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Subject: Legal
Volume: 2
Date Created: 07-06-27

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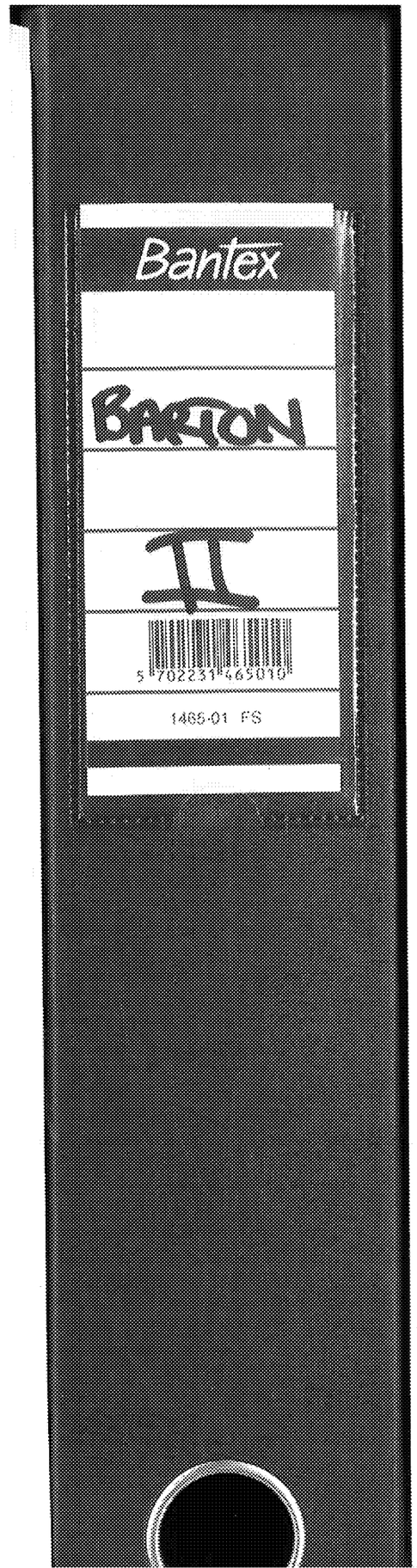
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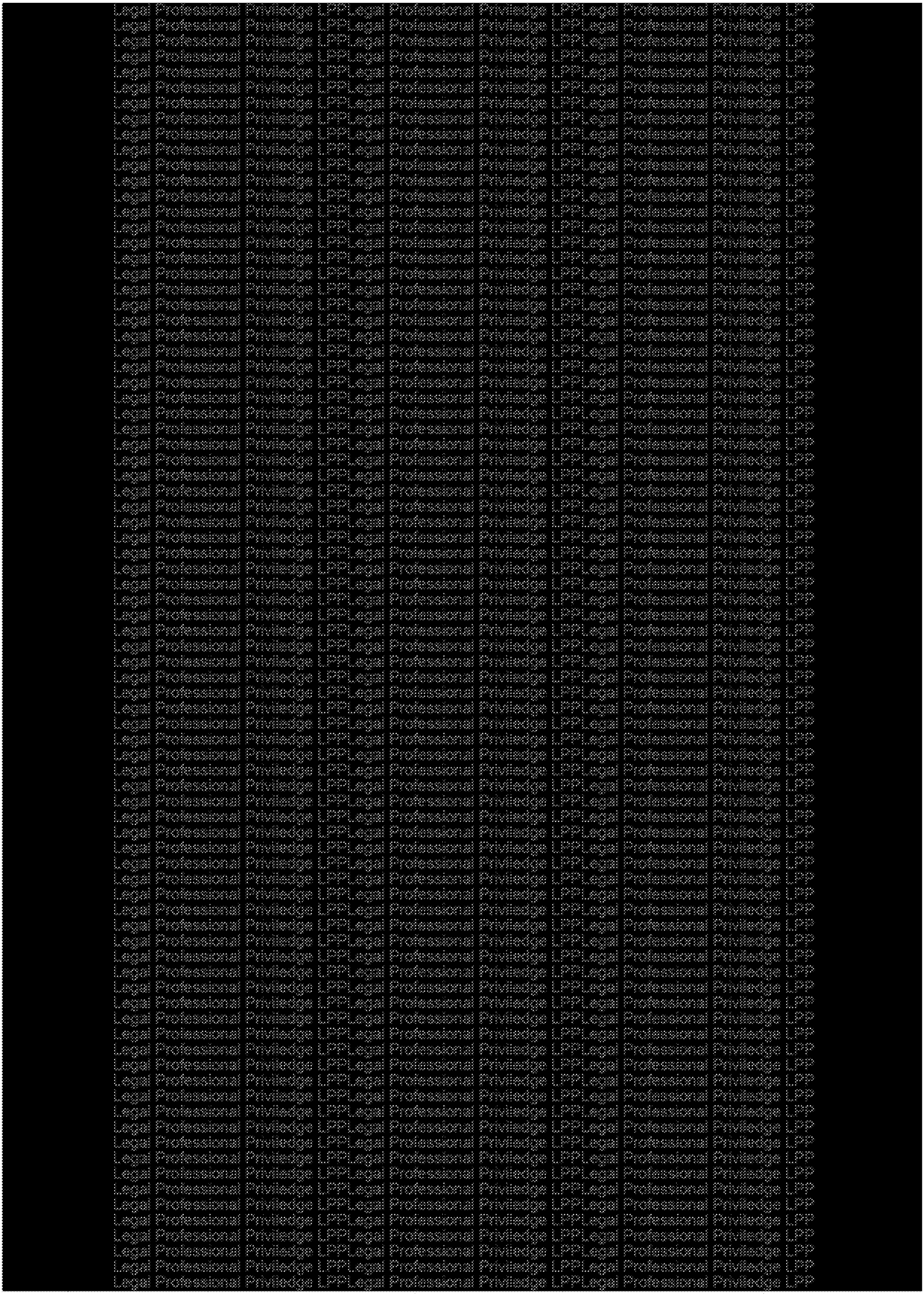
Enclosures

1. Bundle of papers before the Interim Orders Committee on 19 September 2002.
2. Transcript of the hearing before the Interim Orders Committee on 19 September 2002.
3. Relevant, recent internal memoranda.
4. Telephone note re: Report of Professor Baker.
5. S41A Medical Act 1983 (as amended)
6. Interim Orders Committee (Procedure) Rules 2000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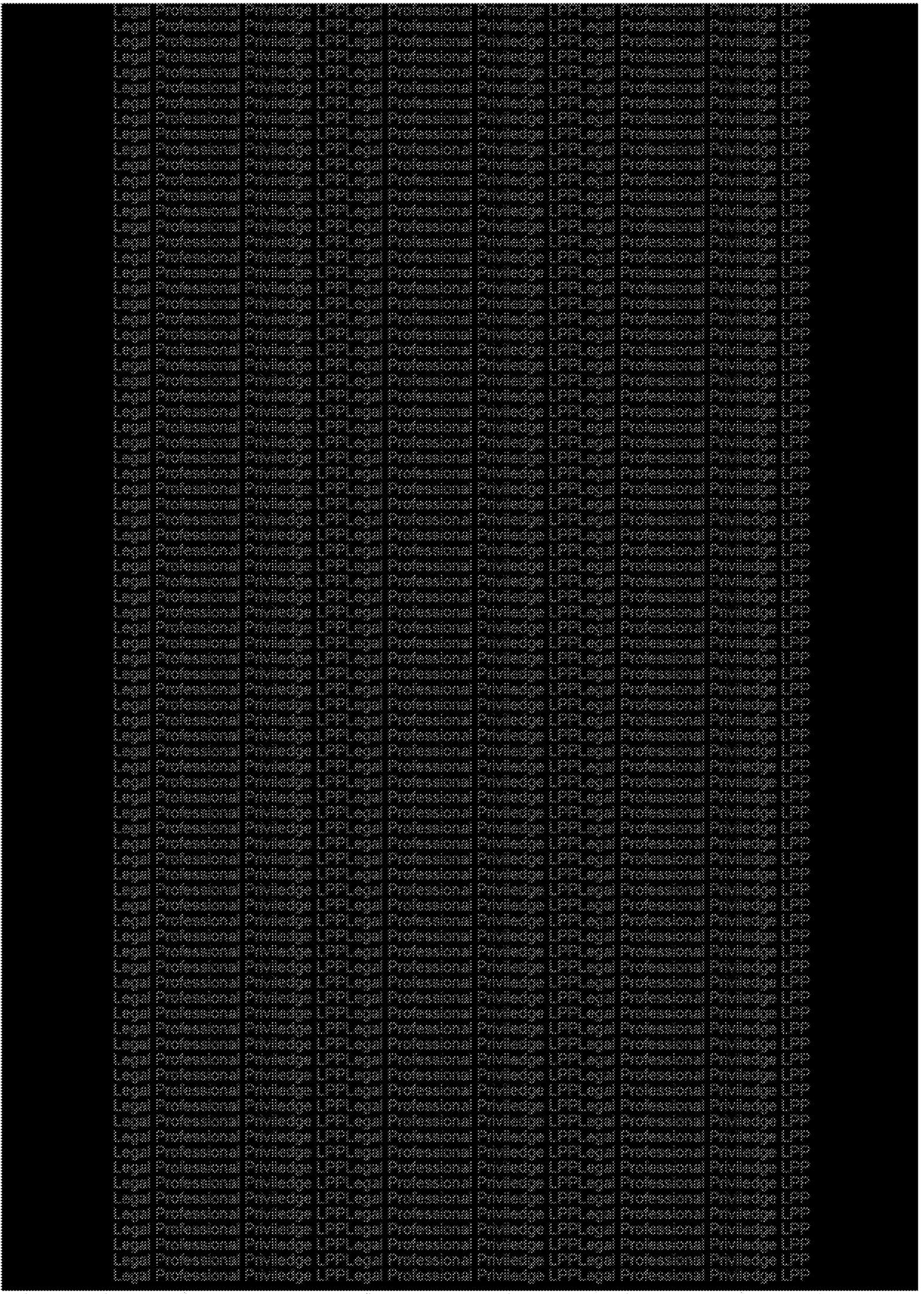
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HAMPSHIRE CONSTABULARY

WALTER CLISSOLD

WALTER CLISSOLD

Walter Clissold

Date of Birth: Code A Age: **90**
Date of Admission to GWMH: **3rd August 1999**
Date of Death: **23.55 hours on 8th September 1999**
Cause of Death:
Post Mortem:
Length of Stay: **37 days**

Mr Clissold's past medical history:

1987 – CA bladder/bowel
1992 - MI
1999 - Cystoscopy
1999 - Prostatectomy
Hypertension
CCF heart
CRF Kidneys
COPD pulmonary.

