2000/2047

DR JANE BARTON

VOLUME 2

April 07 -

Oct 08.

11

Began 22/11/04

SAP Back Scan
Exercise

Case File Number 2000/2047

Doctor Number 1587920

Date Sent to DV

Booked Out By L WHEATLEY

Date Returned from DV

Booked In By

Comments

initiative® office products

Colours available:

Colour	Ref. Code
Blue	SS7089
Buff	SS7092
Green	SS7093
Orange	SS7090
Pink	SS7091

CPT FILE (Lon)

CPT DOCUMENTS BEGIN

[redacted]

At short

Fareham and Gosport NHS
Primary Care Trust

Unit 180, Fareham Reach
166 Fareham Road
Gosport
PO13 0FH

Tel: 01329 233447
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Direct Line: Code A
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Code A
Assistant Registrar
General Medical Council
2nd Floor, Regents Place
350 Euston Road
London
NW1 3JN

25th November 04

Dear Code A

RE: Dr Jane Barton

I have met with Dr Barton on three occasions since October 2002 in order to examine the prescribing data supplied by the Prescription Pricing Authority (PPA). At our last meeting, we looked at the data for benzodiazepine and opiate prescribing from October 2002 until August 2004. The PPA records prescribing data according to the named GP on the bottom of the prescription form NOT the GP signing the form. Consequently, a number of prescriptions were attributed to Dr Barton, which had been initiated by another partner. Dr Barton has agreed to take certain actions, following our last meeting, the details of which are included in the report.

I am enclosing copies of the PPA data, together with graphs and the reports of our meetings. If I can be of any further help, please contact me.

Yours sincerely

Code A

Hazel Bagshaw
Pharmaceutical Adviser

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton Oct 2002 - March 20

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Diazepam_Tab 5mg	2	60.0	£2.29
October 2002	Diazepam_Tab 5mg	1	28.0	£0.55
October 2002	Diazepam_Tab 5mg	1	56.0	£1.07
October 2002	Diazepam_Tab 2mg	2	60.0	£2.11
October 2002	Diazepam_Tab 2mg	1	28.0	£0.51
October 2002	Diazepam_Tab 5mg	1	30.0	£0.59
October 2002	Temazepam_Tab 10mg	1	56.0	£1.65
October 2002	Lorazepam_Tab 1mg	1	28.0	£1.16
October 2002	Diazepam_Oral Soln 2mg/5ml S/F	1	200.0	£2.64
October 2002	Diazepam_Tab 10mg	1	60.0	£1.65
October 2002	Nitrazepam_Tab 5mg	1	60.0	£1.61
October 2002	Nitrazepam_Tab 5mg	1	56.0	£1.51
October 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Diazepam_Tab 5mg	1	28.0	£0.55
December 2002	Diazepam_Tab 5mg	1	60.0	£1.15
December 2002	Temazepam_Tab 20mg	1	28.0	£1.40
December 2002	Temazepam_Tab 20mg	1	30.0	£1.50
January 2003	Diazepam_Tab 2mg	2	28.0	£1.02
January 2003	Diazepam_Tab 2mg	1	56.0	£0.98
January 2003	Temazepam_Tab 20mg	1	28.0	£1.41
February 2003	Diazepam_Tab 2mg	3	28.0	£1.52
February 2003	Temazepam_Tab 10mg	1	56.0	£1.62
March 2003	Diazepam_Tab 5mg	1	6.0	£0.14
March 2003	Diazepam_Tab 5mg	2	28.0	£1.11
		30		***£31.13***

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton 2003-4

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
May 2003	Diazepam_Tab 2mg	1	28.0	£0.51
May 2003	Diazepam_Tab 10mg	1	60.0	£1.65
June 2003	Diazepam_Tab 2mg	1	28.0	£0.51
June 2003	Diazepam_Tab 2mg	1	6.0	£0.13
June 2003	Temazepam_Oral Soln 10mg/5ml S/F	1	100.0	£3.01
June 2003	Diazepam_Tab 5mg	2	28.0	£1.11
July 2003	Diazepam_Tab 2mg	1	28.0	£0.51
July 2003	Diazepam_Tab 10mg	1	60.0	£1.65
September 2003	Chlordiazepox HCl_Cap 5mg	1	52.0	£1.96
October 2003	Diazepam_Tab 2mg	1	28.0	£0.51
October 2003	Diazepam_Tab 2mg	1	10.0	£0.20
October 2003	Diazepam_Tab 5mg	1	10.0	£0.22
November 2003	Diazepam_Tab 2mg	1	21.0	£0.39
November 2003	Diazepam_Tab 2mg	1	28.0	£0.51
November 2003	Diazepam_Tab 5mg	1	60.0	£1.15
December 2003	Diazepam_Tab 2mg	1	28.0	£0.51
February 2004	Diazepam_Tab 2mg	2	28.0	£1.02
February 2004	Diazepam_Tab 5mg	1	56.0	£1.08
		20		***£16.63***

Based on the Selections:

1st Quarter 2003/2004,
2nd Quarter 2003/2004,
3rd Quarter 2003/2004,
4th Quarter 2003/2004
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

