number, these are the people to get in touch with". And of course I have no input as to how much and where they got their information from; but they must have received an enormous amount of positive and negative feedback from the people of Gosport.

THE CHAIRMAN: Technically, as a clinical assistant you did not carry ultimate responsibility for the clinical care of patients?
A No. You will see in a couple of the reports that we were using the Fentanyl skin patch for opiate pain relief. I was not allowed to sign for that. That had to be countersigned by a consultant. I was working for a consultant.

Q And the consultants under whom you worked reviewed the prescribing practices that you indulged in, did they?
A I do not know. Not with me.

Q So you did not do the ward rounds with the consultant?
A Yes.

Q You did?
A Yes, but no comments were made at any time at this point about reckless prescribing or inappropriate prescribing.

Q They did not raise any questions about the prescribing that was being done for these patients?
A They did not raise any concerns, no.

Q Were there any audit meetings in the hospital?
A I did not go. I was not invited to go to audit meetings.
Q Turning to page 380, I would also like some clarification. It implies in the first bullet point there that there is still some relationship to the Gosport War Memorial Hospital. What was the continuing relationship you had?
A In Gosport there is something called the Gosport Medical Committee, which is made up of all the practising doctors on the peninsula, which I think at the moment is about 36. We are employed by the health care trust to look after 20 GP beds upstairs from my erstwhile geriatric beds. We have admitting rights to those beds and we are allowed to look after our own patients. We are also invited to look after step-down patients from the acute unit. Although, as a GP you can be much more hard-nosed about refusing to accept somebody who you feel is beyond the capability of the hospital to look after than I could as a clinical assistant downstairs in the wards. That is why you will see something about, "a

retrospective audit of your prescribing on the Sultan ward". That is, what I was doing – whether I was prescribing inappropriate opiates upstairs on the GP ward.

Q That has been helpful clarification. Was I correct in assuming – this is the second bullet point – that you told us this was in relation to your primary care duties?
A The voluntary stopping prescribing opiates?

Q Yes.
A Yes, I am not prescribing any opiates or benzodiazepines at the moment.

THE CHAIRMAN: I think these are the points I wanted to raise. Are there any further points from members of the panel? In the absence of further points, Mr Jenkins?

MR JENKINS: There is one, sir, and it was raised by Mr Lloyd. Do you have any private patients?
A No.

MR JENKINS: Sir, may I sum up very briefly? You may think that this is plainly an excellent and dedicated doctor. It may appear to you, and I would encourage this view on your behalf, that it may have been problems with the allocation of resources at the Gosport War Memorial Hospital which has led to a situation where best practice was not followed.

You will have to consider the reports of the various experts placed before you. You will have to consider as well whether they are considering Dr Barton's position as it was. I may have missed it, but it is not apparent from my reading of the reports that there is shown to be an understanding by Professor Ford and the other doctors that they were well aware that Dr Barton was working three and a half sessions; that she was effectively, during the period with which we are concerned, the only medical input into the care of these patients; that she had a significant number of patients to see and to evaluate and to continue to care for, in a very restricted period of time.

You have to consider whether it is necessary for the protection of members of the public to impose conditions. I do not deal with the question of suspension because I say that it is plainly not appropriate in this case.

Is it necessary for the protection of members of the public to impose conditions? Dr Barton is no longer undertaking the job that she started in 1988. You know the reasons why. I say she poses absolutely no threat to members of the public, either in her general practice or in any form of hospital medicine. She does not undertake any of the latter.

Is it necessary in her own interests to impose conditions? I say not. The last issue is whether it is otherwise in the public interest. You will know that there has been a police investigation, in fact two, arising out of the complaints in this case. You will know the results of the police investigation: that a decision has been taken not to charge.

I repeat what I have said. It is slightly troubling that it is not apparent that the experts instructed by the police have been presented with the full picture of Dr Barton's clinical involvement with these patients before being invited to express a view. But I say that it is not in the public interest either for this body to impose conditions upon this doctor in the circumstances in which you know she practises. She does not pose a risk to patients. It is not necessary in her interests, and it is not otherwise in the public interest.

If, however, you feel that because of police investigation, because of the possibility of press coverage, that it is necessary to demonstrate that this body is able to make decisions, I would invite you to do no more than reimpose what Dr Barton has voluntarily agreed with the health authority.

Those are the submissions that I make.

THE CHAIRMAN: I now turn to the legal assessor.

THE LEGAL ASSESSOR: The advice I give the Committee is as follows. They may make an order restricting this doctor's registration only if they are satisfied it is necessary to do so for the protection of members of the public, otherwise in the public interest, or in the interests of the doctor. In addition they must be satisfied that the consequences of any restriction that they might impose of her registration will not be disproportionate to the risks posed by the doctor remaining in unrestricted practice.

Mr Jenkins, Mr Lloyd, unless there is anything else on which you would like me to advise the Committee, that is the advice I give.

MR JENKINS: Sir, I have mentioned the little green book with which Dr Barton has helped. I leave it with you.

THE CHAIRMAN: Thank you.

The parties withdrew by direction from the Chair and the Committee deliberated in camera.

The parties having been readmitted:

THE CHAIRMAN: Dr Barton, the Committee has carefully considered all the evidence before it, including the submissions made on your behalf.

The Committee has determined, on the basis of the information available to it today, that it is not satisfied that it is necessary for the protection of members of the public, in the public interest or in your own interests that an interim order

under Section 41A of the Medical Act 1983 as amended should be made in relation to your registration.

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15 Sept - Passed new rules
1 Nov 04 - effective.

THE GENERAL MEDICAL COUNCIL

(FITNESS TO PRACTISE) RULES 2004

The General Medical Council, in exercise of its powers under section 35CC(1) of, paragraph 4A(1) of Schedule 1 to, and paragraphs 1(1) to (5) and 5A(1), (2), (3) and (3A) of Schedule 4 to, the Medical Act 1983(**a**), and article 18 of the Medical Act 1983 (Amendment) Order 2000(**b**), and of all other powers enabling it in that behalf, and after consulting with such bodies or persons representing medical practitioners, or medical practitioners of any description, as appeared to the General Medical Council requisite to be consulted, hereby makes the following Rules:—

Arrangement of Rules

Part 1-Preliminaries

1. Citation and commencement
2. Interpretation
3. Appointment of panels of advisers, assessors and examiners

Part 2-Investigation of allegations

4. Initial consideration and referral of allegations
5. Functions of the Registrar in relation to cautions, convictions and determinations
6. Referral to Interim Orders Panel
7. Investigation of allegations
8. Consideration by Case Examiners
9. Consideration by the Committee
10. Undertakings
11. Warnings
12. Review of decisions
13. Relevant date for the purposes of sections 35A and 35B of the Act

Part 3-Action following referral

14. Appointment of specialist advisers
15. Notice of hearing
16. Case management

Part 4-Procedure of a FTP Panel

17. Procedure before a FTP Panel

(a) 1983 c.54; section 35A and Schedule 4 are as substituted by, and section 35CC was inserted by, S.I. 2002/3135
(b) S.I. 2000/1803

Part 5-Review hearings

18. Application of Part 5
19. Functions of Registrar
20. Notice of review hearing
21. Early review hearing
22. Procedure at a review hearing

Part 6-Restoration to the Register

23. Action on receipt of a restoration application
24. Procedure at a restoration hearing

Part 7-Interim orders

25. Initial consideration
26. Notice of hearing
27. Procedure at an interim orders hearing

Part 8-General

28. Cancellation of a hearing
29. Postponements and adjournments
30. Preliminary legal arguments
31. Absence of the practitioner
32. Joinder
33. Representation
34. Evidence
35. Witnesses
36. Vulnerable witnesses
37. Record of decisions of the Committee or Panel
38. Voting
39. Notes and transcript of proceedings
40. Service
41. Attendance of the public
42. Exclusion from proceedings
43. Consequential amendments
44. Revocation

Schedule 1
Performance assessments

Schedule 2
Health assessments

Part 1-Preliminaries

Citation and commencement

1.— These Rules may be cited as the General Medical Council (Fitness to Practise) Rules 2004, and shall come into force on 1 November 2004.

Interpretation

2. In these Rules—

"**the Act**" means the Medical Act 1983;

"**allegation**" means an allegation that the fitness to practise of a practitioner is impaired and includes an allegation treated as arising by virtue of section 35CC(3) of the Act and an allegation relating to a person whose registration is suspended;

"**application**" means, in Part 6 of these Rules, an application to restore a person's name to the register, and "**the applicant**" shall be construed accordingly;

"**assessment report**" means a report prepared following the assessment of a practitioner's performance or health in accordance with Schedule 1 or 2;

"**Assessment Team**" means a team of three or more performance assessors appointed by the Registrar in order to carry out the assessment of a practitioner's performance in accordance with Schedule 1.

"**Case Examiner**" means a medical or lay officer of the General Council appointed by the Registrar for the purposes of exercising the functions of the Committee, and "**Case Examiners**" means the medical and lay Case Examiners to whom an allegation is referred under rule 4(2) or 5(2) and includes any replacement Case Examiner appointed by the Registrar;

"**Case Manager**" means a legally qualified person appointed by the Registrar for the purposes of rule 16;

"**the Committee**" means the Investigation Committee;

"**FTP Panel**" means a Fitness to Practise Panel constituted under rules made under paragraph 19E of Schedule 1 to the Act;

"**interim order**" means an order made in accordance with section 41A of the Act (and includes an order made in accordance with section 41A and 41B of the Act prior to the coming into force of articles 13 and 14 of the Medical Act 1983 (Amendment) Order 2002);

"**Interim Orders Panel**" means an Interim Orders Panel constituted under paragraph 19A of Schedule 1 to the Act;

"**lay**", in relation to any person, means a person who is neither a registered medical practitioner nor a holder of any qualification registrable under the Act;

“**Legal Assessor**” means a person appointed under paragraph 7 of Schedule 4 to the Act;

“**medical**”, in relation to any person, means a registered medical practitioner;

“**medical examiner**” means a registered medical practitioner appointed by the Registrar under rule 3(1)(b) for the purposes of carrying out health assessments in accordance with Schedule 2;

“**Panel**” means a FTP Panel or an Interim Orders Panel;

“**panellist**” means a person sitting on the Committee or a Panel;

“**party”** means the practitioner or the General Council (or their representatives), and references to “**the parties**” shall be construed accordingly;

“**performance assessor**” means a person appointed by the Registrar under rule 3(1)(a) for the purposes of carrying out performance assessments in accordance with Schedule 1;

“**practitioner**” means a person holding full, provisional or limited registration under the Act (including any person whose registration is suspended) who is the subject of an allegation or in respect of whom a direction has been made under section 35D of the Act;

“the Presenting Officer” means the representative of the General Council instructed by the Registrar to present the case on behalf of the General Council at any hearing before a Panel or the Committee, and may include solicitor or counsel;

“the President” means the President of the General Council;

“**private**” means in the presence of the parties and their representatives but in the absence of the wider public;

“regulatory body” shall be construed in accordance with section 35C(9) of the Act;

“**specialist health adviser**” means a registered medical practitioner appointed by the Registrar under rule 3(2) for the purposes of advising a FTP Panel in relation to medical issues regarding a practitioner’s health;

“**specialist performance adviser**” means a registered medical practitioner appointed by the Registrar under rule 3(2) for the purposes of advising a FTP Panel in relation to medical issues regarding a practitioner’s performance;

“**specialty**” shall be construed to include general medical practice; and

“**warning”** means a warning under section 35C(6) or section 35D(3)of the Act.