Mr Clissold was living independently at home. He had a home help and his neighbour would do the shopping for him. Mr Clissold had slightly impaired hearing but managed quite well. Mr Clissold had no family and his neighbour was noted as his next of kin. He was admitted to Haslar Hospital on 21st June 1999 with shortness of breath and underwent a transurethural resection of prostate and bladder biopsy. He was transferred to the Gosport War Memorial Hospital on 3rd August 1999 for rehabilitation.

On admission a handling profile was completed noting Mr Clissold needed the help of 1 to 2 nurses and a hoist for transfers. It also noted that he was nursed on a biwave plus mattress to prevent pressure damage.
A mouth assessment was undertaken as well as care plans for constipation, long term urinary catheter, hygiene and to settle at night.
A Waterlow score of 19-23 was recorded between August and September. As well as a Barthel ADL index for the same period with a score of between 6-3.
A nutritional assessment was completed in August with a score of 18 recorded.

3rd August 1999

Admitted to Gosport War Memorial Hospital from Haslar Hospital for rehabilitation. Pressure area were noted to be intact and that Mr Clissold had CA bladder he was in renal failure and that his mobilisation was not good.

16th August 1999

Not in pain. Reluctant to do much.

27th August 1999

Abdominal pain noted.

1st September 1999

Small sacral sore. 2 nurses and a hoist to transfer.

6th September 1999

Small split sacrum. Going downhill. Abdominal pain. Fentanyl given more comfortable.

8th September 1999

Anxious – will have to have syringe driver. Syringe driver satisfactory 20mgs diamorphine.

17.30 hours – very rigid, very bubbly, deteriorated. **Syringe driver recharged with 50 mgs diamorphine.**

23.55 hours – died. Verified S/N Collins.

OPERATION ROCHESTER
CLINCAL TEAM'S SCREENING FORM

Patient Identification

Code A

Exhibit number
BJC-12

Care / Death/Harm	Optimal 1	Sub-Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		No drugs chart. Weak, Ca bladder, Oramorph		
Unexplained By Illness C				

General Comments

91-year-old man, living alone, with transitional cell Ca bladder, pleural effusion, fistulae, old MI, previous Ca colon, hard of hearing.

Transferred to Dryad 1999-08-03; ESR 76, Hb 9.3 1999-08-05; 'not in pain' 1999-08-16;
'going downhill – on fentanyl' 1999-09-06;
'Syringe driver 50 mg diamorphine, 20 mg midazolam' 1999-09-08 > 40 mg midazolam > +

Final Score:

Screeners Name: R E Ferner
Date Of Screening:

Signature

BJC/12
WALTER CLISSOLD
91

Unwell with advanced transitional cell carcinoma of the bladder. But originally aiming for home with support. Low in spirits and abilities declined.
Not required any prn analgesia from 3/8/99 up to his death according to the available medication card. Said to be on fentanyl on 6/9/99 but this was not on medication card and not recorded by nurses.
Deteriorating 6/9/99, comfortable night 7/9/99, big dose of diamorphine on 8/9/99 although I cannot find the medication card for this. But the case records do not appear to justify such a high starting dose.

Cause of death probably bronchopneumonia but the diamorphine dose could have contributed.

PL grading B2

	BJC/12	Clissold, Walter	This man was clearly terminally ill when he was transferred from Haslar to GWM, although nobody at Haslar seems to have been explicit about that, and he himself seems to have been unaware of how short his prognosis was. This may have been because he had survived an unexpectedly long time following the diagnosis of locally advanced bladder carcinoma. During his admission to GWM he seems to have realised himself that he was not going to return to independent living (and may have realised he was dying, but there is no mention of any discussion) and to have given his financial affairs into the hands of a close friend, with instructions to ask his solicitor to make a ward visit. Important parts of the record, particularly a second drug chart, are missing from the recording (and therefore from the original file). Without them, it is impossible to make an accurate reconstruction of the sequence of drug escalation. The only analgesic recorded on the drug chart which is preserved is paracetamol. There is a notes entry on 6.9.99 that he was now more comfortable on fentanyl. It seems likely, therefore, that his analgesia was taken straight from paracetamol PRN to fentanyl, presumably at 25mcg/hr, although again one cannot be certain. There are occasional mentions of intermittent abdominal pain, although the cause is not clear (and was not clear to the team caring for him). This does not seem to have been diagnosed at the time as necessarily cancer pain, and does not seem to have been severe enough to keep him awake. But it does seem to have been positional – he is recorded as "very uncomfortable if out of bed for any length of time". It is not clear, in the absence of the relevant drug chart, whether the deterioration noted between 1.9.99 and 6.9.99 antedated or followed the administration of fentanyl, so a causal relationship cannot be inferred. On the day of his death, a syringe driver was set up containing diamorphine 50mg and midazolam 20mg. Again, it is not clear why, given that fentanyl is transdermal, he was now felt to need diamorphine, nor why at least a 25% increase in opioid dosage was prescribed. The midazolam was doubled later that day. He deteriorated rapidly and died. I would be concerned that the drugs administered via syringe driver accelerated his inevitable death.	B3

Expert Review

Walter Clissold

No. BJC/12

Date of Birth: Code A

Date of Death: 8 September 1999

Mr Clissold was admitted to Gosport War Memorial on 3 August 1999 following a resection of his prostate and a bladder biopsy at the Royal Haslar Hospital.

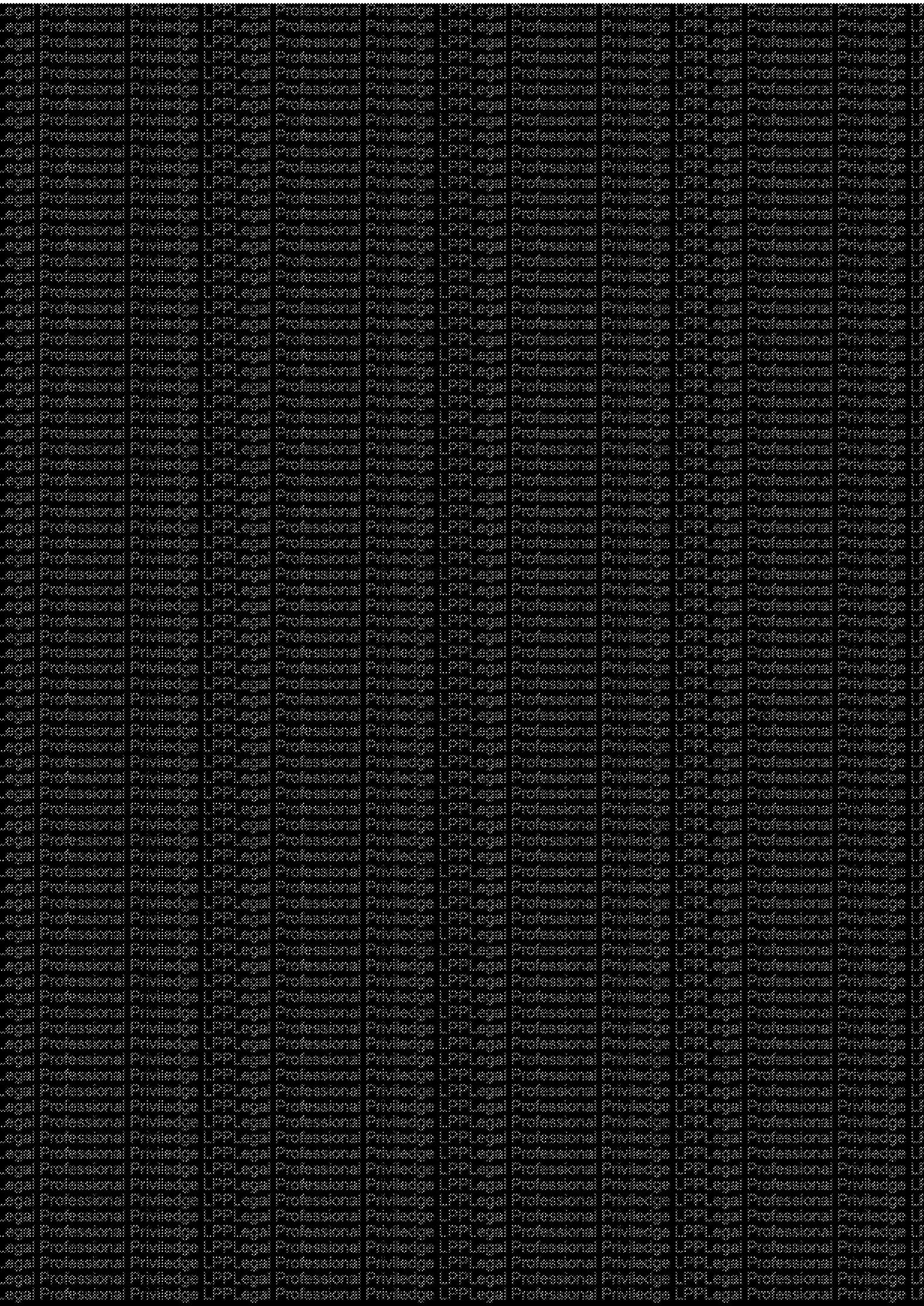
Although the original intention was that Mr Clissold would be transferred home with support, his condition deteriorated.

This case is made more difficult to analyse in the absence of a drug chart but it would appear that Mr Clissold's analgesia was advanced from Paracetamol to Fentanyl.

By 6 September 1999 Mr Clissold was deteriorating. In the absence of a drug chart it is not possible to draw any conclusions as to whether this was related to his medication. On the day of Mr Clissold's death, on 8 September 1999, a syringe driver was set up containing 50mgs of Diamorphine and 20mgs of Midazolam. The Midazolam was doubled later that day.

Mr Clissold deteriorated rapidly and died and Dr Naysmith raised concerns that the drugs administered via the syringe driver accelerated Mr Clissold's albeit inevitable death. Dr Naysmith was the only expert that rated this case as negligent. In the absence of the drug chart, it is not possible to draw firm conclusions as to any liabilities in this case and no further investigation is advised.