NHS

Prescription Pricing Authority

Prescribing Report Benzodiazepines Dr Barton April - August 200

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Diazepam_Tab 2mg	1	28.0	£0.51
April 2004	Lorazepam_Tab 1mg	1	28.0	£1.16
May 2004	Diazepam_Tab 2mg	1	60.0	£1.06
May 2004	Nitrazepam_Tab 5mg	1	56.0	£1.53
June 2004	Diazepam_Tab 2mg	1	60.0	£1.06
June 2004	Diazepam_Tab 2mg	1	28.0	£0.51
June 2004	Diazepam_Tab 5mg	3	14.0	£0.88
July 2004	Diazepam_Tab 5mg	2	14.0	£0.59
July 2004	Temazepam_Tab 10mg	1	56.0	£1.75
August 2004	Diazepam_Tab 2mg	1	28.0	£0.51
		13		***£9.56***

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Diazepam_Syr 2mg/5ml,
Temazepam_Oral Soln 10mg/5ml S/F,
Stesolid_Soln 2mg/ml 2.5ml Rectal Tube,
Chlordiazepox HCl_Cap 5mg,
Diazepam_Tab 10mg,
Diazepam_Oral Soln 2mg/5ml S/F,
Lorazepam_Tab 1mg,
Temazepam_Tab 20mg,
Nitrazepam_Tab 5mg,
Temazepam_Tab 10mg,
Diazepam_Tab 5mg,
Diazepam_Tab 2mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

Prescribing Report Opiates Dr Barton Oct 2002 - March 2003

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
October 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
October 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
October 2002	Tramadol HCl_Cap 50mg	1	30.0	£2.76
October 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£8.52
October 2002	Tramadol HCl_Cap 50mg	1	90.0	£8.22
November 2002	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
November 2002	Codeine Phos_Tab 30mg	1	60.0	£2.82
December 2002	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.43
December 2002	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.64
December 2002	Codeine Phos_Tab 30mg	1	60.0	£2.83
December 2002	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
December 2002	Tramadol HCl_Cap 50mg	1	100.0	£9.36
January 2003	Codeine Phos_Tab 30mg	1	60.0	£2.82
January 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
January 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
January 2003	Dihydrocodeine Tart_Tab 30mg	1	180.0	£6.54
January 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.74
February 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
February 2003	Oramorph_Oral Soln 10mg/5ml	1	300.0	£5.63
February 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
February 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.93
March 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
March 2003	Tramadol HCl_Tab 100mg M/R	2	60.0	£32.88
March 2003	Tramadol HCl_Cap 50mg	2	60.0	£11.26
March 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.58
March 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.43
		29		***£200.48***

Based on the Selections:

3rd Quarter 2002/2003,
4th Quarter 2002/2003
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,

NHS

Prescription Pricing Authority

Prescribing Report Opiates Dr Barton 2003-4

Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2003	Codeine Phos_Tab 30mg	1	60.0	£2.62
April 2003	Tramadol HCl_Cap 50mg	1	90.0	£8.42
May 2003	Codeine Phos_Tab 30mg	2	60.0	£5.65
May 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
May 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.58
May 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.35
June 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.07
June 2003	Mst Continus_Tab 10mg	1	120.0	£10.96
June 2003	Mst Continus_Tab 60mg	1	60.0	£25.63
June 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£3.20
June 2003	Tramadol HCl_Cap 50mg	2	100.0	£18.68
June 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
July 2003	Codeine Phos_Tab 30mg	1	240.0	£11.19
July 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
July 2003	Codeine Phos_Tab 30mg	2	60.0	£5.44
July 2003	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.93
July 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
August 2003	Codeine Phos_Tab 30mg	1	240.0	£11.18
August 2003	Dihydrocodeine Tart_Tab 30mg	1	40.0	£1.97
September 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.04
September 2003	Morph Sulph_Tab 15mg M/R	1	42.0	£6.75
September 2003	Zydol_Cap 50mg	1	60.0	£9.14
September 2003	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.74
September 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.32
September 2003	Codeine Phos_Tab 30mg	2	60.0	£5.42
October 2003	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.14
October 2003	Meptazinol HCl_Tab 200mg	1	60.0	£10.72
October 2003	Tramadol HCl_Cap 50mg	1	100.0	£9.37
October 2003	Codeine Phos_Tab 30mg	1	60.0	£2.84
November 2003	Tramadol HCl_Cap 100mg M/R	1	28.0	£6.95
November 2003	Tramadol HCl_Cap 50mg	1	84.0	£7.87
November 2003	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.79
December 2003	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
December 2003	Codeine Phos_Tab 30mg	2	60.0	£5.46
January 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
January 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
February 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
February 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.07
February 2004	Dihydrocodeine Tart_Tab 30mg	1	180.0	£5.77
February 2004	Dihydrocodeine Tart_Tab 30mg	1	56.0	£2.76
March 2004	Codeine Phos_Tab 30mg	1	60.0	£2.62
March 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.38
March 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90

52 *£340.81*

Based on the Selections:

Financial 2003/2004
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.

Organisation selected from the Practices Current Children organisational view
Report based on Show PCT Prescribing.