Appointment of panels of advisers, assessors and examiners

3.— (1) The Registrar may appoint —

(a) a panel of medical and lay performance assessors for the purposes of carrying out performance assessments in accordance with Schedule 1; and

(b) a panel of medical examiners for the purposes of carrying out health assessments in accordance with Schedule 2.

(2) The Registrar may appoint —

(a) a panel of specialist health advisers for the purposes of advising a FTP Panel in relation to medical issues regarding a practitioner's health which may arise at a hearing before the FTP Panel; and

(b) a panel of specialist performance advisers for the purposes of advising a FTP Panel in relation to medical issues regarding a practitioner's performance which may arise at a hearing before the FTP Panel.

(3) Members of the General Council shall not be eligible for appointment to a panel under paragraph (1) or (2).

(4) In selecting a specialist health adviser in relation to a particular case, the Registrar —

(a) shall have regard to the physical or mental condition which is alleged to impair the practitioner's fitness to practise; and

(b) shall not select a person who has previously been selected to act as a medical examiner in relation to that case.

(5) In selecting a specialist performance adviser in relation to a particular case, the Registrar —

(a) shall have regard to the specialty to which the allegation relates; and

(b) shall not select a person who has previously been selected to act as a member of an Assessment Team in relation to that case.

(6) The advice of a specialist health adviser or a specialist performance adviser shall be given or repeated in the presence of the parties in attendance at the hearing.

Part 2-Investigation of allegations

Initial consideration and referral of allegations

4.— (1) An allegation shall initially be considered by the Registrar.

(2) Subject to paragraph (5) and rule 5, where the Registrar considers that the allegation falls within section 35C(2) of the Act, he shall refer the matter to a medical and a lay Case Examiner for consideration under rule 8.

(3) Where —

(a) the Registrar considers that an allegation does not fall within section 35C(2) of the Act; or

(b) in the case of an allegation falling within paragraph (5), the Registrar does not consider it to be in the public interest for the allegation to proceed,

he shall notify the practitioner and the maker of the allegation (if any) accordingly.

(4) The Registrar may, before deciding whether to refer an allegation, carry out any investigations as in his opinion are appropriate to the consideration of—

(a) whether or not the allegation falls within section 35C(2) of the Act; or

(b) the practitioner's fitness to practise.

(5) No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the allegation, unless the Registrar considers that it is in the public interest, in the exceptional circumstances of the case, for it to proceed.

Functions of the Registrar in relation to cautions, convictions and determinations

5.— (1) Subject to rule 4(5), the Registrar shall refer an allegation falling within section 35C(2)(c) of the Act relating to a conviction resulting in the imposition of a custodial sentence, whether immediate or suspended, directly to a FTP Panel.

(2) Subject to rule 4(5), the Registrar shall refer any other allegation falling within section 35C(2)(c) or (e) of the Act directly to a FTP Panel, unless he is of the opinion that it ought to be referred to a medical and a lay Case Examiner for consideration under rule 8.

Referral to Interim Orders Panel

6.— If, at any stage, the Registrar is of the opinion that an Interim Orders Panel should consider making an interim order in relation to a practitioner, he shall refer the allegation to an Interim Orders Panel accordingly.

Investigation of allegations

7.— (1) As soon as is reasonably practicable after referral of an allegation for consideration under rule 8, the Registrar shall write to the practitioner —

(a) informing him of the allegation and stating the matters which appear to raise a question as to whether his fitness to practise is impaired;

(b) providing him with copies of any documents received by the General Council in support of the allegation;

(c) inviting him to respond to the allegation with written representations within the period of 28 days from the date of the letter; and

(d) informing him that representations received from him will be disclosed, where appropriate, to the maker of the allegation (if any) for comment.

(2) The Registrar shall carry out any investigations, whether or not any have been carried out under rule 4(4), as in his opinion are appropriate to the consideration of the allegation under rule 8.

(3) The Registrar may direct that an assessment of the practitioner's performance or health be carried out in accordance with Schedule 1 or 2.

(4) Where an assessment has been carried out in accordance with Schedule 1 or 2, the Registrar shall send a copy of the assessment report to the practitioner.

(5) Where an assessment has been carried out in accordance with Schedule 1, the Registrar shall send a copy of the assessment report to any person by whom the practitioner is employed to provide medical services or with whom he has an arrangement to do so.

(6) Where the Registrar receives information that —

(a) the practitioner has failed to submit to, or comply with, an assessment under Schedule 1 or 2; or

(b) having submitted to an assessment under Schedule 1, the practitioner has failed to comply with reasonable requirements imposed by the Assessment Team;

the Registrar may —

(i) refer the allegation for determination by a FTP Panel, and

(ii) in a case falling within sub-paragraph (b), refer the practitioner to a FTP Panel for the purposes of making a direction under paragraph 5A(3) of Schedule 4 to the Act.

Consideration by Case Examiners

8.— (1) An allegation referred by the Registrar under rule 4(2) or 5(2) shall be considered by the Case Examiners.

(2) Upon consideration of an allegation, the Case Examiners may unanimously decide —

(a) that the allegation should not proceed further;

(b) to issue a warning to the practitioner in accordance with rule 11(2);

(c) to refer the allegation to the Committee under rule 11(3) for determination under rule 11(6); or

(d) to refer the allegation for determination by a FTP Panel.

(3) The Case Examiners may unanimously decide to recommend that the practitioner be invited to comply with undertakings in accordance with rule 10(2) and, where they do so and the practitioner confirms he is prepared to comply with such undertakings in accordance with rule 10(3), they shall make no decision under paragraph (2) accordingly.

(4) As soon as reasonably practicable, the Case Examiners shall inform the Registrar of their decision, together with the reasons for that decision, and the Registrar shall notify the practitioner and the maker of the allegation (if any), in writing, accordingly.

(5) If the Case Examiners fail to agree as to the disposal of an allegation under paragraph (2), or whether to recommend that the practitioner be invited to comply with undertakings under paragraph (3), they shall notify the Registrar accordingly, and the Registrar shall refer the allegation for consideration by the Committee under rule 9.

(6) If, at any stage, one of the Case Examiners is of the opinion that an Interim Orders Panel should consider making an interim order in relation to a practitioner, he shall direct the Registrar accordingly.

Consideration by the Committee

9.— Upon consideration of an allegation referred under rule 8(5), the Committee may —

(a) determine that the allegation should not proceed further;

(b) dispose of the allegation by issuing a warning to the practitioner without an oral hearing in accordance with rules 11(2) to (4);

(c) determine that an oral hearing should be held for determination under rule 11(6);

(d) refer the allegation for determination by a FTP Panel; or

(e) where the Case Examiners have failed to agree whether to recommend that the practitioner be invited to comply with undertakings in accordance with rule 10(2), determine that the practitioner be invited to comply with such undertakings as the Committee think fit and direct the Case Examiners to make no decision under rule 8(2) accordingly.

Undertakings

10. — (1) Where —

(a) after an assessment has been carried out in accordance with Schedule 1 or 2; and

(b) before the relevant allegation has been determined by the Case Examiners under rule 8 or referred to the Committee or a FTP Panel,

the Registrar considers it appropriate to do so, he may refer the assessment report to the Case Examiners for consideration under this rule.

(2) If after considering the assessment report it appears to the Case Examiners that the practitioner —

(a) is not fit to practise;

(b) is not fit to practise except on a limited basis or under supervision, or both; or

(c) suffers from a continuing or episodic physical or mental condition which, although in remission at the time of the assessment, may be expected to cause a recurrence of impairment of the practitioner's fitness to practise,

they may recommend that the practitioner be invited to comply with such undertakings as they think fit (including any limitations on his practice) and shall inform the Registrar who shall write to the practitioner accordingly, inviting him to state within the period of 28 days from the date of the letter (or

such further period as the Registrar may allow) whether he is prepared to comply with such undertakings.

(3) If, within the period of 28 days from the date of the letter (or such further period as the Registrar may allow), the practitioner confirms in writing that he is prepared to comply with the undertakings proposed under paragraph (2), the Case Examiners shall cease consideration of the allegation and make no decision under rule 8(2) accordingly, and the Registrar shall notify the practitioner and the maker of the allegation (if any), in writing.

(4) The Registrar shall not invite the practitioner to comply with any such undertakings where there is a realistic prospect that, if the allegation were referred to a FTP Panel, his name would be erased from the register.

(5) Where the Case Examiners have ceased consideration of an allegation in accordance with paragraph (3), the Registrar may —

(a) request one or more medical practitioners to supervise the practitioner and to provide reports as necessary;

(b) direct that a further assessment be carried out in accordance with Schedule 1 or 2.

(6) Where, as a result of information received by the General Council it appears to the Case Examiners that any undertakings the practitioner has agreed to comply with under this rule should be varied or cease to apply, they shall inform the Registrar accordingly and the Registrar shall—

(a) invite the practitioner to comply with such varied undertakings as appear to the Case Examiners to be appropriate; or

(b) direct that the undertakings should no longer apply and that the allegation should proceed no further.

(7) Where the Registrar receives information that —

(a) the practitioner has not within the period of 28 days from the date of the letter (or such further period as the Registrar may allow) agreed to comply with the undertakings proposed under paragraph (2) or (6)(a);

(b) the practitioner has failed to observe an undertaking he has agreed to comply with under paragraph (3) or which has been varied under paragraph (6); or

(c) the practitioner's health or performance has deteriorated, or otherwise gives rise to further concern regarding his fitness to practise,

the Registrar may refer the allegation for determination by a FTP Panel.