CPT DOCUMENTS
END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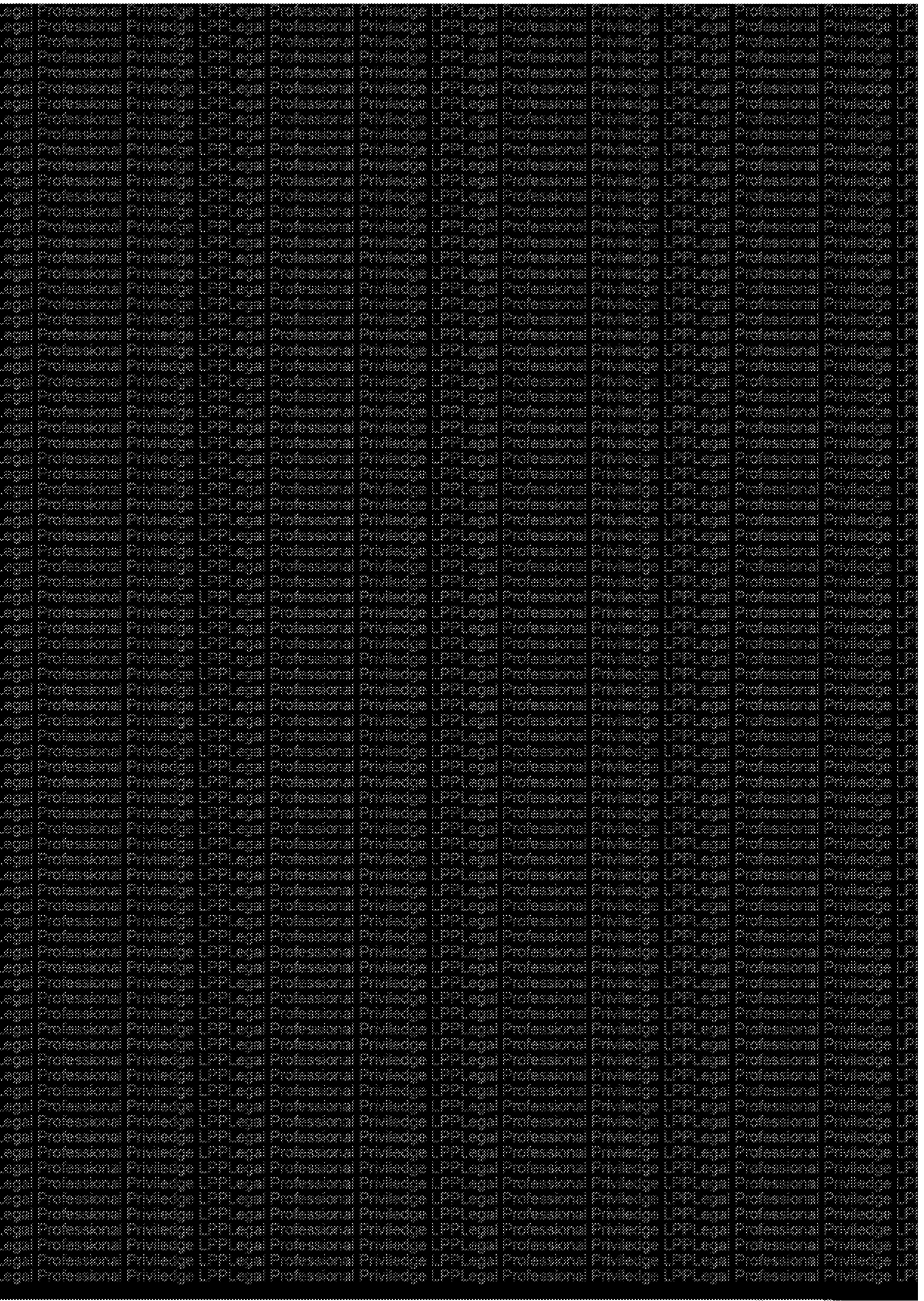
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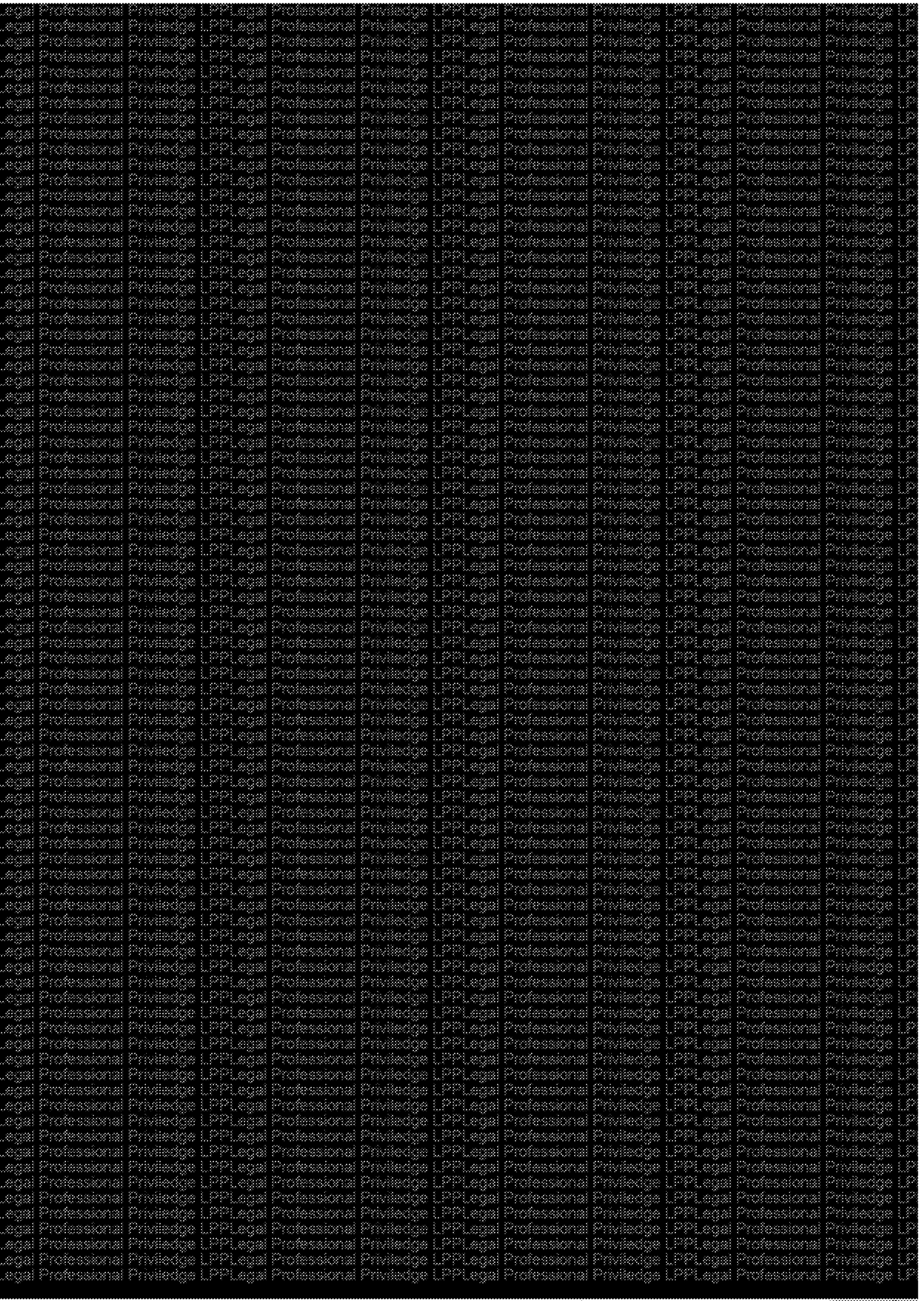
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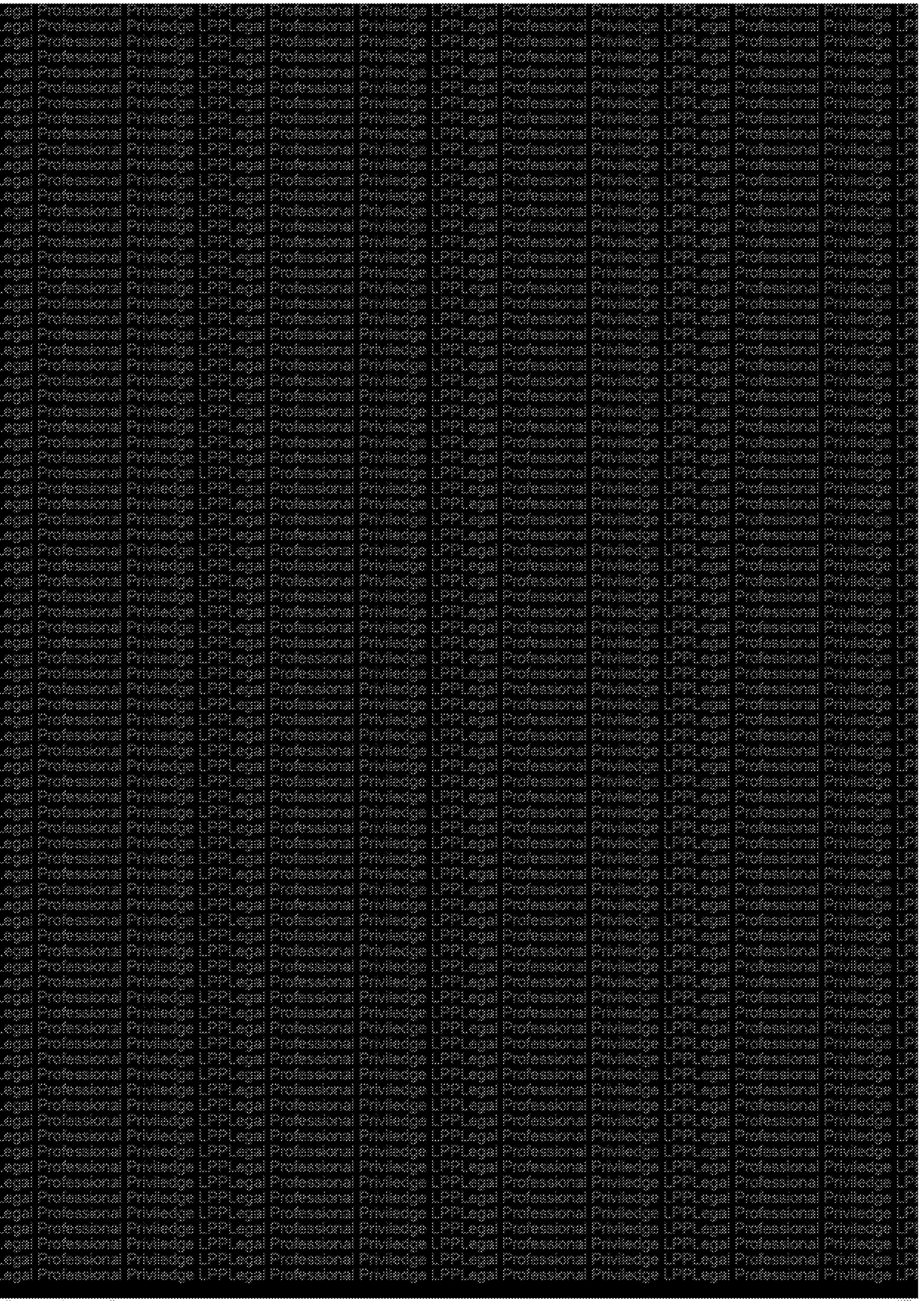
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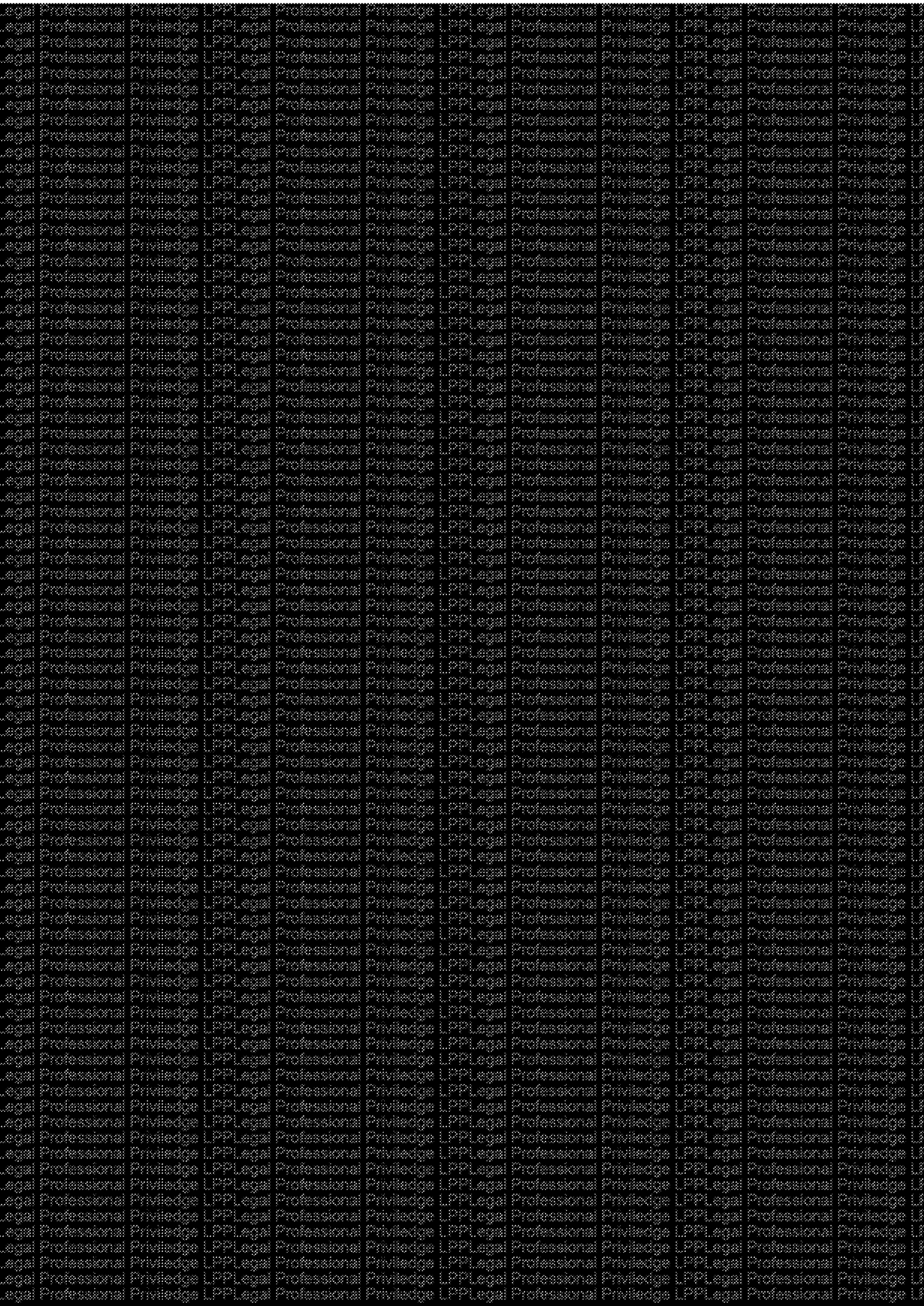
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DR JANE BARTON