Current Structure view for selected organisations

Date produced 26 Oct 2004

NHS

Prescription Pricing Authority

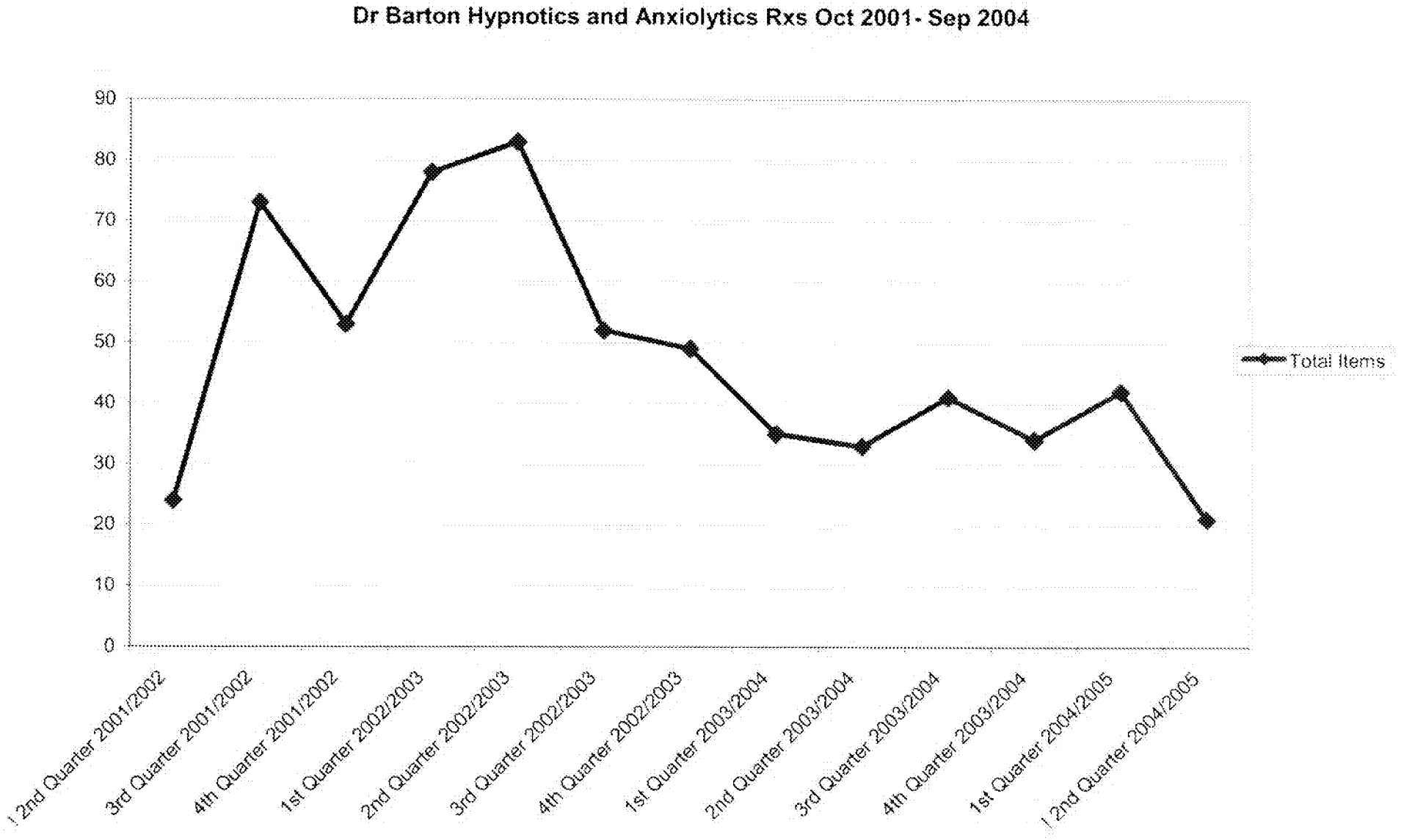
Prescribing Report Opiates Dr Barton April - August 2004