(8) The Registrar shall disclose details of any relevant undertakings (save those relating exclusively to the health of the practitioner) to —

(a) any person by whom the practitioner is employed to provide medical services or has an arrangement to do so; and

(b) any enquirer.

Warnings

11.— (1) If it appears to one or both of the Case Examiners that an allegation is one with respect to which he or they may wish to give a warning, he or they shall inform the Registrar, and the Registrar shall write to the practitioner to inform him that he is entitled to make written representations within the period of 28 days from the date of the letter.

(2) Subject to paragraph (3), if the Case Examiners are satisfied that the allegation ought not to be considered by a FTP Panel and —

(a) the practitioner has made no representations under this rule; or

(b) after considering any representations made, the practitioner has not contested the facts upon which the allegation is based,

they may if they think fit issue a warning to the practitioner.

(3) After considering any representations made by the practitioner, where —

(a) the practitioner has requested that the allegation be referred for an oral hearing before the Committee; or

(b) the Case Examiners otherwise consider it appropriate to do so,

the Case Examiners shall refer the allegation to the Committee for an oral hearing in accordance with this rule.

(4) Where the Committee —

(a) is considering an allegation under rule 9 which has been referred as a result of the failure of the Case Examiners to agree as to disposal under rule 8(2)(a) or (d); and

(b) considers that the allegation is one with respect to which it may wish to give a warning,

it shall inform the Registrar, and the Registrar shall write to the practitioner in accordance with paragraph (1), and paragraphs (2) and (3) shall apply as if references to the Case Examiners were references to the Committee.

(5) Where an allegation has been referred to the Committee for an oral hearing under paragraph (3) or (4), the Registrar shall give notice to the practitioner —

(a) particularising the allegation against the practitioner and the facts upon which it is based;

(b) specifying the date, time and venue of the hearing;

(c) informing him of his right to attend the hearing and to be represented at a hearing in accordance with rule 33;

(d) informing him of the power of the Committee to proceed in his absence under rule 31; and

(e) informing him of the Committee's powers of disposal as set out in paragraph (6).

(6) The Committee shall consider any allegation referred to it under paragraph (3) or (4), and shall —

(a) determine that the matter should not proceed further;

(b) dispose of the allegation by issuing a warning; or

(c) where new information adduced into evidence at the hearing indicates that to do so would be appropriate, refer the allegation for determination by a FTP Panel.

(7) Where an allegation has been referred for an oral hearing under paragraph (3) or (4), the order of proceedings before the Committee shall be as follows —

(a) the Presenting Officer shall outline the allegation and the facts upon which it is based and, where the Committee considers such evidence is desirable to enable it to discharge its functions under this rule, may adduce any relevant oral or documentary evidence;

(b) the practitioner may respond to the allegation and, where the Committee considers such evidence is desirable to enable it to discharge its functions under this rule, may adduce any relevant oral or documentary evidence;

(c) the parties may make such further submissions as the Committee may allow;

(d) before making its decision, the Committee may adjourn for further investigations to be carried out, including an assessment of the practitioner's performance or health under Schedule 1 or 2; and

(e) the Committee shall announce its decision, and shall give its reasons for that decision.

(8) In making its decision, the Committee shall, where appropriate, take into account the practitioner's previous fitness to practise history with the General Council or any other regulatory body.

(9) The Registrar shall serve written notification of the Committee's decision upon the practitioner as soon as practicable.

(10) The notice of decision shall —

(a) where the Committee decides that the matter should be referred to a FTP Panel, particularise the allegation against the practitioner that is to be referred; and

(b) where the Committee decides that the matter should be disposed of by issuing a warning, particularise the terms of the warning issued to the practitioner.

Review of decisions

12. — (1) Subject to paragraph (2), the following decisions may be reviewed by the President —

(a) a decision not to refer an allegation to a FTP Panel;

(b) a decision to issue a warning in accordance with rule 11(2), 11(4) or 11(6); or

(c) a decision to cease consideration of an allegation upon receipt of undertakings from the practitioner in accordance with rule 10(3).

(2) Subject to paragraph (3), the President shall not review a decision specified in paragraph (1) unless he considers that there is new evidence or information which makes such review —

(a) necessary for the protection of the public;

(b) necessary for the prevention of injustice to the practitioner; or

(c) otherwise necessary in the public interest.

(3) The President may review a decision specified in paragraph (1) where he receives information that the General Council has erred in its administrative handling of the case and he is satisfied that it is necessary in the public interest to do so.

(4) Where the President decides to review a decision specified in paragraph (1), the Registrar shall —

(a) inform the practitioner and the maker of the allegation (if any) of the decision to review;

(b) inform the practitioner and the maker of the allegation (if any) of any new evidence or information and, where appropriate, provide them with copies of any new evidence received; and

(c) seek representations from the practitioner and the maker of the allegation (if any) regarding the review of the decision.

(5) Where the President decides to review a decision specified in paragraph (1), he may—

(a) determine that the original decision should stand;

(b) refer the allegation for consideration under rule 8; or

(c) refer the allegation for consideration under rule 10(2).

(6) Where the President has reviewed a decision specified in paragraph (1), the Registrar shall notify —

(a) the practitioner;

(b) the maker of the allegation (if any); and

(c) any other person he considers has an interest in receiving notification,

in writing, as soon as reasonably practicable, of the President's decision, together with his reasons for that decision.

Relevant date for the purpose of sections 35A and 35B of the Act

13. — For the purposes of sections 35A and 35B of the Act, the relevant date shall be the day on which the earliest of the following occurs —

(a) the decision of the Registrar to carry out investigations under rule 4(4) or 7(2);

(b) the referral of an allegation to an Interim Orders Panel;

(c) the referral of an allegation for consideration by the Case Examiners under rule 8;

(d) the referral of an allegation to a FTP Panel; or

(e) the making of a direction that an assessment of the practitioner's performance or health be carried out in accordance with Schedule 1 or 2.

Part 3-Action following referral

Appointment of specialist advisers

14. — Before the opening of any hearing before a FTP Panel, the Registrar may in accordance with rules 3(4) and (5) select from the panels maintained for such purposes—

(a) one or more specialist health advisers;

(b) one or more specialist performance advisers; or

(c) one or more specialist health advisers and specialist performance advisers,

in order to advise the FTP Panel, as required, during the hearing.

Notice of hearing

15. — (1) Subject to rule 16, as soon as reasonably practicable after an allegation has been referred to a FTP Panel the Registrar shall serve a notice of hearing on the practitioner.

(2) The notice of hearing shall —

(a) particularise the allegation against the practitioner and the facts upon which it is based;

(b) specify the date, time and venue of the hearing;

(c) inform the practitioner of his right to attend the hearing and to be represented at the hearing in accordance with rule 33;

(d) inform the practitioner of the power of the FTP Panel to proceed in his absence under rule 31;

(e) inform the practitioner of his right to adduce evidence in accordance with rule 34 and to call and cross-examine witnesses; and

(f) inform the practitioner of the FTP Panel's powers of disposal under section 35D, section 38 and section 41A of the Act.

(3) The Registrar shall give no less than 28 days' notice of the date and location of the hearing and no less than 7 days' notice of the precise time and venue of the hearing.

(4) The Registrar may give a shorter period of notice than that specified in paragraph (3) where the practitioner consents or the Registrar considers it reasonable in the public interest in the exceptional circumstances of the case.

Case management

16. — (1) The Registrar shall appoint one or more legally qualified Case Managers for the purposes of this rule.

(2) Following the referral of a case to a FTP Panel for —

(a) a hearing to consider an allegation in accordance with rule 17;

(b) a review hearing to consider an allegation in accordance with rule 22; or

(c) consideration of an application for restoration in accordance with rule 24,

the Registrar may list the matter for a case review before a Case Manager.

(3) Unless the parties agree otherwise, the practitioner shall be given no less than 14 days' notice of any case review.

(4) A case review may be conducted by telephone or by such other method as may be agreed between the parties or, where the parties fail to agree, as decided by the Case Manager.

(5) The Case Manager shall act independently of the parties and may give directions to secure the just, expeditious and effective running of proceedings before the FTP Panel.

(6) Directions issued by the Case Manager may include, but are not limited to, such of the following as he considers appropriate having regard to the nature of the allegation, any representations made by the parties and all other material factors —

(a) that each party disclose to the other—

(i) any documentary evidence in their possession or power relating to the allegation,

(ii) details of the witnesses (including the practitioner) on whom they intend to rely and signed witness statements setting out the substance of their evidence,

(iii) a curriculum vitae and an expert report in respect of any expert on whom they intend to rely, and

(iv) skeleton arguments;

(b) that each party provide an estimate as to the likely length of the hearing and the date or dates on which they propose that the hearing should take place;

(c) that the parties state whether or not the health of the practitioner is to be raised as an issue in the proceedings;

(d) that the practitioner indicates, so far as is practicable —

(i) whether the allegation is admitted,

(ii) which facts are admitted and which facts remain in dispute,

(iii) which witness evidence is admitted and which witnesses are required for cross examination, and

(iv) whether any preliminary legal arguments are to be made;

(e) where the allegation is admitted, a direction that the parties produce a statement of agreed facts;

(f) where the parties agree, a direction that a witness statement shall stand as the evidence-in-chief of that witness;

(g) a direction that a particular witness should be treated as a vulnerable witness, and directions as to how the evidence of such witness should be obtained or presented to the FTP Panel;

(h) a direction for an adjournment of the case review or an additional case review where the circumstances of the case require; and

(i) time limits for compliance with any of the directions listed above.

(7) Within the period of 7 days beginning with the date of a case review, the Case Manager shall serve on the parties a record of the directions issued by him.

(8) A FTP Panel may draw such inferences as it considers appropriate in respect of the failure by a party to comply with directions issued by the Case Manager.

Part 4-Procedure of a FTP Panel

Procedure before a FTP Panel

17.— (1) A FTP Panel shall consider any allegations referred to it in accordance with these Rules, and shall dispose of the case in accordance with sections 35D, 38 and 41A of the Act.