CHRONOLOGY
(with the more important dates in bold type)

1 May 1988	Dr Barton began work as clinical assistant at GWMH.
Jul 1991	RCN convenor met nurses to discuss improper use of opiates at GWMH.
Feb-Oct 1998	Alleged mistreatment (of five patients principally) by improper use of opiates at GWMH.
Sep 1998	**Concerns first raised by Richards family. Police investigation began.**
Mar 1999	**CPS decided there was insufficient evidence to pursue criminal prosecution in respect of Mrs Richards.**
Jan 2000	NHS Independent Review Panel found that opiate doses were high but appropriate in circumstances.
?????? 2000	Health Service Ombudsman rejected complaint.
5 Jul 2000	**Dr Barton resigned from GWMH.**
27 Jul 2000	**Police notified GMC of allegation by Richards family against Dr Barton and restarted investigation. But no complaint ever made directly to GMC by any family[1].**
Mar 2001	11 other families raised similar concerns with police. Four (Page, Wilkie, Cunningham and Wilson) were investigated.
Jun 2001	**First IOC hearing. IOC considered Richards allegation and made no order.**
Aug 2001	Police passed concerns to CHI, which began investigating care at GWMH *since* 1998 (including through interviews of relatives and staff).
Feb 2002	**CPS decided not to pursue criminal prosecution in respect of four other patients (Page, Wilkie, Cunningham and Wilson). CPS papers disclosed to GMC.**

[1] All are "information", not "complaint", cases.

Feb 2002	**Barton gave voluntary undertaking to Health Authority (not to prescribe opiates or benzodiazepines).**
21 Mar 2002	**Second IOC hearing. IOC considered allegations in respect of all five patients and made no order.**
31 Mar 2002	**Dr Barton's voluntary undertaking given to Health Authority (not to prescribe opiates or benzodiazepines) lapsed.**
28 May 2002	Mrs Richards' daughter protested about lack of progress.
Jul 2002	CHI reported concerns (especially about anticipatory prescribing).
Aug - Oct 2002	**Pressure (in political quarters) created by Mrs Richards' daughter's protest led, despite some apparent reluctance, to police sending further papers to CPS and re-opening investigation to encompass all (62) patients who died while under Dr Barton's care at GWMH. GMC's investigation put on hold.**
29 Aug 2002	**PPC referred all five cases to PCC but made no referral to IOC.**
Sep 2002 - Sep 2003	Police referred all 62 patients to panel of five experts, who began investigation.
12 Sep 2002	Suspension of GMC's investigation.
19 Sep 2002	**Third IOC hearing. In response to referral by GMC's President, IOC again considered allegations[2] in respect of all five patients but again made no order (in view of the absence of any new material[3]).**
19 Sep 2002	Health Authority sent GMC file of correspondence concerning use of diamorphine in 1991.
9 Oct 2002	FFW advised that screeners would be misdirecting themselves if they were to refer Dr Barton to IOC again in light of Health Authority's disclosure.
20 Nov 2002	Meeting between GMC and police.
2 Dec 2002	Police asked GMC to removed Dr Barton's case from PCC hearing list. GMC did so[4].

[2] It had reports from Dr Ford and Dr Mundy.
[3] The Legal Assessor advised that in the absence of "new evidence ... it would be unfair to the doctor ... to consider the matter any further": apparently a reference to the doctrine of *res judicata*.
[4] Dr Barton's case has not yet been reinstated into the list.

30 Sep 2003	**Police met GMC and stated that panel of five experts had concluded that treatment of about 25% (15-16) of patients and cause of death gave rise to concern and should be investigated further (by a single new expert, auditing and refining the work of his five predecessors). GMC sought disclosure but this was refused because of risk of disclosure to Dr Barton if her case were to return to IOC.**
2 Oct 2003	GMC letter again pressed police for disclosure.
Oct 2003	**Baker report (independent clinical audit of care of 81 patients, sampled at random, who died at GWMH from 1988 to 2000 with particular emphasis on Dr Barton's conduct) sent to CMO but not to GMC[5].**
Oct 2003	**Screener refused to refer case for a fourth time to IOC (in view of absence of new evidence).**
Jan 2004	GMC believed (wrongly according to police) that audit and refinement of conclusions of panel of five experts by another, single expert was due to be completed.
7 Jan 2004	GMC pressed police for update on progress.
28 Jan 2004	Police unable to provide any further information on progress.
6 Feb 2004	GMC confirmed to police that GMC inquiries were "on hold" pending conclusion of the police investigations.
Mid-Feb 2004	Conclusions of panel of five experts were to be communicated to relatives[6].
Feb 2004	GMC met CMO, at latter's request, to discuss Dr Barton's case.
27 Feb 2004	**Meeting between GMC, FFW and police. Police said that the investigation was still incomplete, that they did not know when it would end or when Dr Barton would be interviewed and that they would not release any information to GMC unless GMC guaranteed not to pass it on to Dr Barton.**
5 May 2004	GMC again pressed police for report on progress.
17 May 2004	Baker report sent to GMC, subject to undertaking not to copy or disseminate.
11 Jun 2004	CMO met police to discuss Dr Barton's case.

[5] A copy was, however, passed to GMC by CMO. A summary of is attached. It should be treated as confidential because circulation of the Baker report is still strictly limited.
[6] It is unclear whether this took place.

13 Jan 2005	Meeting between GMC and police.
25 Jan 2005	GMC wrote to police seeking disclosure of material in relation to Mrs Devine, backed by reference to section 35A of the 1983 Act.
Feb 2005	Police planned to interview Dr Barton[7].
28 Feb 2005	Police email to GMC gave update.
28 Apr 2005	Police replied to GMC letter dated 25 January 2005 refusing the disclosure sought.

Code A

25/4/05

[7] Not yet occurred.

DR JANE BARTON

SUMMARY OF BAKER REPORT

Overview

Commissioned by CMO and written by Head(?) of Department of Health Sciences, University of Leicester.

Completed in October 2003.

Audit of care of 81 patients (random sample) who died within DMfEP (not just under Dr Barton's care) at GWMH from 1988 to 2000.

Only documentary evidence audited and no opportunity given for relatives or staff (including Dr Barton) to comment on issues or findings.

Conclusions

- A practice of almost routine and liberal use of opiates before death was followed in order to "make [patients] comfortable": culture of limited hope/expectation towards recovery.
- Patients who experienced pain and whose death was expected in the short term were given opiates.
- Alternative treatment with other pain-relief and detailed assessment of the cause of pain/distress was generally ruled out.
- Practice (of premature use of opiates) began in 1988 at latest.
- Impossible to identify its origin but Dr Barton may merely have implemented it.
- It almost certainly shortened the lives of some patients.
- In some patients, determined rehabilitation could well have led to a different outcome.
- In some (but fewer) cases it is probable that patients would otherwise have had a good chance of being discharged from hospital alive.
- Opiates administered to almost all sampled patients regardless of illness.