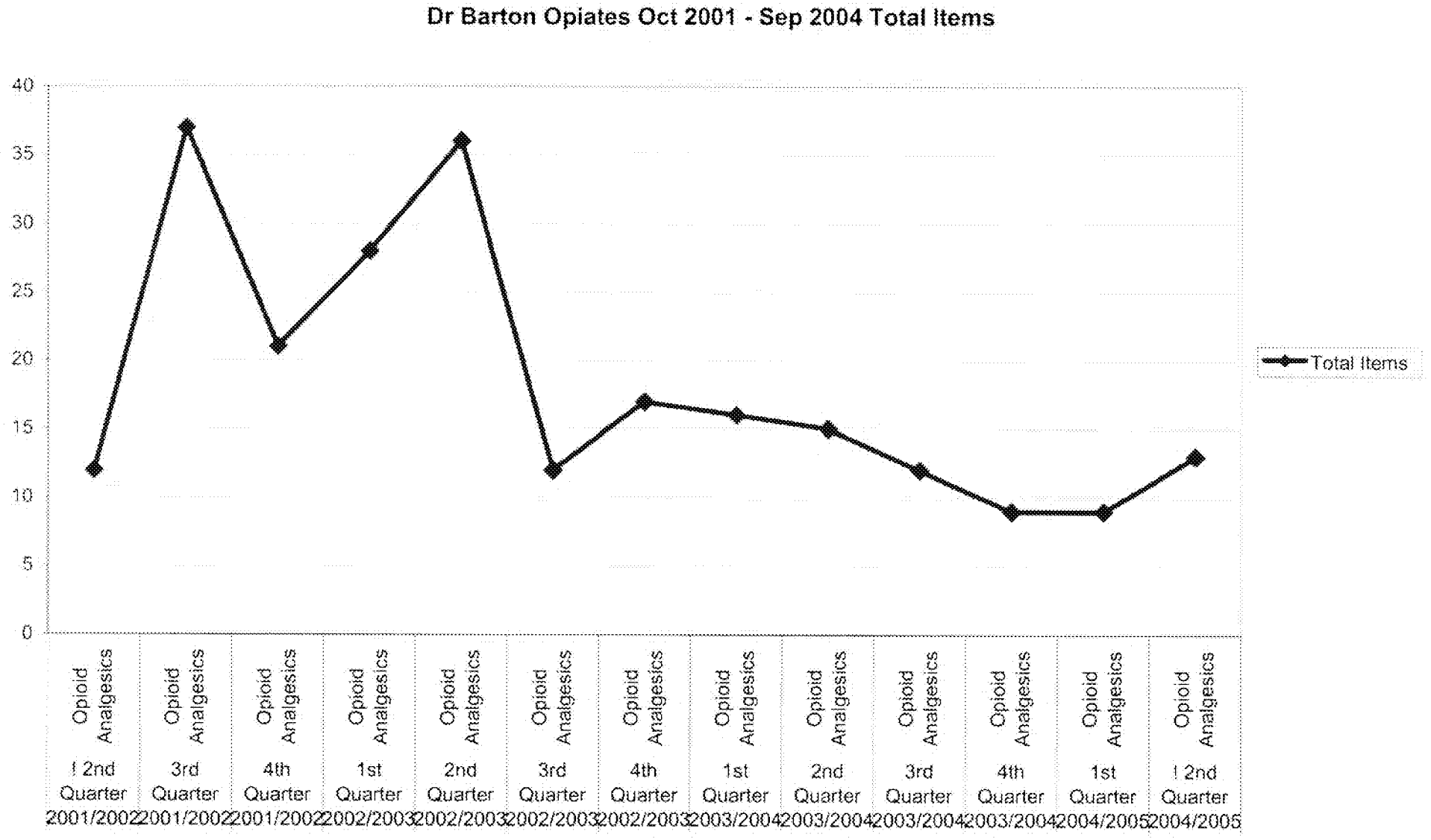
Period Name	BNF Name	Total Items	Quantity	Total Act Cost
April 2004	Dihydrocodeine Tart_Tab 60mg M/R	2	56.0	£12.13
April 2004	Codeine Phos_Tab 30mg	1	60.0	£2.84
April 2004	Tramadol HCl_Cap 50mg	2	150.0	£28.07
May 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
June 2004	Tramadol HCl_Tab 100mg M/R	2	60.0	£33.02
June 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.90
July 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
July 2004	Tramadol HCl_Tab 100mg M/R	3	60.0	£49.49
July 2004	Dihydrocodeine Tart_Tab 30mg	1	100.0	£4.89
July 2004	Tramadol HCl_Cap 50mg	2	100.0	£18.71
August 2004	Dihydrocodeine Tart_Tab 60mg M/R	1	56.0	£6.06
August 2004	Tramadol HCl_Tab 100mg M/R	1	60.0	£16.50
August 2004	Tramadol HCl_Cap 50mg	1	100.0	£9.12
August 2004	Dihydrocodeine Tart_Tab 30mg	2	100.0	£9.86
August 2004	Tramadol HCl_Cap 50mg	1	150.0	£13.67
		22		*£221.38*

Based on the Selections:

1st Quarter 2004/2005,
! 2nd Quarter 2004/2005
for Financial Year at Summary Level Month
Dr BARTON JA
for Practices Current Children at Summary Level Accumulate Organisations
Dihydrocodeine Tart_Tab 30mg,
Tramadol HCl_Cap 50mg,
Codeine Phos_Tab 30mg,
Dihydrocodeine Tart_Tab 60mg M/R,
Tramadol HCl_Tab 100mg M/R,
Mst Continus_Tab 10mg,
Morph Sulph_Tab 10mg M/R,
Oramorph_Oral Soln 10mg/5ml,
Sevredol_Tab 10mg,
Mst Continus_Tab 30mg,
Diconal_Tab,
Morph Sulph_Tab 15mg M/R,
Mst Continus_Tab 5mg,
Mst Continus_Tab 60mg,
Zydol_Cap 50mg,
Tramadol HCl_Eff Pdr Sach 100mg,
Tramadol HCl_Cap 100mg M/R,
Oxycodone HCl_Cap 5mg,
Morph Sulph_Tab 30mg M/R,
Morph Sulph_Tab 60mg M/R,
Meptazinol HCl_Tab 200mg
for BNF at Summary Level Presentation

Report based on top 600 records.