(2) The order of proceedings at the hearing shall be as follows —

(a) the FTP Panel shall hear and consider any preliminary legal arguments;

(b) the Chairman of the FTP Panel shall —

(i) where the practitioner is present, require the practitioner to confirm his name and registration number, or

(ii) otherwise, require the Presenting Officer to confirm the practitioner's name and registration number;

(c) the person acting as secretary to the FTP Panel shall read out the allegation, and the alleged facts upon which it is based;

(d) the Chairman of the FTP Panel shall inquire whether the practitioner wishes to make any admissions;

(e) where facts have been admitted, the Chairman of the FTP Panel shall announce that such facts have been found proved;

(f) where facts remain in dispute, the Presenting Officer shall open the case for the General Council and may adduce evidence and call witnesses in support of it;

(g) the practitioner may make submissions regarding whether sufficient evidence has been adduced to find the facts proved or to support a finding of impairment, and the FTP Panel shall consider and announce its decision as to whether any such submissions should be upheld;

(h) the practitioner may open his case and may adduce evidence and call witnesses in support of it;

(i) the FTP Panel shall consider and announce its findings of fact;

(j) the FTP Panel shall receive further evidence and hear any further submissions from the parties as to whether, on the basis of any facts found proved, the practitioner's fitness to practise is impaired;

(k) the FTP Panel shall consider and announce its finding on the question of whether the fitness to practise of the practitioner is impaired, and shall give its reasons for that decision;

(l) the FTP Panel may receive further evidence and hear any further submissions from the parties as to the appropriate sanction, if any, to be imposed or, where the practitioner's fitness to practise is not found to be impaired, the question of whether a warning should be imposed;

(m) the FTP Panel may take into account any written undertakings (including limitations on his practice) entered into by the practitioner —

(i) which it considers to be sufficient to protect patients and protect the public interest, and

(ii) where the practitioner expressly agrees that the Registrar shall disclose details of any such undertakings (save those relating exclusively to the health of the practitioner) to —

(aa) any person by whom the practitioner is employed to provide medical services or with whom he has an arrangement to do so;

(bb) any person from whom the practitioner is seeking such employment or such an arrangement; and

(cc) any enquirer;

(n) the FTP Panel shall consider and announce its decision as to the sanction or warning, if any, to be imposed or undertakings to be taken into account and shall give its reasons for that decision;

(o) where the FTP Panel considers that an order for immediate suspension or immediate conditions should be imposed on the practitioner's registration, it shall invite representations from the parties before considering and announcing whether it shall impose such order, together with its reasons for that decision; and

(p) the FTP Panel shall deal with any interim order in place in respect of the practitioner.

(3) Where it appears to the FTP Panel at any time that—

(a) the particulars of the allegation or the facts upon which it is based, of which notice has been given under rule 15, should be amended; and

(b) the amendment can be made without injustice,

it may, after hearing the parties and consulting with the Legal Assessor, amend the particulars on appropriate terms.

(4) At any stage in the proceedings, before making a determination that a practitioner's fitness to practise is impaired, the FTP Panel may, having regard to the nature of the allegation under consideration, adjourn and direct —

(a) that a specialist health adviser or specialist performance adviser be appointed to assist the FTP Panel; or

(b) that an assessment of the practitioner's performance or health be carried out in accordance with Schedule 1 or 2.

(5) On receipt of an assessment report produced further to a direction under paragraph (4)(b), the FTP Panel may —

(a) proceed to consider and determine the allegation in accordance with paragraph (2); or

(b) refer the allegation to the Registrar for consideration by the Case Examiners in accordance with rule 10(2).

(6) When determining whether a practitioner's fitness to practise is impaired by reason of adverse physical or mental health, the FTP Panel may take into account—

(a) the practitioner's current physical or mental condition;

(b) any continuing or episodic condition suffered by the practitioner; and

(c) a condition suffered by the practitioner which, although currently in remission, may be expected to cause a recurrence of impairment of the practitioner's fitness to practise.

(7) Where a practitioner has been referred under rule 7(6)(ii) for failure to comply with reasonable requirements imposed by an Assessment Team, the FTP Panel may dispose of the case, where it considers it appropriate to do so, by suspending the practitioner's name from the register or imposing conditions on his registration in accordance with section 35D of the Act.

(8) Subject to paragraph (7), where a practitioner has failed to submit to, or to comply with, an assessment under Schedule 1 or 2, and —

(a) there is credible evidence before the FTP Panel that the practitioner's fitness to practise is impaired;

(b) a reasonable request has been made by the Registrar to the practitioner that he submit to or comply with the assessment; and

(c) no reasonable excuse for such failure has been provided by the practitioner,

the FTP Panel may take such failure into account in determining the question of

whether the practitioner's fitness to practise is impaired.

(9) At any stage before making its decision as to sanction or warning, the FTP Panel may adjourn for further information or reports to be obtained in order to assist it in exercising its functions.

Part 5-Review hearings

Application of Part 5

18.— This Part shall apply to any hearing (a "review hearing") at which an FTP Panel is to determine whether or not to make a direction under section 35D(5), (6), (8), (10) or (12) of the Act.

Functions of Registrar

19.— Prior to the opening of a review hearing, the Registrar shall consider the directions made by a FTP Panel in respect of the practitioner at any previous hearing, and may —

(a) make such inquiry or procure the production of such expert or other report as he considers necessary; and

(b) invite the practitioner to undergo an assessment of his performance or health in accordance with Schedule 1 or 2.

Notice of review hearing

20.— (1) No later than 28 days before the hearing, the Registrar shall serve on the practitioner notice of the review hearing —

(a) particularising the direction made at the previous hearing and the grounds for the same;

(b) stating the matters set out at rule 15(2)(b) to (e);

(c) where an early review hearing is to be held, disclosing the information that makes such early review desirable;

(d) indicating the subsection of section 35D of the Act under which the FTP Panel is proposing to act, and the powers available to the FTP Panel under that provision;

(e) requesting the practitioner to notify the Registrar, within 14 days of the date of the notice, whether he wishes to attend the hearing; and

(f) inviting the practitioner, if he chooses not to attend the hearing, to make written representations to be received by the Registrar no later than 14 days before the hearing.

(2) The notice under paragraph (1) shall be accompanied by a copy of any statement, report or other document which –

(a) has not previously been sent to the practitioner or his representative; and

(b) is relevant to the question whether a direction should be made under this Part or the terms on which it should be made.

(3) If any statement, report or other document is subsequently obtained by the General Council which is relevant to the question whether a direction should be made under this Part or the terms on which it should be made, the practitioner shall be given a reasonable opportunity of responding before the FTP Panel makes such direction.

Early review hearing

21.— The Registrar may refer a case to a FTP Panel for an early review hearing, where information is received that, in the opinion of the Registrar, makes an early review hearing desirable.

Procedure at a review hearing

22.— The order of proceedings at a review hearing shall be as follows —

(a) the FTP Panel shall hear and consider any preliminary legal arguments;

(b) the Chairman of the FTP Panel shall —

(i) where the practitioner is present, require the practitioner to confirm his name and registration number, or

(ii) otherwise, require the Presenting Officer to confirm the practitioner's name and registration number;

(c) the Presenting Officer shall —

(i) inform the FTP Panel of the background to the case, and the sanction previously imposed,

(ii) direct the attention of the FTP Panel to any relevant evidence, including transcripts of previous hearings, and may adduce evidence and call witnesses in relation to the practitioner's fitness to practise or his failure to comply with any requirement imposed upon him as a condition of registration;

(d) the practitioner may present his case and may adduce evidence and call witnesses in support of it;

(e) the FTP Panel shall receive further evidence and hear any further submissions from the parties as to whether the fitness to practise of the practitioner is impaired or whether the practitioner has failed to comply with any requirement imposed upon him as a condition of registration;

(f) the FTP Panel shall consider and announce its finding on the question of whether the fitness to practise of the practitioner is impaired or whether the practitioner has failed to comply with any requirement imposed upon him as a condition of registration, and shall give its reasons for that decision;

(g) the FTP Panel may receive further evidence and hear any further submissions from the parties as to its decision whether to make a direction under section 35D(5), (6), (8), (10) or (12) of the Act;

(h) the FTP Panel may take into account any written undertakings (including limitations on his practice) entered into by the practitioner —

 (i) which it considers to be sufficient to protect patients and protect the public interest, and

 (ii) where the practitioner expressly agrees that the Registrar shall disclose details of any such undertakings (save those relating exclusively to the health of the practitioner) to —

  (aa) any person by whom the practitioner is employed to provide medical services or with whom he has an arrangement to do so;

  (bb) any person from whom the practitioner is seeking such employment or such an arrangement; and

  (cc) any enquirer; and

(i) the FTP Panel shall consider and announce its decision as to the direction, if any, to be made or undertakings to be taken into account and shall give its reasons for that decision.

Part 6-Restoration to the Register

Action on receipt of a restoration application

23.— (1) Upon receipt of an application for restoration made under section 41 of the Act, the Registrar may—

(a) make such investigations, and obtain such information, documents or reports as he considers appropriate; and

(b) direct the applicant to undergo an assessment of his performance or health in accordance with Schedule 1 or 2.

(2) No later than 28 days before the hearing before a FTP Panel to consider his application, the Registrar shall serve on the applicant notice of the hearing —

(a) stating the matters set out at rule 15(2)(b) to (e);

(b) requesting the applicant to notify the Registrar, within 14 days of the date of the notice, whether he wishes to attend the hearing; and

(c) inviting the applicant, if he chooses not to attend the hearing, to make written representations to be received by the Registrar no later than 14 days before the hearing;

(d) where the applicant has made a previous unsuccessful application, informing him of the FTP Panel's power to suspend indefinitely his right to make further applications for restoration under section 41(9) of the Act; and

(e) where the applicant has made a previous unsuccessful application and chooses not to attend the hearing, inviting him to make written representations on the issue of indefinite suspension of his right to make further applications, to be received by the Registrar no later than 14 days before the hearing.

(3) The notice under paragraph (2) shall be accompanied by a copy of any statement, report or other document which —

(a) has not previously been sent to the applicant or his representative; and

(b) is relevant to the question whether his name should be restored to the register.

(4) If any statement, report or other document is subsequently obtained by the General Council which is relevant to the FTP Panel's decision whether to direct that the applicant's name be restored to the register, the applicant shall be given a reasonable opportunity of responding before the FTP Panel makes its decision.

Procedure at a restoration hearing

24.— (1) The FTP Panel shall consider an application in accordance with the procedure set out in this Rule.