- Opiates often prescribed before needed (often on admission), even if not administered for days or weeks.
- Proportion of patients who received opiates before death was remarkably high.
- Difficult not to conclude that some patients were given opiates but should have received other treatment.
- Many records did not show a careful clinical assessment before use of opiates or a proper stepped approach to management of pain in palliative care.
- Records often poor: silent on recent fractures, on deteriorations and their causes and on causes of pain.
- Most patients had acute, chronic illness and were believed unlikely ever to be capable of discharge to nursing home.
- Unlikely that death rate was higher than in a comparator unit.
- Starting doses were too high.
- In 16 cases, because of inadequate records, there were concerns about the indications for starting opiates, the investigation of pain or the choice of pain-relief.
- Dr Barton was part of a team (under a consultant) but she:
  - issued most of the MCCDs;
  - made most of the entries in records; and
  - was responsible for most of the prescribing.

<u>Recommendations</u>

- Audit reinforces concerns (raised by relatives) so investigations should continue.
- Rota followed by Dr Barton and partners should be obtained and analysed to explore patterns of death.
- National and local policies/guidelines on opiate medication should be devised and applied.
- Use of opiate medication should not be limited to needy patients; sometimes insufficient opiates was used.
- Better statistics/codes should be compiled to enable better monitoring in future.

Code A


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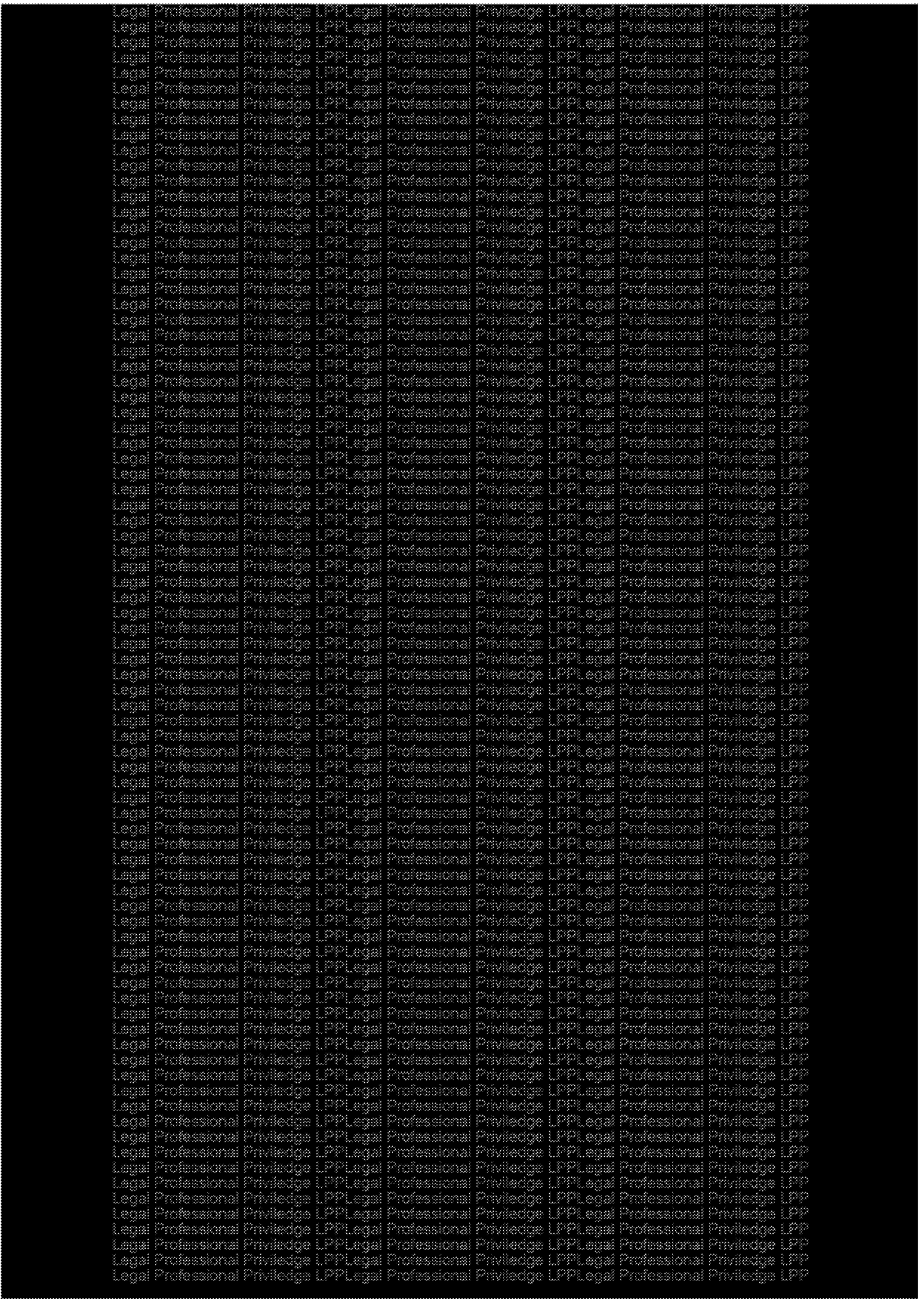
REV. KF26082

CONNECT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SENDING CONFIRMATION

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NAME : FPD
TEL : Code A

PHONE	:	Code A
PAGES	:	3/3
START TIME	:	25-MAY 10:29
ELAPSED TIME	:	00'43"
MODE	:	ECM
RESULTS	:	OK

FIRST PAGE OF RECENT DOCUMENT TRANSMITTED...

Fax

General Medical Council

Regulating doctors
Ensuring good medical practice

To: Code A
From:
Date: 25 May 2005
Re: Dr Jane Barton

Fax no: Code A
Pages: 3 pages inclusive
CC: [Name]

Dear Mr Code A

In response to your email of 23 May 2005 to Code A requesting copies of a number of documents.

Code A has asked me to fax to you a copy of our letter of 21 April 2005 to DCS Steve Watts, please find a copy attached.

I can also confirm that the GMC does not have a copy of an email from Hants Constabulary dated 28 February 2005, and that no official note was made of the meeting between the GMC and Hants Constabulary on 13 January 2005.

If you have any further queries please do not hesitate to contact me.

Yours sincerely

Code A

Fax

General Medical Council

Regulating doctors
Ensuring good medical practice

To: Mr Code A

From: Code A

Fax no: Code A

Date: 25 May 2005

Pages: 3 pages inclusive

Re: Dr Jane Barton

CC: [Name]

Dear Mr Code A

In response to your email of 23 May 2005 to Code A requesting copies of a number of documents.

Code A has asked me to fax to you a copy of our letter of 21 April 2005 to DCS Steve Watts, please find a copy attached.

I can also confirm that the GMC does not have a copy of an email from Hants Constabulary dated 28 February 2005, and that no official note was made of the meeting between the GMC and Hants Constabulary on 13 January 2005.

If you have any further queries please do not hesitate to contact me.

Yours sincerely

Code A

FIG. 3A

MISC

IN THE PROFESSIONAL CONDUCT COMMITTEE OF THE GENERAL MEDICAL COUNCIL

and

IN THE MATTER OF DR

REQUEST FOR DOCUMENTATION PURSUANT TO SECTION 35A(1) OF THE MEDICAL ACT 1983 (AS AMENDED)

To:

I, **PAUL PHILIP**, Director of Fitness to Practise Directorate, General Medical Council ('GMC'), 178 Great Portland Street, London, WIW 5JE say that:

1. I am an authorised person for the purposes of Section 35A(1) of the Medical Act 1983 (as amended by the Medical Act Amendment Order 2000).

2. I request that you make available to the GMC's solicitors, <name of Solicitors>, the following documents:

   a. <Description of document>

   b. <Description of document>

   c. <Description of document>

3. This documentation is relevant to the discharge by the GMC of its functions in relation to professional conduct and disclosure of this documentation is required accordingly.

4. I confirm that <name of Solicitors> will reimburse your reasonable costs incurred in providing the information requested.

We ask that the documents requested be provided to Field Fisher Waterhouse **within 14 days**.

SIGNED : ..... DATED:.....

Paul Philip
Director of Fitness to Practise
GENERAL MEDICAL COUNCIL

Privy Council Appeals

Procedure Note

Background

Section 40 Medical Act 1983 ("MA 1983") provides that certain decisions made by the Professional Conduct Committee can be appealed to the Judicial Committee of the Privy Council.

The following decisions of the Professional Conduct Committee ("the PCC") can be appealed to the Privy Council under Section 40 MA 1983:

1. Section 40(1)(a) - a decision of the PCC under Section 36 giving a direction of erasure, for suspension or for conditional registration or varying the conditions imposed by a direction for conditional registration;

   This includes any direction imposed at a resumed hearing.

2. Section 40(1)(d) - a decision of the PCC under section 41(6) giving a direction that the right to make further applications under that section shall be suspended indefinitely

   When a doctor applies for restoration and this is refused by the PCC, the PCC may, if it is the doctor's second or subsequent application for restoration, direct that his right to apply for restoration be suspended indefinitely. Section 40(1)(d) provides that this decision may be appealed to the Privy Council (but not the original decision to apply for restoration).

Any decision made by the PCC which is not listed above, including a finding of serious professional misconduct, the imposition of a reprimand, or a decision to refuse an application for restoration, is subject to review by way of judicial review proceedings in the Administrative Court.

New Rules – 1 April 2003

With effect from 1 April 2003, appeals from decisions of the PCC will be to the High Court by virtue of Section 30 of the NHS Reform and Health Care Professions Act 2002. Guidance on procedure is awaited from the Courts and Lord Chancellor's Department.

Time Limits/procedure

Petition of Appeal

A doctor has 28 days from the date of service of the formal notification of the determination of the PCC to appeal. (Rule 2 Judicial Committee (Medical Rules) Order 1980)

Appearance/Notice of appearance

The GMC has 21 days from the receipt of the petition of appeal to enter an appearance with the Privy Council. (Rule 3 of the Judicial Committee (Medical Rules) Order 1980)

To enter an appearance, the form at Annex A should be completed and sent with the original transcript of the evidence given at PCC plus 7 copies of the transcript to the Privy Council Office.

A notice of the entry of appearance and 3 copies of the transcript should be sent to the other side.

The relevant committee officer/section should be notified once an appearance has been entered.

Respondent's Case

The GMC has 28 days from entering an appearance and lodging the transcript with the Privy Council Office to lodge the Respondent's case. Counsel who did the PCC hearing will normally draft (this)

The solicitor will need to send Counsel a full brief including the transcripts, any exhibits and other documents presented to the PCC.