Dr Barton Hypnotics and Anxiolytics Rxs Oct 2001- Sep 2004
90
80
70
60
50
40
30
20
10
0
Total Items
2nd Quarter 2001/2002
3rd Quarter 2001/2002
4th Quarter 2001/2002
1st Quarter 2002/2003
2nd Quarter 2002/2003
3rd Quarter 2002/2003
4th Quarter 2002/2003
1st Quarter 2003/2004
2nd Quarter 2003/2004
3rd Quarter 2003/2004
4th Quarter 2003/2004
1st Quarter 2004/2005
2nd Quarter 2004/2005


Dr Barton Opiates Oct 2001 - Sep 2004 Total Items
40
35
30
25
20
15
10
5
0
Total Items
Opioid Analgesics
! 2nd Quarter 2001/2002
3rd Quarter 2001/2002
4th Quarter 2001/2002
1st Quarter 2002/2003
2nd Quarter 2002/2003
3rd Quarter 2002/2003
4th Quarter 2002/2003
1st Quarter 2003/2004
2nd Quarter 2003/2004
3rd Quarter 2003/2004
4th Quarter 2003/2004
1st Quarter 2004/2005
! 2nd Quarter 2004/2005

Meetings with Dr J Barton.

The meetings were held to discuss matters raised in the CHI report on Gosport War Memorial Hospital. PACT data was obtained for 2001-2 to establish Dr Barton's prescribing patterns for benzodiazepines and opiates (see attached PPA data and analysis table). PACT catalogue data is also available on file.

Meeting on November 1st 2002.
Dr Barton has undertaken not to prescribe benzodiazepines or opiate analgesics from October 1st 2002. All patients requiring ongoing therapy with such drugs are being transferred to other partners within the practice so that their 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. Problems may arise with her work for Health Call as a prescription may be required for a 14-day supply of benzodiazepines for bereavement.
Dr Barton also agreed to follow up all previous prescriptions for high quantities using the practice computer system and the patients' notes.
The next meeting will be in 6 months time

Visits to local pharmacies for spot checks on Dr Barton's prescriptions was discussed and deemed to be impractical.

Meeting on June 27th 2003
Data was available from the PPA up to and including April 2003. 12 months data was discussed.
Dr Barton had initiated searches on the practice computer system and the data collected by the practice IT manager for the 4th quarter of 2002-3 was studied. 7 of the 8 diazepam prescriptions had been prescribed by other partners for Dr Barton's patients.
Copies of the breakdown of PACT data from October 2002 to April 2003 for nitrazepam, temazepam, diazepam and opiates were given to Dr Barton. Monthly reports on these drugs will be prepared for Dr Barton.

Hazel Bagshaw
Pharmaceutical Adviser
Fareham and Gosport PCT
05.09.03

Notes from meeting with Dr J Barton

3rd November 2004

Details of the voluntary agreement - from October 2002 as confirmed in an e-mail from Dr Sommerville. It was agreed that this should run until Dr Barton had been before the Conduct Committee. The agreement was for a restriction on the prescribing of opiates and for benzodiazepines to only be prescribed in line with BNF guidance.

The Prescription Pricing Authority data was examined for the period October 2002 until August 2004 (the latest data on the system at the time of the meeting). Dr Barton had made great efforts to transfer patients requiring opiates or benzodiazepines to other partners within the practice. The practice data analyst had produced a list of the prescriptions for diazepam 2mg, which had been issued with Dr Barton's name as the prescriber. Dr Barton had written 5 prescriptions and a reason for the treatment was documented. The remaining prescriptions had been issued during consultations with other partners.

Only 3 of the opiate prescriptions were for controlled drugs in tablet form. Dr Barton will ask the practice data analyst to follow up this matter. The remainder of the prescriptions were for drugs such as codeine phosphate, tramadol and dihydrocodeine tablets or capsules.

Dr Barton will also ask the data analyst to follow up the diazepam 10mg prescriptions.

As far as Dr Barton is concerned, the voluntary agreement is still in place. The agreement for opiates was a restriction on controlled drugs, in particular, for injection.

The PPA data is recorded against the GP name printed in the bottom of the prescription not against the signature. Dr Barton continues to assure me that all patients requiring long-term treatment with opiates or benzodiazepines are asked to see other partners within the practice.

Hazel Bagshaw
Pharmaceutical Adviser
Fareham and Gosport PCT
04.11.04

Confidential
Addendum (I)
BARTON

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee
13 October 2004

Information: Further information:

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:

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> "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.

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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.

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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 maternity 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 <u>that</u> 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

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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 pregnant, who commenced her annual leave on 27 April 1998 and followed on with maternity 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.

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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

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

CATHERINE LEE

Catherine Lee

Date of Birth: Code A Age: **92**
Date of admission to GWMH: **14th April 1998**
Date and time of Death: **14.45 hours on 27th May 1998**
Cause of Death:
Post Mortem: **Cremation**
Length of Stay: **44 days**

Mrs Lee's past medical history:-

1998 Fracture neck of femur
1998 TIA
IHD
Glaucoma
Rectal prolapse

Mrs Lee lived at Addenbrookes Residential Home. She had a daughter and grand-daughter. It was noted that she had poor mobility and was confused at times. Mrs Lee sustained a fractured neck of femur at Addenbrookes on 2nd April 1998 and was admitted to Haslar Hospital for surgery to correct the fracture. She was then admitted to Gosport War Memorial Hospital on 14th April 1998 for continuing care.