(2) The order of proceedings at a hearing to determine an application shall be as follows —

(a) the FTP Panel shall hear and consider any preliminary legal arguments;

(b) the Chairman of the FTP Panel shall —

(i) where the applicant is present, require the applicant to confirm his name and registration number, or

(ii) otherwise, require the Presenting Officer to confirm the applicant's name and registration number;

(c) the Presenting Officer shall —

(i) address the FTP Panel as to the background to the case and the circumstances in which the applicant's name was erased from the register,

(ii) direct the attention of the FTP Panel to any relevant evidence, including transcripts of previous hearings, and may adduce evidence and call witnesses in relation to the practitioner's fitness to practise;

(d) the applicant may address the FTP Panel and adduce evidence and call witnesses in relation to any relevant matter, including his suitability for restoration to the register;

(e) the FTP Panel may receive further evidence and hear any further submissions from the parties as to its decision whether to grant or refuse the application;

(f) the FTP Panel shall then consider and announce whether to grant or refuse the application, and shall give its reasons for that decision;

(g) before reaching a decision under sub-paragraph (f), the FTP Panel may adjourn and give such directions as it sees fit, including that the applicant should undergo an assessment of his performance or health in accordance with Schedule 1 or 2;

(h) where the FTP Panel adjourns under sub-paragraph (g), it shall —

(i) consider any assessment reports produced further to a direction under sub-paragraph (g), together with any other relevant evidence and reports, and

(ii) invite further representations and evidence from the parties,

before reaching a decision as to whether the applicant should be restored to the register; and

(i) before deciding whether or not to make a direction to suspend indefinitely the applicant's right to make further applications for restoration under section 41(9) of the Act, the FTP Panel shall —

(i) consider any representations made and evidence received, and

(ii) where the applicant is present, invite further representations and evidence from him specifically upon this issue.

Part 7-Interim orders

Initial consideration

25.— (1) This Part applies where an allegation has been referred to an Interim Orders Panel by the Registrar for consideration as to whether to make or review an interim order.

(2) Where an interim order has previously been made in respect of a practitioner the Registrar —

(a) shall refer the case to an Interim Orders Panel for the purposes of subsection (2)(a) or (9) of section 41A of the Act; or

(b) may refer the case to an Interim Orders Panel where new information is received by the General Council which, in his opinion, suggests that the interim order imposed on the practitioner's registration ought to be reviewed.

Notice of hearing

26.— (1) Prior to the initial or any review hearing relating to an interim order, the Registrar shall serve on the practitioner —

(a) a notice of hearing;

(b) a copy of any written evidence obtained by the General Council which is relevant to the question of whether or not an interim order should be made or reviewed; and

(c) in relation to a review hearing, a copy of the order to be reviewed,

in such time before the hearing as is reasonable in the circumstances of the case.

(2) The notice of hearing shall —

(a) state the matters set out at rules 15(2)(a) to (c);

(b) inform the practitioner of the power of the Interim Orders Panel to proceed in his absence under rule 31;

(c) set out briefly the reasons why it is necessary to make or review an interim order;

(d) inform the practitioner of the Interim Orders Panel's powers of disposal under section 41A of the Act;

(e) request the practitioner to notify the Registrar as soon as possible whether he intends to attend the hearing; and

(f) invite the practitioner, if he chooses not to attend the hearing, to submit any written representations, within such period as is reasonable in the circumstances and as is specified in the notice, to the Registrar.

Procedure at an interim orders hearing

— (1) At the hearing, the Interim Orders Panel may, subject to paragraphs (2) and (3), receive any evidence which appears to it to be fair and relevant to its consideration under section 41A(1), (2) or (3) of the Act.

(2) No person shall give oral evidence at the hearing unless the Interim Orders Panel consider such evidence is desirable to enable it to discharge its functions.

(3) The Interim Orders Panel may, at any stage in the proceedings —

(a) with the consent of the practitioner; or

(b) where, after consultation with the Legal Assessor, it is satisfied that to do so would be desirable to enable it to discharge its functions,

allow a party to produce at the hearing any written evidence, notwithstanding that a copy has not been provided to the other party before the hearing or that its author is not being called as a witness.

(4) At an interim orders hearing—

(a) the Interim Orders Panel shall hear and consider any preliminary legal arguments;

(b) the Chairman of the Interim Orders Panel shall announce that the hearing has commenced and shall —

(i) where the practitioner is present, require the practitioner to confirm his name and registration number, or

(ii) otherwise, require the Presenting Officer to confirm the practitioner's name and registration number;

(c) the Presenting Officer shall address the Interim Orders Panel regarding whether it is necessary to make or review an interim order in respect of the practitioner and, subject to paragraphs (1) to (3), may adduce evidence in this regard;

(d) the practitioner may present his case and, subject to paragraphs (1) to (3), may adduce evidence in support of it;

(e) the parties and members of the Interim Orders Panel may put questions to any witness;

(f) where the practitioner gives oral evidence, the Presenting Officer and members of the Interim Orders Panel may put questions to him; and

(g) the Interim Orders Panel shall announce its decision, and shall give its reasons for that decision.

(5) The Interim Orders Panel may vary the order of proceedings under paragraph (4) where it is in the interests of justice to do so.

(6) Where —

(a) an interim order is being reviewed by an Interim Orders Panel; and

(b) the hearing is, or is likely to be, the last such hearing before the expiry of the interim order,

the Interim Orders Panel may, after making its determination, notify the Registrar that an application should be made to the relevant court for the interim order to be extended under section 41A(6) of the Act.

Part 8-General

Cancellation of a hearing

28.—(1) Where, after an allegation has been referred to a Panel and before the opening of the hearing before the Panel —

(a) evidence becomes available that suggests that the practitioner's fitness to practise is not impaired;

(b) in the case of proceedings under Part 7, evidence becomes available that suggests an issue does not arise as to whether the Interim Orders Panel should make or review an interim order; or

(c) it appears that for some other reason, the hearing before the Panel should not be held,

the Registrar may refer the matter to a person listed in paragraph (2) for a decision as to whether or not the hearing should be cancelled.

(2) A decision under paragraph (1) may be made by —

(a) a member of the Committee; or

(b) the President.

(3) Where a decision is taken under this rule that a hearing should be cancelled, the Registrar shall, as soon as practicable, serve notice of the decision upon the practitioner and the maker of the allegation (if any), and shall give the reasons for that decision.

Postponements and adjournments

29.— (1) Before the opening of any hearing of which notice has been served on the practitioner in accordance with these Rules —

(a) a member of the Committee; or

(b) the President,

may, of their own motion or upon the application of a party to the proceedings, postpone the hearing until such time and date as they think fit.

(2) Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Panel considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.

(3) No hearing shall be postponed or adjourned under paragraphs (1) or (2) unless the parties have been given a reasonable opportunity to make representations on the matter.

(4) Where a hearing has been postponed or adjourned, the Registrar shall, as soon as practicable, notify the parties of the time, date and place at which the hearing is to take place or to resume.

Preliminary legal arguments

30.— Where the Committee or a Panel considers and determines any preliminary legal arguments, such determination shall bind any subsequent Committee or Panel considering the case notwithstanding that any panellists present at the original hearing are not present at the subsequent hearing, or that any panellists present at the subsequent hearing were not present at the original hearing, unless the subsequent Committee or Panel, on the advice of the Legal Assessor, considers such determination to have been wrongly decided.

Absence of the practitioner

31.— Where the practitioner is neither present nor represented at a hearing, the Committee or Panel may nevertheless proceed to consider and determine the allegation if they are satisfied that all reasonable efforts have been made to serve the practitioner with notice of the hearing in accordance with these Rules.

Joinder

32. — The Committee or Panel may consider and determine together —

(a) two or more allegations against the same practitioner which fall within—

(i) the same category; or

(ii) separate categories,

of impairment as set out in sections 35C(2)(a) to (e) of the Act; or

(b) allegations against two or more practitioners,

where it would be just to do so.

Representation

33. — (1) At a hearing, the practitioner may be represented by —

(a) a solicitor or counsel;

(b) a representative from any professional organisation of which he is a member; or

(c) at the discretion of the Committee or Panel, a member of his family or other person.

(2) A person who gives evidence at a hearing shall not be entitled to represent or accompany the practitioner at that hearing.

(3) The practitioner (either in person or by a representative under paragraph (1)) and the Presenting Officer shall be entitled to be heard by the Committee or Panel.

Evidence

34.— (1) Subject to paragraph (2), the Committee or a Panel may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.

(2) Where evidence would not be admissible in criminal proceedings in England, the Committee or Panel shall not admit such evidence unless, on the advice of the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable.

(3) Production of a certificate purporting to be under the hand of a competent officer of a Court in the United Kingdom or overseas that a person has been convicted of a criminal offence or, in Scotland, an extract conviction, shall be conclusive evidence of the offence committed.

(4) Production of a certificate signed by an officer of a regulatory body that has made a determination about the fitness to practise of a person shall be conclusive evidence of the facts found proved in relation to that determination.

(5) The only evidence which may be adduced by the practitioner in rebuttal of a conviction or determination certified in the manner specified in paragraph (3) or (4) is evidence for the purposes of proving that he is not the person referred to in the certificate or extract.

(6) The practitioner may admit a fact or description of a fact, and a fact or description of a fact so admitted may be treated as proved.

(7) A copy of a document of which the original is admissible may be received by the Committee or a Panel without strict proof.

(8) A party may, at any time, serve notice on the other party to produce the original or a copy of any document that is —

(a) relevant to the proceedings; and

(b) alleged to be in the possession, ownership or control of that party,

and such notice may be admitted into evidence by the Committee or Panel.

(9) In relation to proceedings before the Committee or a FTP Panel, unless otherwise agreed between the parties or directed by a Case Manager, each party shall not less than 28 days before the date of a hearing —

(a) provide to the other party a list of every document which he proposes to introduce as evidence;

(b) provide to the other party a copy of every document listed in paragraph (a) which the other party has not previously received; and

(c) require the other party to notify him, within 14 days of the list being provided to him, whether or not he requires any relevant person to attend and give oral evidence in relation to the subject matter or making of such document.

(10) Where one party notifies the other under paragraph (9)(c) that he requires a relevant person to attend to give oral evidence, the document concerned may nonetheless be received into evidence without such oral evidence where the Committee or FTP Panel is of the view that, having regard to all the circumstances (including the difficulty or expense of obtaining such attendance) and the justice of the case, it is proper to do so.

(11) Having regard to any directions given by a Case Manager, on the application of a party, the Committee or a Panel may admit any signed witness statement containing a statement of truth as the evidence-in-chief of the witness concerned.

Witnesses

35. — (1) Witnesses shall be required to take an oath, or to affirm, before giving oral evidence at a hearing.