Once the draft case is received from Counsel it should be copied to the appropriate Committee officer for their comments. As soon as all comments are received and the draft case is finalised, 7 copies should be lodged with the Privy Council Office and 3 copies exchanged with the other side.

Skeleton Arguments/Authorities

A total of 8 sets of authorities are required, at least 2 of which must be lodged before the end of the second week before the hearing.

If skeleton arguments are lodged, 8 copies will be required.

The timetable for the lodging of authorities and skeleton arguments is not set out in the rules but the above details are given in a Practice Direction issued on 21 September 2000. Presumably, the timetable will need to be worked out based on the date set for hearing or in discussions with Counsel.

Date of hearing

Once a date of hearing is received from the Privy Council Office, Counsel's clerks should be notified and Counsel booked for the hearing. The date should be entered in your diary and the appropriate committee officer notified.

Hearing

The Solicitor should attend the hearing with Counsel and make a full note of the hearing. The appropriate caseworker may also attend.

Post hearing

After the hearing, notify the appropriate committee officer of the result and any follow up action.

Obtain a copy of the ratified judgement for the file and Precedent folder

Caseworker/Appropriate Committee Officer Procedure

This is the procedure that caseworkers will follow in Privy Council appeals.

1. Letter of appeal or telephone call from a doctor wishing to appeal but no petition of appeal received.

    a. Caseworker will write to the doctor and include the following information

        i. A reminder that an appeal notice was sent to him with the formal notification following the PCC decision,

        ii. that in order to comply with the rules, he should arrange for his petition to be issued at the Privy Council and serve it on the Privy Council before the end of the appeal period.

        iii. the telephone number of the Privy Council so that they can advise him further.

    NB: As a result of secure scanning of the post at the Privy Council delays can occur at the end of the appeal period. Therefore the Caseworker will telephone the Privy Council to confirm whether the doctor has appealed before taking further action in case.

2. Petition of Appeal received

    NB: petitions of appeal received prior to 28 February 2003 will continue to be dealt with by the outside Solicitors for the GMC. The In-House Legal Team will deal with petitions of appeal received on or after 1 March 2003.

    Upon receipt of the petition of appeal, the caseworker will carry out the following actions:

    a. Send a note round on PCC Decisions confirming

        i. That the doctor has appealed

ii. The doctors current registration status (an immediate suspension, an IOC order that was not revoked by the Privy Council, full registration)

iii. The name of the Committee Section contact for the appeal.

iv. The number of the Privy Council appeal.

b. Send formal notification to the doctor (an Assistant Registrar letter) confirming receipt of the appeal and his/her current registration status. (send copies to the doctors defence team, CCPS and to the external solicitors for the GMC or the In House Legal Team as appropriate).

c. Send an email to the NHSE gmc-info@doh.gsi.gov.uk confirming that the doctor has appealed and confirmation of his current registration status.

d. Send a letter to the external solicitors to the Council or the In-House Legal Team, including the petition and any other accompanying documentation, a copy of the formal notification sent to the doctor and confirmation that the transcripts and exhibits will be sent within 7 days.

e. Obtain copies of the exhibits and the transcript of the complete PCC hearing. Upon receipt send to the external solicitors for the GMC or the In House Legal Team. (This should be done within seven days, or any delay should be notified to the external solicitors to the GMC or the In House Legal Team).

f. Enter the appeal on the Appeals Log saved at E/Committee/Appeals/Appeal.

g. Send a letter to the PCC members who sat on the Committee advising them of the appeal and advising them that they will be informed of the result of the appeal when it is determined, which may take many months.

3. Deadline for lodgement of the Record

a. The Caseworker will contact the external solicitors for the GMC or the In House Legal Team, to confirm the date that the original transcript and copies were lodged with the Privy Council.

4. Deadline for lodgement of the Case

a. The caseworker will contact the external solicitors to the GMC or the In House Legal Team, to confirm when the Respondent's Case will be sent to the caseworker for comments.

b. The caseworker will provide comments and also invite comments from the caseworker in CCPS in writing. The caseworker will also request that

a copy of the skeleton argument be copied to them and to the Caseworker in CCPS.

5. Petition for Want of Prosecution

The doctor may not comply with the rules of the Privy Council, for example, he/she may not lodge the case within the 28 day deadline. It is usual to agree to short extension periods if asked to by the Registrar of the Privy Council.

However, in the event of an unreasonable extension period, the caseworker may instruct the external solicitors to the Council or the In House Legal Team, to issue a petition for want of prosecution. Any delay should be brought to the attention of CCPS. There will be a hearing at the Privy Council. The caseworker will instruct the external solicitors to the Council or the In House Legal Team in respect of the costs.

6. Withdrawal of an Appeal

If the caseworker is informed that a doctor wishes to withdraw an appeal, all steps in relation to this will be referred to the external solicitors to the Council or the In House Legal Team.

7. Exchanging of Skeleton Arguments for the Appeal

The instructions for an appeal will usually be given by CCPS. The only exception to this is where the decision deals with a Committee issue. If the skeleton arguments identify a problem with the advice given by the Legal Assessor or a complaint about a member of the Committee, the instructions for the appeal will be dealt with by Committee Section.

8. The Case is set down for a Date

The caseworker may attend the appeal hearing.

9. The Day after the Appeal

The caseworker will telephone the external solicitor to the Council or the In house solicitor to confirm how the appeal went. In the event that the appeal has been lost, the caseworker will inform the Committee Manager.

10. Judgement

After the appeal has been heard, the caseworker will;

a. Check the Privy Council website every week to obtain an advance copy of the judgement.

b. Send a copy of the Advance Judgement to the Appeals Team.

c. Telephone the Privy Council to ask when the appeal is likely to be ratified. (Note that any appeal heard in July may not be ratified until the new term in October, although usually the appeal is ratified within weeks.)

d. Write to the employers to advise the result of the appeal and confirming that the decision will become effective following ratification by Her Majesty. This will usually be a matter of weeks.

Occasionally, the appeal will be ratified before the judgement is issued. In this case, the caseworker will obtain written confirmation of the ratification from the Privy Council. This will confirm the result of the appeal.

11. Confirmation that the Appeal has been ratified

The caseworker will obtain this in writing from the Privy Council which will confirm the date of ratification.

12. Post Appeal Follow Up

a. Appeal is Dismissed or Withdrawn

i. The caseworker will send formal notification of dismissal of appeal to doctor and confirm directions of PCC. (Copy to the doctors solicitors, the external solicitors to the Council or the In House Legal Team, and to CCPS)

ii. The caseworker will send formal notification of the decision to the NHSE on gmc-info@doh.gsi.gov.uk.

iii. The caseworker will send formal notification of the decision to the Employer.

iv. The caseworker will send a notification to 'PCC Decisions' confirming the result of the appeal and the date of the effect of the direction of the Committee. If the case is to be resumed, inform the Resumed Cases Team and send them a copy of your appeal file.

v. The caseworker will Update IRS (if Manchester).

vi. The caseworker will send a copy of all follow up documentation to CCPS including a reminder to update FPD.

vii. The caseworker will update appeals log and turn blue indicating that the appeal has been closed.

viii. If any correspondence about costs is received this will be sent to CCPS.

ix. The caseworker will send a copy of the Appeal Judgement to the Committee Members of the Original PCC Committee.

b. Appeal is Quashed or Remitted back to the PCC

i. The caseworker will carry out follow up work as above recording the result of the appeal including confirmation of the date of the new PCC hearing if relevant.

ii. The caseworker will inform CCPS and ensure case is relisted if remitted.

iii. The caseworker will inform the Appeals Team and send them a copy of the final judgement.

The Appeals Team will carry out the follow up as set out below:

a. Send the appeal judgement to Distribution List which will include the members of the original PCC.

b. Update the Committee Appeal Folders in each PCC room and the electronic index saved in Committee/Appeals.

c. Update the PCC Minutes and Folio Views.

IN THE PRIVY COUNCIL

Appeal No. of 2003

Between

(APPELLANT)

And

THE GENERAL MEDICAL COUNCIL

From the decision of the General Medical Council

We hereby enter appearance on behalf of the General Medical Council the Respondent in the above appeal.

Signed:
Solicitor for the Respondent

General Medical Council
Fitness to Practise
178 Great Portland Street
London, W1W 5JE
REF
NAME
TEL
DATE

ADVOCACY TRAINING

(25th March 2003)

Advocacy is an argument.

The purpose of advocacy is to –

- Convey information
- Persuade the tribunal to adopt your argument

METHOD

- Preparation, preparation, preparation – the advocate's response to the estate agent's motto.
- Organisation of material – know how and where to find the documents.
- Clear and lucid presentation.
- Pace of speech – there are people taking notes, trying to find a page or a volume of documents.
- The speech must be appropriate to the proceedings – legal Latin tends to depress scholars.
- Modulate your voice – if you drone, you drone alone.
- No emotive language or emotional outbursts.
- Appropriate demeanour – you are a professional within a formal forum.
- Polite – even in the face of what seems to be crassness.
- Answer questions put to you directly and honestly.

KNOW YOUR TRIBUNAL

- Who will you be appearing before?
- Mode of address (to Committee; Chairman; opponent and unrepresented respondent).
- What is the order of speaking and what rights do you have to speak at various times? (Know the Rules).
- Have the Rules been complied with? Take nothing for granted!

AT HEARING

- Aim to arrive very early and arrive early.
- Check that the witnesses are present and have a copy of their witness statement.
- Speak to your opponent
  - what will be admitted?
  - what are the issues?
  - have they got the same bundle as you?
  - are there any objections to the evidence?

CASE PREPARATION

- If the case is one where there are allegations (e.g. Registration or Conduct Committee) then remove the document containing the allegations and study it carefully. This is what you have to prove – it is your starting point, your destination and the map or chart to get to your destination.
- READ the case papers thoroughly and carefully.
- Set out the ISSUES in the case.
- What is the EVIDENCE to prove those issues?
- Identify the facts that SUPPORT your case and the facts that either, do not support the case, or those that CONTRADICT it. This will help you to clarify what facts you wish to elicit from the witnesses.
- Note down the points for and against your case. The points for can be used for cross-examination and a final speech. The points against might precipitate you seeking further evidence or altering your case in some way and will also need to be dealt with in your final speech.
- Compose the questions that you deem necessary to elicit the facts you need to prove the case and to undermine the points against your case.

OPENING

- The purpose of an opening is to provide the tribunal with a fair introduction to the case. The introduction is to the facts or evidence that you anticipate will be given and an introduction to the documents that you intend to produce.