On admission a Waterlow score of 30 was recorded with another score of 29 recorded on 8th May 1998
A nutritional assessment plan was completed on 15th April 1998 with a score of 4.
Barthel ADL index was recorded on 14th April 1998 scoring 0, another on 25th April 1998 scoring 1 and another one on 9th May 1998 scoring 4
A handling profile was completed on 16th April 1998 noting that Mrs Lee needed the assistance of 2 and a hoist for transfers.
A mouth assessment was completed on 15th April 1998.
Care plans commenced on 14th April 1998 for MRSA screening, 15th April 1998 for sleep, 16th April 1998 for hygiene, nutrition, constipation and on 26th April 1998 for small laceration right elbow.

14th April 1998

Clinical notes – transferred to Dryad Ward from Haslar for continuing care. Barthel 0. Make comfortable, **happy for nursing staff to confirm death.** It was noted that Mrs Lee has sustained a right fracture neck of femur and had undergone surgery of canulating screws on 3rd April 1998. It noted that Mrs Lee had poor mobiltiy needed the assistance of 2 nurses, was confused at times, needed full assistance with eating and drinkng due to poor eye sight and that she had a poor appetite. She needed all care for hygiene and dressing and her pressure area were intact and that she needed nursing on a pressure relieving mattress.

Summary – Cold on arrival on Dryad Ward, been sick in ambulance. Settle on ward and given 2.5ml oramorph. Nursed on Pegusus airwave mattress.

15th April 1998

Summary – oramorph 5mgs 4 hourly.

17th April 1998

Summary – restless, confused. Oramorph 5mg 4 hourly.

18th April 1998

Summary – oramorph 5mgs 4 hourly.

23rd April 1998

Clinical notes – MRSA negative. Bottom slightly sore. Start gentle mobilisation will not be suitable for Addenbrookes. Seen by Dr Banks has severe dementia.

24th April 1998

Summary – fell while attempting to get up from commode. Sustained skin flat to right elbow. Accident form completed. Daughter informed.

27th April 1998

Clinical notes – gentle rehabilitation here for next 4-6 weeks probably for Nursing home on discharge.

Pleased with progress agree Nursing Home would be best option.

11th May 1998

Pain in left chest.

15th May 1998

Summary – seen by Dr Barton re pain oramorph increased to 10mgs 4 hourly (20 mgs nocte).

18th May 1998

Clinical notes – increasingly uncomfortable when I called much better on oramorph.

20th May 1998

Summary – visited by daughter. For cremation.

21st May 1998

Clinical notes – further deterioration uncomfortable and restless. Needs S/C analgesia. **Happy for nursing staff to confirm death.**

Summary – restless, agitated. Seen by Dr Barton. Syringe driver commenced diamorphine 20mgs at 09.40. Fentanyl patch 25mgs removed at 13.30.

22nd May 1998

Summary – grimacing when turned. Syringe driver renewed at 09.30 diamorphine 20mgs and midazolam 40mgs. Continues to mark, position changed every couple of hours.

23rd May 1998

Summary – syringe driver recharged at 7.35. 20mgs diamorphine 40mgs midazolam. Position changed every 2 hours.

25th May 1998

Summary – further deterioration. Syringe driver renewed at 07.00 in some distress when being turned. Syringe driver renewed at 14.55 diamorphine 40mgs.

26th May 1998

Clinical notes – died peacefully at 14.45.

Death verified by SR Hamblin and SN Barrett.

In reply please quote PCH/2000/2047
Please address your reply to the Committee Section FPD
Fax: 020 7915 7406

COPY

By Special Delivery and First Class Mail

24 September 2004

Dr Jane Ann Barton

Code A

Dear Dr Barton

I am writing to notify you that the President has considered information received by the GMC about your conduct.

The President, exercising his powers under rule 4 of the General Medical Council (Interim Orders Committee)(Procedure) Rules 2000, considers that the circumstances are such that you should be invited to appear before the Interim Orders Committee (IOC) in order that it may consider whether it is necessary for the protection of members of the public, or is otherwise in the public interest, or in your own interests, that an interim order should be made suspending your registration, or imposing conditions upon your registration, for a period not exceeding eighteen months, in exercise of their powers under section 41A of the Medical Act 1983 as amended.

The President has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved. The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

You are invited to appear before the IOC **at 09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you so wish, to address the Committee on whether such an order should be made in your case.

You may, if you wish, be represented by Counsel, or a solicitor, or by a member of your family, or by a representative of any professional organisation of which you may

be a member. You may also be accompanied by not more than one medical adviser. The IOC is, however, empowered to make an order in relation to your registration irrespective of whether or not you are present or represented.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for the attention of **Adam Elliott, Committee Section** Code A

Code A

You are invited to state in writing whether you propose to attend the meeting, whether you will be represented or accompanied as indicated above, and if so, by whom.

The IOC normally meets in private but you may if you wish, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public. If you wish for the meeting to be held in public could you please notify Adam Elliott, Committee Section (fax number as above), as soon as possible.