(2) Subject to rule 36, witnesses —

(a) shall first be examined by the party calling them;

(b) may then be cross-examined by the opposing party;

(c) may then be re-examined by the party calling them; and

(d) may at any time be questioned by the Committee or Panel and, with the leave of the Chairman at the hearing, a specialist health adviser or specialist performance adviser.

(3) Any further questioning of the witnesses by the parties shall be at the discretion of the Committee or Panel.

(4) The Committee or Panel may, upon the application of a party, agree that the identity of a witness should not be revealed in public.

(5) The Committee or Panel may, on the application of a party or of its own motion, require a witness to attend a hearing and the relevant party shall exercise its power to compel attendance under paragraph 2 of Schedule 4 to the Act accordingly.

(6) A witness of fact shall not, without leave of the Committee or Panel, be entitled to give evidence at a hearing unless he has been excluded from the proceedings until such time as he is called.

Vulnerable witnesses

36.— (1) In proceedings before the Committee or a Panel, the following may, if the quality of their evidence is likely to be adversely affected as a result, be treated as a vulnerable witness —

(a) any witness under the age of 17 at the time of the hearing;

(b) any witness with a mental disorder within the meaning of the Mental Health Act 1983;

(c) any witness who is significantly impaired in relation to intelligence and social functioning;

(d) any witness with physical disabilities who requires assistance to give evidence;

(e) any witness, where the allegation against the practitioner is of a sexual nature and the witness was the alleged victim; and

(f) any witness who complains of intimidation.

(2) Subject to the advice of the Legal Assessor, and upon hearing representations from the parties, the Committee or Panel may adopt such measures as it considers desirable to enable it to receive evidence from a vulnerable witness.

(3) Measures adopted by the Committee or Panel may include, but shall not be limited to:

(a) use of video links;

(b) use of pre-recorded evidence as the evidence-in-chief of a witness, provided always that such witness is available at the hearing for cross-examination and questioning by the Committee or Panel;

(c) use of interpreters (including signers and translators) or intermediaries;

(d) use of screens or such other measures as the Committee or Panel consider necessary in the circumstances, in order to prevent—

(i) the identity of the witness being revealed to the press or the general public; or

(ii) access to the witness by the practitioner; and

(e) the hearing of evidence by the Committee or Panel in private.

(4) Where—

(a) the allegation against a practitioner is based on facts which are sexual in nature;

(b) a witness is an alleged victim; and

(c) the practitioner is acting in person,

the practitioner shall not without the written consent of the witness be allowed to cross-examine the witness in person.

(5) In the circumstances set out in paragraph (4), in the absence of written consent, the practitioner shall no less than 7 days before the hearing appoint a legally qualified person to cross-examine the witness on his behalf and, in default, the General Council shall appoint such person on behalf of the practitioner.

Record of decisions of the Committee or Panel

37.— The person acting as secretary to the Committee or Panel shall —

(a) record in writing the decision of the Committee or Panel and reasons for their decision;

(b) with the exception of confidential issues concerning the physical or mental health of the practitioner, publish the decision; and

(c) inform the Registrar of the decision and the reasons for it.

Voting

38.— (1) Decisions of the Committee or of a Panel shall be taken by simple majority.

(2) No Chairman of the Committee or Panel may exercise a casting vote.

(3) No member of the Committee or Panel may abstain from voting.

(4) Subject to paragraph (5), where the votes are equal, the Committee or Panel shall decide the issue under consideration in favour of the practitioner.

(5) Where a FTP Panel is considering —

(a) an application to restore a practitioner's name to the register; or

(b) submissions made by the practitioner under rule 17(2)(g),

and the votes are equal, it shall decide the issue against the practitioner.

Notes and transcript of proceedings

39.— (1) The Registrar shall arrange for the proceedings of the Committee or Panel to be recorded by electronic means or otherwise.

(2) Any party to the proceedings shall, on application to the Registrar, be furnished with a copy of the record of any part of the proceedings at which he was entitled to be present.

(3) Paragraphs (1) and (2) shall not apply to the deliberations of the Committee or Panel.

Service

40. — (1) Any notice of hearing required to be served upon the practitioner under these Rules shall be served in accordance with paragraph 8 of Schedule 4 to the Act.

(2) If the practitioner is represented by a solicitor, any such notice shall be served at the solicitor's practising address.

(3) Any other notice or document to be served on a person under these Rules may be sent by ordinary post.

(4) The service of any notice under these Rules may be proved by —

(a) a confirmation of posting issued by or on behalf of the Post Office, or other postal operator or delivery service; or

(b) a signed statement from any person serving the notice by hand.

Attendance of the public

41. — (1) Subject to paragraphs (2) to (6) below, hearings before the Committee and a FTP Panel shall be held in public.

(2) The Committee or FTP Panel may determine that the public shall be excluded from the proceedings or any part of the proceedings, where they consider that the particular circumstances of the case outweigh the public interest in holding the hearing in public.

(3) Subject to paragraphs (4) to (6), the Committee or a Panel shall sit in private, where they are considering—

(a) whether to make or review an interim order; or

(b) the physical or mental health of the practitioner.

(4) Where it is considering an allegation, the FTP Panel may revoke an interim order in public.

(5) A Panel shall, where it is considering matters under paragraph (3)(a), sit in public where the practitioner requests it to do so.

(6) Subject to paragraph (5), the Committee or Panel may, where they are considering matters under paragraph (3)(a) or (b), hold a hearing in public where they consider that to do so would be appropriate, having regard to—

(a) the interests of the maker of the allegation (if any);

(b) the interests of any patient concerned;

(c) whether a public hearing would adversely affect the health of the practitioner; and

(d) all the circumstances, including the public interest.

(7) The Committee or Panel may deliberate in camera, in the absence of the parties and of their representatives and of the public, at any time.

Exclusion from proceedings

42.— The Committee or Panel may exclude from any hearing any person whose conduct, in their opinion, is likely to disrupt the orderly conduct of the proceedings.

Consequential amendments

43.— In rule 3 of the General Medical Council (Suspension and Removal of Members from Office) Rules 2004 (**c**) —

(a) in paragraphs (3)(1)(b) and (2), "section 38 or 41A of the Act" shall be substituted for "section 38, 41A or 41B of the Act"; and

(b) in paragraph (3)(b)(ii), "section 35D of the Act" shall be substituted for "section 36, 36A or 37 of the Act".

Revocation

44.— The General Medical Council (Interim Orders Committee) (Transitional Provisions) Rules 2000 (**d**) are hereby revoked.

(c) Scheduled to S.I. 2004/215
(d) Scheduled to S.I. 2000/2054

Given under the official seal of the General Medical Council this 15th day of September 2004

Professor Sir Graeme Catto
President

Rules 2, 3(1)(a), 7(3) to (6), 10(1), 10(5)(b), 11(7)(d), 13(e), 17(4)(b), 17(8), 19(b), 23(1)(b), 24(2)(g)

SCHEDULE 1-PERFORMANCE ASSESSMENTS

Interpretation

1. In this Schedule "assessment" means an assessment of the standard of the practitioner's professional performance

Assessment Teams

2. (1) An assessment shall be carried out by an Assessment Team.

(2) The Registrar shall select from the panel of performance assessors appointed under rule 3, an Assessment Team comprising–

(a) a team leader, who shall be a medical performance assessor;

(b) one or more other medical performance assessors; and

(c) one or more lay performance assessors.

(3) A person shall not be selected as a member of an Assessment Team in any case where he has been selected to act as a specialist adviser at a previous hearing of the case.

(4) In selecting a medical performance assessor as a member of an Assessment Team, the Registrar shall have regard to the specialty to which the allegation relates.

Proceedings and procedures of Assessment Teams

3. (1) Subject to sub-paragraphs (2) to (4), and having regard to the nature of the practitioner's employment, the Assessment Team shall adopt such procedures as appear to it to be necessary in order to assess the standard of the practitioner's professional performance.

(2) The Assessment Team may seek advice or information from any person who might, in the opinion of the Assessment Team, assist them in carrying out the assessment.

(3) The Assessment Team shall disclose to the practitioner any written information or opinion received by the Assessment Team which in their opinion may influence their assessment of the standard of his professional performance, and shall afford him a reasonable opportunity to respond.

(4) The Assessment Team shall produce a report on the standard of the practitioner's professional performance which shall express —

(a) an opinion as to whether the practitioner is fit to practise either generally or on a limited basis; and

(b) any recommendations as to the management of the case.

'Trust me, I'm a doctor'

In the first programme of a new series, Real Story investigates whether enough is being done to protect patients from rogue GPs.

The Harold Shipman murders demonstrated that it is possible for some GPs to get away with abusing their privileged position of trust.

In tonight's programme, presenter Fiona Bruce meets a number of victims who have suffered shocking sexual abuse at the hands of their doctors.

She also exposes the unscrupulous GPs who use their patients as unwitting medical "guinea pigs", earning money by testing new drugs on them without their consent.

Does the system that polices the medical profession and determines a doctor's fitness to practice need a radical overhaul?

Real Story: BBC One, Monday, 8 November 2004, 1930 GMT and streamed on the Real Story website.

Story from BBC NEWS:
http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/3991135.stm

Published: 2004/11/08 19:17:37 GMT

© BBC MMIV

Green Lever Arch File Labelled "Barton"

Document	Relates to
Tab 1 - PPC Bundle - appears same as IOC Bundle for 19/09/02	Various
Tab 1 - PPC Outcome	Various
Tab 2 - Barton's written response to PPC	Page, Wilkie, Richards, Cunningham, Wilson
Tab 3 - Internal memo advising referral to PCC	
Tab 3 - Transcript of IOC on 19/09/02	

Rules 2, 3(1)(b), 7(3), 7(4), 7(6), 10(1), 10(5)(b), 11(7)(d), 13(e), 17(4)(b), 17(8), 19(b), 23(1)(b), 24(2)(g)

SCHEDULE 2-HEALTH ASSESSMENTS

1. In this Schedule "assessment" means an assessment of the physical or mental condition of the practitioner.

2. The Registrar shall invite the practitioner within 14 days to agree to attend before two medical examiners selected by the Registrar from the panel appointed under rule 3 for the purposes of assessing the practitioner's physical or mental condition.

3. If the practitioner accepts the invitation under paragraph (2) within 14 days from the date of such invitation (or such further period as the Registrar may allow) the Registrar shall make arrangements for the assessments to be carried out.

4. The medical examiners shall each be required to prepare a report on the practitioner's physical or mental condition which shall express —

   (a) an opinion as to whether the practitioner is fit to practise either generally or on limited basis; and

   (b) any recommendations as to the management of the case.