- If the tribunal has not seen any papers in advance of the hearing it is important that this is recognised by the length and pace of the opening.
- An opening differs in style and content from a final speech. A final speech is the opportunity to bring the facts together and comment on them in relation to the case you are advancing. As stated above, an opening is more in the way of a guided tour with few comments, if any.

EXAMINATION-IN-CHIEF

- No leading questions i.e. one that suggests the answer.
- Short and simple questions dealing with one point at a time.
- One question leading to another i.e. "piggy-backing".
- Elicit relevant and admissible evidence only.
- Control the witness.

CROSS-EXAMINATION

- It is not a repeat of examination-in-chief.
- The purpose of cross-examination is to undermine the evidence against your case and to elicit evidence that bolsters your own case.
- Ask simple leading questions.
- Only ask necessary questions. Do not give the witness an opportunity to destroy a point that you did not need to raise.
- Questions can be asked firmly but do not quarrel with the witness.
- Put your case to the witness so that he/she has an opportunity of dealing with it.

FINAL SPEECH

- Check the Rules to ensure you have a right to make a speech.
- Remind the tribunal of the relevant law e.g. burden/standard of proof.
- Go through the allegations one by one and summarise the evidence in relation to each. Now is the opportunity to comment on the inferences you are inviting the tribunal to draw from the evidence and to comment on any evidence the other side have called.
- Avoid histrionics.
- Do not interrupt your opponent's final speech. If you think he/she has made an error on the facts then if it is a mistake against his/her interests you should politely correct the position at the conclusion of the speech. If the error is too much in his/her favour you should consider carefully how significant the point is and whether it is absolutely necessary to correct the position. If the point is, in reality, trivial, you will be perceived as seeking to make a further speech and as taking an unfair advantage.

LEGAL ASSESSOR

- Make a checklist of points that you expect the legal assessor to deal with. If he/she does not deal with a particular point then you should, respectfully, raise it for consideration.
- If you are asked your view on a question of law that you feel you need to look up and think about then do not be afraid to ask for a short (15 minutes or so) adjournment.

CONCLUSION

The highs and lows, the victories and the failures, provide the adrenalin of advocacy. In the shortest and most ordinary case you may not always experience such a feeling but the satisfaction of presenting a case efficiently, courteously and fairly has its own reward. To achieve that goal is to achieve all that any civilised system of justice can ask of you.

Code A
Queen Elizabeth Building,
Temple,
London,
EC4Y 9BS.
6th March 2003.


Legal Professional Privilege LPPLegal Professional Privilege LPPLegal Professional Privilege LPP

Litigator's double

District judges Michael Walker (listing questionnaires) and Chris Lethem (litigants in person) outline some crucial changes for civil practitioners from 2 December

The old style of listing questionnaire (LQ) will be replaced on 2 December 2002 by a wholly revamped and renamed form, the pre-trial checklist (PTC). There are also consequential changes to parts 28 and 29 of the Civil Procedure Rules 1998 (CPR).

However, the change is not just a change in title. The emphasis of the new form is to ensure that parties are ready for their trial – if there has to be one; that trial dates and trial windows are kept and that settlements at the door of the court are avoided. It also heralds a completely different approach by the profession, and by the courts, to that period between despatch of the PTC to solicitors and commencement of the trial itself.

The title 'listing questionnaire' was the wrong one for the form. It is filed too late in the day to be the tool triggering the actual listing of a case. By the time of filing of an LQ, the case, whether in the fast or multi-track, will almost certainly already have an allotted date for the (start of the) trial. If only a trial window has previously been given then the court will be listing the case within that period and, therefore, questions related to the availability of witnesses, experts and representatives relate only to that narrow window.

Also gone will be the 'blame culture' so often reflected at the moment in LQs – 'we have not been able to serve our witness statements as we are still waiting for disclosure from the other side' – and all the other excuses procedural judges regularly see. The new PTC is expressly designed to prevent last-minute applications that may otherwise affect trial dates or trial windows. Instead, it assumes that the person completing the PTC is himself ready for trial. The opening question seeks confirmation that the party concerned has complied with those directions already given which require action by him. The next asks for the date by which any outstanding directions will be done. If directions are required then the party seeking them must return the PTC with an application notice (form N244), fee and draft order. If possible, that draft order should be agreed with the other side. The intention is to put an end to the present practice of treating the LQ itself as the vehicle for making a request for last minute further directions.

Tosh, you say. Things will not change. Don't be so sure. One of the fundamental principles of Lord Woolf's reforms is that only in exceptional circumstances will a trial date be vacated. Another is that judge time is properly utilised; if a case is going to settle then it should do so sufficiently in advance for the judge to be found other work. Judges are keen to see the PTC made an effective tool of case management. Be ready for that trial.

LIPs lose their gloss

As from 2 December 2002, one sector of the litigating community will be finding life a little less lucrative. The 29th amendment to the CPR significantly alters the rules for the recovery of costs by a litigant in person (LIP).

Currently, successful litigants in person fall into one of two categories when their costs come to be considered. Those who cannot prove financial loss are paid at the prescribed rate for the time spent reasonably doing the work at the rate specified in the practice direction (CPR rule 48.6(4)). The prescribed rate is £9.25 per hour.

The second group is those who can prove financial loss. They recover their costs at up to two-thirds of the amount that would have been allowed if they had been represented by a legal representative (CPR rule 48.6(2)).

These rules contain an anomaly. Once litigants in person have proved that they have suffered some financial loss, no matter how small, they are entitled to claim at the higher rate for all the work that they have reasonably done in connection with the case. This applies to areas of work where it is plain that there was no financial loss. This 'all or nothing' approach can provide a windfall to the receiving party, although it seems that Parliament never intended that they should make a profit out of the litigation.

The 29th amendment seeks to address this anomaly. CPR rules 48.6(3) and (4) have been completely rewritten. The position remains the same for those who cannot show financial loss and they will continue to receive the £9.25 per hour (the new rule 48.6(4)(b)). For those who can show that they have suffered financial loss, there still remains the ceiling that their costs will not exceed two-thirds of the costs that would have been allowed to a solicitor. The significant change is in rule 48.6(4)(a) which states the allowable costs are, 'where the litigant can prove financial loss, the amount that he can prove he has lost for the time reasonably spent in doing the work'. Thus the receiving party is limited to his or her actual financial loss.

Can a litigant in person claim £9.25 per hour for some work and a higher rate for the areas where he has suffered financial loss or are 48(4)(a) and (b) mutually exclusive? The wording of the new section is unclear whether one adopts the test on an item-by-item approach.

The rules remain the same for disbursements, experts and sums paid for legal services, in that the LIP can still recover a reasonable amount. It also remains the case that a LIP who is seeking to claim financial loss must serve the evidence he relies upon to show that loss, not less than 24 hours prior to the hearing where there is a summary assessment or on starting a detailed assessment. (costs PD 52(2) and (3)).

Finally, solicitors acting as LIPs have a special status. Recently, in *Malkinson v Trim* (2002) *The Times*, 11 October, the Court of Appeal affirmed the old rule in *London Scottish Benefit Society v Chorley Crawford and Chester* (1885) 13 QBD 872 that a solicitor's firm acting for one of the partners are entitled to charge as if acting for an ordinary client.

District Judge Walker sits at Wandsworth County Court and is a contributor to Jordan's Civil Court Service. District Judge Lethem sits at Tunbridge Wells County Court

Code A

Subject: W:Drive General Advices

I have discussed with IT and this appears to be the best way to deal with the general advice file.

Saving new advices

I have reorganised the W: Drive General Advices 2003 folder. There are now the following sub folders within it:
Briefings
Case summaries
Confidentiality
Data protection
Disclosure
Double jeopardy
Patient consent
Public interest
Resurrection
Vexatious Litigants

More sub folders can be added as and when. To add a sub folder:
Go to my computer
Click on W: Drive
click on file
click on new
click on folder

All new advices should be saved within a sub folder. When saving an advice which covers more than one topic save the advice in whichever sub folders are relevant. As there are a number of us creating advices now all new advices should be saved as: date, initials, person whom advice is to.
e.g. an advice by me created on 3 April 2003 to Neil Jinks should be saved as : 0403-RB-Code A

Previous advices

I will attempt at some point to move previous advices into the sub folders but this may take some time.

Searching for a key word within the advice file

The best search mechanism is:
Right click on the start button
Click on explore
Click on tools
Click on find
Click on files or folders
On the look in box scroll to W: Drive
Then put your key word in the containing text box

Hyperlinks

If you are referring to another document such as a previous advice you can create a hyperlink to take the reader to that document by:
Highlight relevant text
Click on insert on the toolbar
Click on hyperlink
Click on browse if you want to link to another word document which has been saved and then scroll though to find the document.
If you want to link to an internet site click on browse and then on the search the web icon. If you want to link to a web page you need to actually go to the page, highlight the web page address from the address box, go back to the edit hyperlink box and then press control v to paste the address into the box.

Bookmarks

We are not able to put bookmarks within our documents for the purposes of searching across the W: Drive although this should not be necessary if we search using the process set out above.

Code A


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Legal Professional Privledge LPPLegal Professional Privledge LPPLegal Professional Privledge LPP


Unrelated 3rd party information


Unrelated 3rd party information


Unrelated 3rd party information


Legal Professional Privilege LPP

OPERATION ROCHESTER.

Issue. Disclosure of Material to the General Medical Council.

Situation Report.
7th January 2005.

Operation ROCHESTER is an investigation into the circumstances of a number of deaths of elderly patients at the Gosport War Memorial Hospital between 1988 and 2000.

Police investigation first commenced during 1998 following the death of patient Gladys RICHARDS on the 21st August 1998. It was alleged that prescription of Opiates by Dr Jane BARTON hastened Mrs RICHARDS death.

Papers were forwarded to the Crown Prosecution Service who concluded that upon the basis of those papers that there was not a sufficiency of evidence to prosecute.

Following an upheld complaint that the matter had not been fully investigated the investigation was passed to Det Chief Inspector BURT on 29th September 1999.

The services of a medical expert Professor LIVESEY were commissioned. In November 2000 he concluded that Dr Jane BARTON prescribed drugs Diamorphine, Haloperidol, Midazopam and Hyoscine in a manner as to cause her death. He added that as a result of being given these drugs Mrs RICHARDS death occurred earlier than it would have done from natural causes.

In August 2001 the Crown Prosecution Service following advice from Treasury Counsel David PERRY concluded that there was no reliable evidence that Gladys RICHARDS was unlawfully killed, that Bronchopneumonia as a cause of death could not be contradicted and that Dr BARTONS decisions could find support amongst a reasonable body of medical opinion.

During July 2001 following media reporting of the investigation, four further families reported serious concerns regarding the deaths of their family members at Gosport War memorial Hospital.

Esa PAGE Died 3.3.1998.
Brian CUNNINGHAM Died 26.9.1998.
Robert WILSON Died 18.10.1998.
Alice WILKIE Died 21.8.1998.