The GMC is under a statutory duty to publish the outcome of IOC hearings. It is our usual practice to do so by placing the outcomes of hearings on our website. If you do not attend the hearing could you please supply Adam Elliott (fax number as above) with a telephone or fax number where you can be contacted on the day of the hearing so we can let you know of the decision before placing the information on our website. If you do not provide such a contact number, or we are unable to contact you, the outcome of the hearing will still be published.

If you intend to consult your medical defence society, or to take other legal advice, you should do so without delay.

In accordance with Section 35A(2) of the Medical Act 1983 (as amended), you are required to inform us, within 7 days of receipt of this letter, of the name and address of the following: -

- all of your current employers,
- the Health Authority with which you have a service agreement,
- locum agency/agencies with whom you are registered, and
- the hospital/surgery at which you are currently working.
- If you engage in any non-NHS work, you are also required to notify us, within the same period of time, of the name of the organisation/hospital by which you are employed, or have any working arrangements. Please forward this information directly to me. Upon receipt of these details, your employers will be notified of the Committee's consideration of the matter.
- If you are approved under Section 12 of the Mental Health Act, or Section 20 (b) of the Mental Health (Scotland) Act 1984, you must also notify us of this fact.

I enclose copies of the relevant provisions of the Medical Act, the IOC Procedure Rules, a paper about our fitness to practise procedures and a paper about the procedures of the IOC.

The documents enclosed with this letter may contain confidential information. This material is sent to you solely to enable you to prepare for this hearing. The documents must not be disclosed to anyone else, except for the purpose of helping you to prepare your defence.

Please will you write personally to acknowledge receipt of this letter quoting the reference above.

Yours sincerely

COPY

Paul Hylton
Assistant Registrar

Cc: Mr Ian Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ
ISPB/TOC/0005940/Legal

FAO Paul Hylton
Committee Section FPD
General Medical Council
178, Great Portland Street
London W1W5JE

Dr Jane Barton

Code A

Your Reference PCH/2000/2047

27th September 2004

Dear Mr Hylton

re Interim Order Committee hearing on 7th October 2004

I am a Principal in General Practice contracted to Fareham and Gosport Primary Care Trust.

I am on the Bed Fund for Gosport War Memorial Hospital, Bury Road Gosport, administered by the same Primary Care Trust.

I am a partner in the practice of Dr PA Beasley and partners,

Forton Medical Centre,
White's Place
Forton Road,
Gosport PO123JP.

I have no other employment or contract either NHS or non NHS and I am not approved under Section 12 of the Mental Health Act.

I propose to attend the hearing on 7th October 2004. I will be represented by my solicitor Ian Barker of the MDU .

Yours Sincerely

Code A

Dr Jane Barton

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

THE MDU

MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

DX No. 36505
Lambeth

Legal Department of The MDU

Telephone: 020 7202 1500
Fax: 020 7202 1663

Email: mdu@the-mdu.com
Website www.the-mdu.com

Mr Adam Elliott
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: Code A

Dear Mr Elliott

Dr Jane Barton – Interim Orders Committee – 7th October 2004

Further to the letter from Mr Hylton to Dr Barton of the 24th September, and indeed our telephone conversation today, can I confirm that I continue to act for Dr Barton.

As you know, Dr Barton has previously appeared before the Interim Orders Committee on three occasions. On each occasion the matters raised have been essentially of the same origin and nature.

On each occasion Dr Barton has been represented by Mr Alan Jenkins of Counsel. The matter is necessarily a little complex and continuity of representation, somewhat unusually for the purposes of such hearings, in this instance is of clear importance. Indeed I would respectfully submit that it would only be reasonable and fair for Dr Barton to have that continuity of representation.

I very much regret to advise you that Mr Jenkins is unavailable on 7th October. I have made enquiries to see if it might be possible for his existing commitment to be dealt with on another occasion, but understand this is simply not possible.

In these circumstances I would be most grateful if consideration could be given to the provision of an alternative date for the hearing of this matter. I appreciate that the General Medical Council would not seek to delay the matter for any significant period of time, but it may be relevant to observe that at none of the previous three hearings, in June 2001, March 2002 and September 2002 was considered necessary by the Committee to make an Order affecting Dr Barton's registration.

Can I also take the opportunity to point out that the letter to Dr Barton of 24th September, advising her of the forthcoming hearing does not appear to comply with Rule 5 (1) of the General Medical Council (Interim Orders Committee) (Procedure) Rules Order of Council 2000. The letter does not contain a brief statement of the matters which appear to raise the relevant question set out sub sub rule (b).

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
27 September 2002

Further, Dr Barton has not yet been provided with any documentation. Curiously, it seems to be suggested that the issue of what documentation will be disclosed has still to be determined. Specifically, in paragraph 3 of the letter from Mr Hylton it is said that the GMC is in the process of clarifying with the Police the level of disclosure that can take place. As you will appreciate, Rule 5 (3) of the procedure rules requires that the Registrar shall send a Practitioner copies of any documents received in connection with a case. It is therefore not open to the GMC to be selective – any document received should be disclosed.

I make the points in relation to compliance with Rule 5 (1) and Rule 5 (3) as clearly there are issues to resolve before the matter can reasonably proceed and in those circumstances too brief adjournment might be sensible for all concerned.

I would be most grateful if this application could be given urgent consideration and if I can assist with the provision of any further information, including further details of Mr Jenkins' availability, I will be pleased to do so immediately.