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PORTSMOUTH
HealthCare
NHS
TRUST

DR R I REID, FRCP
CONSULTANT GERIATRICIAN

Elderly Medicine
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY

Tel:	01705 822444
Extension:	6920
Direct Line:	01705 286920
Fax:	01705 200381

RIR/BJG/WVTQ130407

5th August 1998

H00302284

Surgeon Commander M Scott
The Royal Hospital Haslar
Gosport
Hants

Dear Surgeon Commander Scott

RE: WARD VISIT - E6 WARD HASLAR
Gladys RICHARDS - DOB Code A
HA: GLENHEATHERS NURSING HOME, LEE-ON-SOLENT, HANTS

Thank you for referring Mrs Richards whom I saw on Ward E6 at Haslar Hospital on 3rd August.

Fortunately two of her daughters were present when I visited so I was able to obtain information from them, about Mrs Richards pre-morbid health. It would appear that Mrs Richards has been confused for some years but was mobile in her nursing home until around Christmas 1997 when she sustained a fall. She started to become increasingly noisy. She was seen by Dr Banks whom presumably felt she was depressed as well as suffering from a dementing illness. She has been on treatment with Haloperidol and Trazodone. According to her daughters she has been "knocked off" by this medication for months and has not spoken to them for some six to seven months. Her mobility has also deteriorated during that time and when unsupervised she has a tendency to get up and fall. In the last such incident, she sustained a fracture to the neck of her right femur, for which she has had a hemi-arthroplasty. I believe that she is usually continent of urine but has had occasional episodes of faecal incontinence.

Since her operation she has been catheterised. She has had occasional faecal incontinence and has been noisy at times. She has been continued on Haloperidol, her Trazodone has been omitted. According to her daughters it would seem that since her Trazodone has been omitted she has been much brighter mentally and has been speaking to them at times.

contd.......

Code A

A=/C 3

Gladys RICHARDS

When I saw Mrs Richards she was clearly confused and unable to give any coherent history. However she was pleasant and cooperative. She was able to move her left leg quite freely and although not able to actively lift her extended right leg from the bed, she appeared to have a little discomfort on passive movement of the right hip. I understand that she has been sitting out in a chair and I think that, despite her dementia, she should be given the opportunity to try to re-mobilise. I will arrange for her transfer to Gosport War Memorial Hospital. I understand that her daughters intend to give up the place in Glenheathers Nursing Home as they have been unhappy with the care, but would be happy to arrange care in another nursing home.

Yours sincerely

Code A

DR R I REID, FRCP
Consultant Physician in Geriatrics

cc. Dr J H Bassett
Lee-on-Solent Health Centre
Manor Way
Lee-on-Solent
Hampshire

Royal Hospital Haslar

Gosport • Hants • PO12 2AA

Telephone 01705 584255 Ext. 2739 Fax. 01705 762403

The Sister in Charge
Ward Memorial Hospital
Bury Road
GOSPORT
Hants

Date: 10th August 1998

Your ref:

Our ref: H 302284

Dear Sister

RE: MRS GLADYS RICHARDS **Code A**

Gladys sustained a right fractured neck of femur on 30th July 1998 in Glen Heathers Nursing Home. She was admitted to E6 ward and had a right cemented hemi-arthroplasty and she is now fully weight bearing, walking with the aid of two nurses and a zimmer frame.

PAST MEDICAL HISTORY:
Deaf in both ears
Cataract operations to both eyes.
Six month history of falls.
Alzheimers – worse over last six months.
Hysterectomy 1955.

ALLERGIES: Penicillin V

DRUGS:
Haloperidol suspension 1mg bd
Lactulose 10 – 15mls bd
Co-codamol 2 prn.

Gladys needs total care with washing and dressing, eating and drinking, although her daugters are extremely devoted and like to come in and feed her at mealtimes (although I feel they could do with a rest). Gladys has a soft diet and enjoys a cup of tea.

ELIMINATION: Gladys is continent, when she become fidgety and agitated it means she wants the toilet. Occasionally incontinent at night, but usually wakes. Bowels opened on 9th August 1998.

SPEECH: Occasionally says recognisable words, but not very often.

WOUND: Is healed, clean and dry.

PRESSURE AREAS: All intact, bottom slightly red, but not broken.

Thank you for taking Gladys and I hopes she settles in well.

Yours sincerely

N J Curran
Sergeant
Staff Nurse

Code A

Code A

Code A

Code A

Code A

Past Medical History

Deaf in both ears

Cataract operations - Both eyes

Six month history of falls

Alzheimers — Worse over last 6/12

Hysterectomy 1955

Code A

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PORTSMOUTH HealthCare NHS TRUST

Patient Name ....

Care Plan

Date	
	Evaluation

CONSTIPATION

Daedalus Ward GWMH
Nursing Care Plan

Patient Gladys Richards.

Named Nurse Margaret Couchman

Date	
11·8·98	Problem:-
	Due to *patient is prone to constipation*
	Desired Outcome:
	To promote normal bowel habit
	Evaluation Interval or Date:
	Daily
	Nursing Action:
	Encourage high fibre diet *Encourage high fluid intake* *Monitor bowels & record when open* *Ensure bowels are opened every 2-3 days* *Give apperients or enemas when necessary* *Ensure privacy & dignity when toiletting*
	Signature of Nurse Initiating Care Plan
	Evaluation
12.8.98	BNO AR [signature]
14-8.98	BNO [signature]
21.8.98	BNO [signature]

(LHH/C/3212S

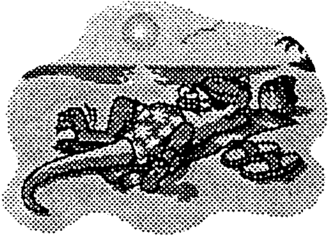
PORTSMOUTH HealthCare NHS TRUST

Patient Name ....

Care Plan

Date	Evaluation

Mrs Gladys Richards [LAH/1/C/22/3]



AUGUST 1998

M	T	W	T	F	S	S
					1	2
3	4	5	6	7	8	9
10	11					16
17	18					23
24	25	26	27	28	29	30
31						

Code A

Code A

Code A

B

PRESCRIPTION SHEET

for the safety of the patient

DOCTOR

1. Use approved names, BLOCK LETTERS, and metric dosage.
2. Be specific in indicating the timing and route:-
   - (a) For regular prescriptions tick (✓) the appropriate boxes and indicate time in blank space.
   - (b) For drugs which are likely to have frequently changing doses, use the section at "Daily Review Prescriptions" on back of sheet.
3. Any CHANGES in your drug therapy MUST be ordered by a NEW PRESCRIPTION: do NOT alter existing instructions.
4. Discontinue a drug by clearly crossing out the discontinued drugs (viz TETRACYCLINE) draw line through the unused recording panels and sign in with full name.
5. Prescribe INFUSION THERAPY and any drugs to be added on the INFUSION CHART.
6. Take home drugs will be written up on form MR15 which then will be placed in the appointment and prescription record card.
7. All prescriptions must be signed in full.
8. The following should be used to indicate route.

   S.C. .... Subcutaneous
   I.M. .... Intramuscular
   I.V. .... Intravenous
   Sub Ling .... Sublingual
   Intrathecal
   Oral
   Rectal
   Topical
   P.V. - per vaginum

9. Put date prescription needs to be reviewed in "review" box of Regular Prescription Section.

NURSE

1. Initial the administration in the appropriate box. (This must be done by the Senior Nurse).
2. Check all sections to avoid omission.
3. Use the top continuation sheet only for recording administration.
4. If a dose is missed write "X" in the box and give the reason in the Exceptions to Prescribed Orders.

If for some reason **all** the drugs prescribed for a certain time are not given, e.g. patient fasting, patient absent, there is no need to itemise each drug. Enter date, time and write **ALL** in name and dose column.

ADDITIONAL CHARTS	ANTICOAGULATION	
	INTRAVENOUS FLUIDS	
	INTRAVENOUS INFUSIONS	

Code A

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10/30

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Code A

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

CARE PLAN

NAME OF PATIENT

HOSPITAL NUMBER

DATE SIGN	PROBLEM		
	DESIRED OUTCOME		
	PRESCRIBED CARE	REVIEW	

Code A

Code A

EVALUATION

	EVALUATION		
MOVEMENT	RAG	AT BEST	AT WORST
1.Turning/Rolling			
2.Up/down Bed			
3.In to bed			
4. Out of bed			
5.Sit to Stand/Standing			
6.On/Off Toilet/Commode			
7.In/Out of Chair			
8.Walking			
9.Bath/Shower			
Signature of Assessor Print Name Designation Date of Assessment	…………………… …………………… …………………… ……………………		RE-EVALUATION …………………… …………………… …………………… ……………………

Red = Much assistance required **A**mber = Some help **G**reen = Independent

Code A

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DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

NAME OF PATIENT HOSPITAL NUMBER

DAILY SUMMARY

DATE/ TIME	COMMENT	SIGN

Code A

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PORTSMOUTH HealthCare NHS TRUST

Patient Name Arthur Cunningham SS18104.

Nursing Care Plan

Named Nurse SIN F Shaw

Date	
	Problem/Need Number
21.9.98	Large sacral sore present on admission
	SPSSS 3.4.
	F Shaw
	Desired Outcome To aim to promote healing
	and prevent further breakdown
	Evaluation Date or Interval Daily
	Nursing Action
1)	Clean with normal saline
2)	Apply Iavanit cover with allevyn
3)	Secure with Hypafix
25.9.98	Renewed using Granuflex bordered.
	F Shaw

NR9

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Code A

GMC100648-0282

Code A

Code A

GMC100648-0284

Dr R.A. PENNELLS,
M.B., B.S., D.Obst., R.C.O.G., F.P.Cert.
Dr D.B. TRAYNOR,
M.B., Ch.B., D.Obst., R.C.O.G., M.R.C.G.P., F.P.Cert.
Dr M.C. DAVIS,
B.M., D.Obst., R.C.O.G., F.P.Cert.
Dr H. YEO,
B.Sc., M.B., B.S., D.R.C.O.G., M.R.C.G.P., F.P.Cert.
Dr F. SHAW,
B.M., D.R.C.O.G., M.R.C.G.P., F.P.Cert.
Dr D.M. CHILVERS,
M.B.B.S., D.R.C.O.G., M.R.C.G.P., F.P.Cert.

Dr PENNELLS & PARTNERS
GOSPORT HEALTH CENTRE
BURY ROAD
GOSPORT
HANTS.
PO12 3PN
Tel. 01705-583344
Fax: 01705-602704

31.7.98.