The senior Investigation officer (Det Supt JAMES) decided to investigate these deaths and employed the services of 2 further medical experts Dr MUNDY and Professor FORD to review the appropriateness of care afforded to those patients and Gladys RICHARDS prior to death.

Professor FORD reported an' inappropriate and reckless prescription of Opiate and sedative drugs.'

Professor MUNDY reported that 'Morphine had been started prematurely, that Diamorphine was excessive, and that no analgesia had been tried prior to morphine, there was no documentation of pain experienced by patients'.

Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 staff at Gosport War Memorial Hospital reporting that 'had adequate checking mechanisms existed in the trust the level of prescribing would have been questioned, and that a number of factors contributed towards the failure of trust systems to ensure good quality patient care'.

During May 2002 the Crown Prosecution Service having reviewed the evidence in respect of patients RICHARDS, CUNNINGHAM, WILSON,WILKIE and PAGE, determined that there was not a sufficiency of evidence to prosecute Dr BARTON in respect of the deaths of those patients.

In September 2002 a third police investigation into deaths at Gosport War Memorial Hospital commenced under the leadership of Detective Chief Superintendent WATTS. A total of 90 deaths were reviewed following complaints from family members of deceased, and information received on behalf of the Chief Medical officer.

These cases were reviewed by a panel of medical experts (key clinical team) in toxicology, palliative care, geriatrics, nursing and general medicine.

Category 1. 17 cases were assessed as having received optimal care, death being by natural causes.

Category 2. 60 cases were assessed as having received sub- optimal care, but not extending to negligent care.

Category 3. 13 cases were assessed as having received negligent care (that is to say outside the bounds of acceptable clinical practice. (In four of these cases death was by natural causes).

Of the 13 cases, 9 were assessed as 'negligent care cause of death unclear'. These cases are being actively investigated. 4 of those cases assessed as 'most negligent' are being subject to a fast-track investigation with a view to placing papers before the Crown Prosecution Service by the end of September 2004.

The findings of the key clinical team have been independently reviewed by a legal-medico lawyer Code A On 20th July 2004 Mr Code A reported concern in respect of the categorisation of 7 of the category 2 cases. He is available to discuss those concerns from 2nd August 2004.

General Medical Council Disclosure.

Following the Crown Prosecution service decision not to prosecute, Detective Superintendent JAMES raised issues of Dr BARTONS professional conduct with the GMC Fitness to practice Directorate on 6th February 2002.

In his immediate reply Code A wrote that as the statutory body responsible for regulating the medical profession, the GMC was concerned to learn of any doctor who had been the subject of a criminal investigation. Whilst acknowledging the decision not to prosecute Dr BARTON the GMC needed to satisfy themselves that there were no matters relating to the professional conduct of performance of Dr BARTON which warranted formal action under the GMC 's fitness to practice procedures.

Code A requested a case summary, witness statements, copies of expert reports and copies of relevant medical records.

Code A made mention of section 35A of the Medical Act 1983 (Amendment) Order 2000 which in broad terms gave the GMC the right to demand disclosure of information when considered necessary for the purpose of assisting the GMC to carry out a statutory regulatory role.

Mention was made of Woolgar v Chief Constable of Sussex Police 2000 where it was stated "Obviously in each case a balance has to be struck between competing public interests and at least arguably in some cases the reasonableness of the police view may be open to challenge. If they refuse to disclose the regulatory body may, if aware of the existence of information make an appropriate application to the court".

On the 14th February 2002 the Hampshire Constabulary through Detective Superintendent JAMES handed to the GMC statements of Professors LIVESEY, FORD, and MUNDY, patient notes in respect of patients RICHARDS, CUNNINGHAM, WILKIE, WILSON, and PAGE, and supporting documentation. An offer was made to make any other material available if so required.

On 21st March 2002 the GMC's Interim Orders Committee considered the case of Dr BARTON including submissions from counsel instructed by the GMC and from Dr BARTONS legal representatives. The IOC considered that it was not necessary for the protection of members of the public and in the public interests or in Dr BARTONS own interests to make an order affecting her registration.

On the 12th September 2002 the GMC's Preliminary Proceedings Committee decided that upon the basis of the full disclosure of information provided about Dr BARTON that a charge should be formulated against Dr BARTON and that an enquiry into the charge should be heard by the Councils Professional Conduct Committee.

Following the decision of 12th September 2002 the president of the GMC referred Dr BARTONS case back to the Interim Orders Committee.

On the 19th September 2002 the IOC considered Dr BARTONS case and decided not to make an order affecting her registration.

On the 23rd September 2002 the Investigation under Detective Chief Superintendent WATTS commenced.

On 30th September 2003 DCS WATTS met with Code A of the GMC presenting an overview of the Police Investigation.

On 2nd October 2003 Mrs Code A requested a detailed written summary of the evidence of the case, including reports compiled by experts in order that a decision could be made whether or not to further refer to the IOC.

On the 3rd October 2003 DCS WATTS responded that further work was required to validate the findings of the clinical team in respect of the deaths of 62 patients, but that in a significant number of those cases the experts had taken the view that there was negligent care and that the causation of death was unclear.

DCS WATTS added that his primary concern was the safety of the public, and that a balance needed to be struck between conducting the investigation in the appropriate fashion and realistically assessing the risk to the public.

DCS WATTS pointed out that information disclosed to the GMC would also be revealed in totality to DR BARTON and that this could prejudice the police investigation particularly interviews with Dr BARTON.

On the 7th January 2004 Mrs Code A responded that as there was no new evidence, the matter would not be referred back to the IOC.

On the 27th February 2004 a further meeting was held between Hampshire Police and the GMC.

During a detailed exchange in respect of the Police Investigation under agreed confidentiality DCS WATTS explained that it was unlikely that the investigation would be concluded by the end of 2004, but that he would be happy to explain the investigation to anybody, and wondered whether the GMC could utilise this information.

On 2nd July 2004 DCS's WATTS offer to appear before a GMC IOC hearing was communicated by Chief Constable KERNAGHAN to the Chief Executive of the GMC Mr FINDLAY SCOTT, along with a further summary of the police investigation and proposed timescales.

The investigation was further summarised to Code A of the GMC Fitness to Practice Directorate during a meeting of 6th July 2004.

During that meeting it was agreed that consideration would be given regarding disclosure of the Category 2 cases (sub-optimal care) to the GMC once the validation work had been completed by Code A and following consultation with the CPS. It may also be possible to use the key clinical team to give evidence to the GMC in respect of the category 2 cases.

DCS WATTS again offered to appear as a witness before any GMC hearing.

During a meeting with the Crown Prosecution Service the same day Mr Robert DRYBOROUGH –SMITH and Paul CLOSE, it was agreed that a written proposal in respect of disclosure to the GMC would be made for CPS consideration, but that ultimately it was a decision for the police investigation having regard to the competing interests.

CPS advised that in respect of the ongoing category 3 cases that release of such information before being heard in a criminal arena could amount to an abuse of process.

Disclosure Options for consideration Friday 23rd July 2004.

1. Do not disclosure any information to the GMC prior to a decision being taken in respect of a criminal prosecution upon the basis that such disclosure could be taken as an abuse of process and could prejudice police investigation and the course of justice.

2. Consider partial/incremental disclosure of information to the GMC including category 2 cases that will not/unlikely to form part of any prosecution case, but will be treated as unused material. This disclosure will enable the GMC to place fresh evidence of sub optimal treatment of patients to the IOC. Consideration needs to be made of the likely impact of a high profile GMC hearing upon the right of Dr BARTON to receive a fair trial should there be a criminal prosecution.

NB.

Dr BARTON since October 2002 has been voluntary subject to the following conditions :-

Not to prescribe Benzodiazepines or opiate analgesics from 1.10.2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that there care would not be compromised.

Dr BARTON will not accept any house visits if there is a possible need for such drugs to be prescribed.

Since April 2003 Dr BARTON has written 20 prescriptions for Diazepam to relatives of deceased, and has not prescribed any Diamorphine, Morphine or other controlled drug.

On 12th August 2004 Head of London division for the CPS Mr Robert Drybrough-Code A advised in respect of the police proposal to disclose material to the GMC relating to the 60 or so cases assessed as sub-optimal care cases, he having discussed the issue with Code A of the GMC.

Mrs Code A had commented that her advice to the GMC would be that the material under consideration would be used to base an investigation for submission to the interim orders committee. The committee would sit in private and it would be her advice that no further disciplinary proceedings which would be public should follow until the police investigation and any trial had been completed. Mr RDS main concern was that there should be no adverse publicity in the period immediately before or during the criminal proceedings in the event of them commencing.

Mr RDS asked that should any decision be contemplated to the contrary then advanced notice should be given to the police so that representations could be made regarding postponement.

Any statements taken in the course of a GMC investigation should be disclosed to the police and advanced notice should be given to police in respect of interviewing potential witnesses.

Necessary permissions should be obtained from family members before their statements or records were disclosed.

Subject to the aforementioned conditions RDS did not consider that there were substantial reasons preventing the disclosure of category 2 cases to the GMC.

On 17th August 2004 SIO WATTS agreed disclosure subject to notifications being made to key stakeholders and 19 category 2 cases were identified as ready for immediate disclosure.

On 26th August 2004 Code A (special projects GMC) confirmed that the GMC would review the content of the material to be disclosed and if appropriate make application to the Interim Orders Committee.

Mrs Code A added that in general terms the GMC would not proceed to a public inquiry at the Professional Conduct Committee in relation to matters subject to investigation until the conclusion of that investigation or criminal trial. She added that however the GMC had statutory duties and that any agreement to delay was subject to the police keeping the GMC informed as to the progress of the investigation and prosecution within a reasonable time...(she cited an example of proceeding should the police investigation be held in abeyance for an indefinite period or subject to unreasonable delay.

On 10th September 2004 the police disclosed 19 category 2 cases to the GMC along with relevant officer's reports, the observations of the multi-disciplinary medical review team and the quality assurance analysis summary completed by an independent legal/medico lawyer.

On the 17th September 2004 GMC caseworker Mr Code A commented that 14 of the 19 cases disclosed would form evidence towards the Interim Order Committee.

On 30th September 2004 the SIO Det Chief Supt WATTS supplied a statement of evidence to the GMC outlining the conduct of the investigation.
On the 7th October 2004 Dr BARTON appeared before an Interim Order Committee, who determined that it was not satisfied that it was necessary to make an order against Dr BARTON, in the interests of protection of the public or Dr BARTON herself.

On 16th December 2004 disclosure of a further 28 category 2 cases was made to the GMC.

David WILLIAMS
Det Supt Code A
7th January 2005.

Trust