Dear Doctor,

Alice Wilkie, 2.9.16.
Addenbrooke House.

This demented lady has been in this psycho geriatric care home for a year.

[illegible]

I am grateful for your help
& her management.

Yours sincerely

[illegible]

Code A

Code A

HealthCare
NHS
TRUST

HANDLING PROFILE

Name Alice Wilkie — Date of Birth 2-9-16
Hosp. No — Location
Care Group Blue Team — Weight 47·1Kg
Diagnosis

PATIENT/CLIENT RISK FACTORS eg	EFFECTS OF RISK FACTORS ON ABILITIES/HANDLING NEEDS
COMMUNICATION	Very poor Suffers from demestia
[illegible]PLIANCE	Mobilises with lots of encouragement
PAIN	Some pain in abdomen
SKIN INTEGRITY	
CLIENT/CARER PREFERENCE	
[illegible]IRONMENTAL RISK FACTORS	
EG. PRESSURE RELIEVING MATTRESSES	
ADDITIONAL HANDLING CONSTRAINTS	
EG. IVI, URINARY CATHETER	

		RE-EVALUATION
Date of Assessment	31/7/98	
Name of Assessor	S. Rule	
Signature of Assessor	[signature]	
Designation of Assessor	STN	

Code A

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

PATIENT OBSERVATIONS NAME: Alice Wilkie D.O.B. 2·9·16 HOSPITAL NO.

T. 38.3 (Ax) P. 82 R. BP. 143/62 WEIGHT.

URINE PH6 +2 protein +3 Blood NUTRITIONAL SCORE 16 WATERLOW SCORE

ADMISSION SUMMARY INCLUDING PAST MEDICAL HISTORY/HOME SITUATION & TYPE OF ACCOMMODATION AND OTHER HEALTH AND SOCIAL CARE PROFESSIONALS

MEDICATION

Depixol 10mg Prozac syrup (20mgs) 5mls AM
Co Danthramer 5-10mls nocte promazine (50mg) 2.5mls PRN
Lactulose 10mls BD zoplidone (375mg) ½ tab nocte PRN

Social

Psychogeriatric care home 24° care
contact Marie Wood for any more information

PMH

Dementia

REFERRALS TO	BY	WHY	DATE	ACTIONED
Dietician	SN STN	Nutritional score 16	31/7/98	

INVESTIGATIONS

TYPE	DATE REQ	ACTIONED	RESULT

Code A

Code A

Code A

PORTSMOUTH
HealthCare
NHS
TRUST

Patient Name ....Alice Wilkie....

The Barthel ADL Index

Date:	31-7-98	5/8/98							
Bowels 0 = Incontinent 1 = Occasional accident 2 = Continent	N/A								
Bladder 0 = Incontinent or catheterised & unable to manage 1 = Occasional accident (max 1 per 24 hours) 2 = Continent (for over 7 days)	0	0							
Grooming 0 = Needs help 1 = Independent, face / hair / teeth / shaving	0	0							
Toilet 0 = Dependent 1 = Needs some help but can do something 2 = Independent	0	0							
Feeding 0 = Unable 1 = Needs help cutting, spreading butter etc. 2 = Independent	0	1							
Transfer 0 = Unable 1 = Major help (1-2 people, physical 2 = Minor help (verbal or physical) 3 = Independent	1	1							
Mobility 0 = Unable 1 = Wheelchair independent, including corners etc. 2 = Walks with help of **one** person (verbal or physical) 3 = Independent, (but may use any aid, e.g. stick)	0	0							
Dressing 0 = Dependent 1 = Needs help, but can do half unaided 2 = Independent	0	0							
Stairs 0 = Unable 1 = Needs help (verbal, physical, carrying aid) 2 = Independent, up and down	/	0							
Bathing 0 = Dependent 1 = Independent	0	0							
Total	1	2							

NR4

Code A

Code A

Code A

Code A

Code A

Code A

Code A

Code A

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

NAME OF PATIENT Alice Wilkie HOSPITAL NUMBER

DAILY SUMMARY

DATE/ TIME	COMMENT	SIGN
	this a.m. Blue pad insitu.	KS J Atwish HCA
	Little fluids taken this am due to	
	bath.	K Shergold RN
2-8-98 20.15	Quite afternoon. Encourage with fluids.	Pebbs HCA
0700.	Slept well. Confused when awake	B Farrell
3-8-98 10.00	Assisted with washing and dressing.	
	Ate most of breakfast. Encouraged with	
	fluid intake.	P Wells HCSW
1400	PR - microlette enema given with soft	
BO	medium result.	K Shergold
1955	Quiet pm. S/C fluids continue.	
	Pad insitu.	K Shergold RN
Nocte	Slept for long periods, remains confused	
	S/C fluids continue	C M Symons
04/08	Full wash given, [illegible] pad	
	insitu, catheter draining little	
	amount. Minimal fluids taken	
	Seems confused and sleepy this	
	am. Bowels not open. K Shergold.	[illegible]
	S/C fluids continue.	K Shergold
20-30	Quiet pm, family visited,	
	Sub cut fluids continue, otherwise	
	remains in her chair.	[illegible]
5.8.98	slept well, S/C fluids continued, Cather	
	draining	[illegible]
5.8.98	Assisted wash given. Pad insitu. Food and fluids	[illegible]
	encouraged. Bowels not open this am.	J Atwish HCA
	Sub cut fluids continue	
	output only [illegible] in bag (catheter)	
	not emptied though.	[illegible]

DEPARTMENT OF MEDICINE FOR ELDERLY PEOPLE

NAME OF PATIENT Alice Wilkie HOSPITAL NUMBER

D.O.B. 2-9-16

DAILY SUMMARY

DATE/ TIME	COMMENT	SIGN
5.8.98 1930	Quiet pm - visited by daughter & granddaughter. Fluid intake very poor. Subcut fluids very slow.	[illegible signature]
6.8.98 0700	Slept very well S/cut fluids continued for Dryad Gosport today	[illegible signature]
6.8.98 10.00	Assisted with washing and dressing. Catheter draining poor. Suppositries given with good result. Packed and ready for transfer.	[illegible signature] HCSW P Webb

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REGULAR PRESCRIPTION

TURN OVER FOR DAILY REVIEW PRESCRIPTIONS
Administration Record
FIX CONTINUATION MR 411 (C) HERE

19 Month → Feb.

Date → 13 14 15 16 25

DRUG (Approved Name)	Route	Dose	Start Date	Pharm.	Time
FLUCLOXACILLIN	PO	250mg	13/2	S	0600, 1200, 1700, 2200
THIORIDAZINE SYRUP	[illegible]	10mg	25/2/93		14, 18, 22
DRUG (Approved Name)	Route	Dose	Start Date / Review Date	Pharm.	Time
DRUG (Approved Name)	Route	Dose	Start Date / Review Date	Pharm.	Time
DRUG (Approved Name)	Route	Dose	Start Date / Review Date	Pharm.	Time
DRUG (Approved Name)	Route	Dose	Start Date / Review Date	Pharm.	Time

SIGNATURE

Dr G Harris

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GMC100648-0567

PORTSMOUTH HealthCare NHS TRUST

Patient Name ....

Abbreviated Mental Study

	Hospital No:				Study No:
	Adm	Day 7-10	Interim Optional		Disch
Please fill in the date (day/month)					
1. Age	❑	❑	❑	❑	❑
2. Time (to the nearest hour)	❑	❑	❑	❑	❑
3. Give address for recall at end of test. This should be repeated by the patient to ensure it has been heard correctly.					
42 West Street	❑	❑	❑	❑	❑
4. Year	❑	❑	❑	❑	❑
5. Name of institution	❑	❑	❑	❑	❑
6. Recognition of **two** persons, (Doctor, Nurse etc.)	❑	❑	❑	❑	❑
7. Date of birth, (day & month sufficient)	❑	❑	❑	❑	❑
8. Year of the First World War	❑	❑	❑	❑	❑
9. Name of the present Monarch	❑	❑	❑	❑	❑
10. Count backwards 20 to 1	❑	❑	❑	❑	❑

Don't forget the address for recall

Total Score					

If assessment not possible, please give reason

Coma	❑	❑	❑	❑	❑
A/Dysphasia	❑	❑	❑	❑	❑
Refusal	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑
Specify					

Centre:

479

NR5

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Patient Name ....

Summary

Summary of Significant Events *(Including Relevant Medical History)*

Date	
	Son has stayed c̄ Eva all day & is aware
	of poor condition. Pastor Mary has visited [illegible]
3. 3. 98	Condition continued to deteriorate at Died
	peacefully at 21-30hrs Son returned to
	ward at 22-45h. For Cremation [illegible]

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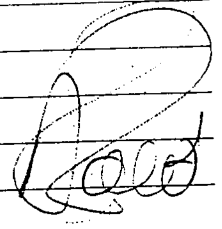
DATE	CLINICAL NOTES (Each entry must be signed)
	Discussed with Radiologist
	I don't think Bronchoscopy is a good idea. Maybe CT Scan of Thorax
	In view of advanced age. Aim in the management should be palliative care. Chalmers ward is suitable.
	Not for CPR.
	T. Shaw
15/2/98	Remains v. low
	Appears to have given up
	D/w son re probable Ca
	.. pt re ability to cope.
	
	D/w son - explained probable Ca bronchus
	- agrees not for further invasive Tx
	- will see from pt visiting today - will decide on ability to cope

UNIT NO   S.M.W.   M.F.

Name PAGE EVA
(Surname First)

.... HOSPITAL

Address

HISTORY SHEET

Date of Birth 09/12/09

Family Dr.

DATE	CLINICAL NOTES (Each entry must be signed)
14/02/98	ATSP lump under (L) eye lid.
	Apparently had it on/off for some time usually comes to head then bursts.
	O/E Red swelling ~ 1/2 cm diameter Small punctum
	On IV antibiotics.
	Imp simple cyst ± infection.
	Plan. - continue ABCs
	NB UNABLE TO FIND CURRENT NOTES.
	[signature] ([illegible])
1/7	ATSP FALL.
	Patient was trying to make way to toilet when suffered a fall: feeling about in the dark.
	A little confused. Refuses to participate in M.S.S. - says it hurts her brain! I am told this is not a new occurrence. Maybe that pt. is depressed.
	O/E 2 cuts (minor): one on nose / one on forehead. No reason to suspect fracture or tenderness. PERLA G.C.S (15) No focal neurological deficit.
	CVS Pulse 100 AF nil else. BP 180/85

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