It may assist if I mention now that Mr Jenkins would be available both on the 13th and 15th October, when I understand the IOC will be sitting to consider cases generally.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

Code A

E:\Committee\ioc\PHC\2004\Barton\Barker(MDU)290904

Your reference **ISPB/TOC/0005940/Legal**
In reply please quote **ACE/JJC/PCH/2000/2047**

By post and fax – 020 7202 1663

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

30 September 2004

Mr Ian Barker
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear Mr Barker

Dr Jane Barton – Interim Orders Committee (IOC) 7 October 2004

Thank you for your letter of 27 September 2004 in which you request that the Chairman of the IOC consider postponing the scheduled hearing of Dr Barton's case in accordance with Rule 7(1) of the Committee's Rules.

I can confirm that the Chairman of the Committee considered your request and that he did not accede to it.

The Chairman in considering this request considered the nature and purpose of the IOC, which is namely, to determine whether interim action is required to be taken against the registration of a doctor who may pose a risk to the public, the public interest or their own interests and in fulfilling this function it is considered that the Committee should meet as soon as practicable whilst bearing in mind the need to balance the consequences for the practitioner of the imposition of an interim order and to ensure that the doctor is afforded the opportunity to attend any hearing and be represented, although not necessarily by the Counsel of their choice.

The Chairman took account of the Council's letter notifying Dr Barton of the forthcoming hearing and the timetable contained therein and in reaching his decision considered that the date of 7 October 2004.

In reaching his decision the Chairman determined that whilst unfortunate that Dr Barton's chosen Counsel is not available, there was still sufficient time to instruct fresh Counsel to attend and make representations. It is the Council's intention to dispatch a copy of all the papers in the case on 30 September 2004, providing Dr Barton with 7 days in which to prepare a defence. It was the opinion of the Chairman that this was sufficient time in which to fully instruct new Counsel to prepare such a defence. The Chairman further considered that the Council's letter of 24 September 2004 put Dr Barton on notice that the hearing would be taking place on 7October

178 Great Portland Street London W1W 5JE Telephone 020 7580 7642 Fax 020 7915 3641
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Registered Charity No. 1089278

5C

In all the circumstances, the Chairman having taken into account your letter of 27 September 2004 and balanced the information contained within against the reasons for Dr Barton's referral considered that, it was important in the public interest that Dr Barton's case be heard as soon as possible.

The hearing scheduled to take place on 7 October 2004 will take place as listed and Dr Barton is invited to appear before the IOC **at 09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. You are further invited to state in writing whether you propose to attend the meeting, whether Dr Barton will attend and whether she will be represented by Counsel, and if so, by whom.

The IOC normally meets in private but Dr Barton may if she wishes, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Secretariat having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

With regard to your point regarding Rule 5(1)b it is the opinion of the Council that the letter dated 24 September gave the following brief statement of the matters which appear to raise the relevant question set out in Rule 5(1)b:

> *The President has reached this decision as he was of the view, after considering the information provided by Hampshire Constabulary in respect of its enquiries into the deaths of a number of patients at Gosport War Memorial Hospital, that the information was such that the Committee should be invited to consider whether it is necessary for the protection of members of the public, or otherwise be in the public interest for your registration to be restricted whilst Hampshire Constabulary's enquiries and any action resulting from those enquiries is resolved.*

Further, the Council submits that its letter of 24 September also gives a full explanation as to when Dr Barton can expect to have disclosure of the information to be considered by the Committee, and what information she can expect to be disclosed. The Council is mindful of the provisions of Rule 5(3) but it is not of the view that it's letter contravened those provisions. The letter states that:

The GMC is in the process of clarifying with the Police the level of disclosure that can take place before the IOC. Once we have done so we will disclose to you a copy of all the information that will be put before the IOC. You should expect this disclosure of information by 30 September 2004.

The clarification with the Police is in respect of what information the CPS determines can be disclosed to the GMC. The Police are fully aware that any information disclosed to the GMC and subsequently disclosed to any of its Committees must also be disclosed to Dr Barton. The Council will disclose to Dr Barton all information that is to be put before the IOC.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

Code A

Adam Elliott
Interim Orders Committee Secretariat

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

Mr Adam Elliott
Committee Section
General Medical Council
178 Great Portland Street
London, W1W 5JE

Also by fax: Code A

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Dear Mr Elliott

Dr Jane Barton – Interim Orders Committee – 7th October 2004

Thank you for your letter of 30th September, and I am grateful for the provision of written reasons of the decision not to grant adjournment in this matter.

I am grateful too for the observations concerning Rule 5 (1). It remains my contention, however, that the brief statement required by that Rule has not been provided. The information that you quote within the letter is hardly sufficient. There is no basic summary or indication of what the information provided by Hampshire Constabulary might be. Indeed, as I understood the position yesterday no written statement or evidence had been supplied by Hampshire Constabulary to the GMC at that time.

In any event, I am concerned to make further request for adjournment of Dr Barton's case with the benefit of additional information, and indeed having had the opportunity to consider the written reasons for the Chairman's previous decision.

As you will know, Dr Barton has thus far received no documentation at all in this matter. The statement from the Hampshire Constabulary which it is understood you were to receive yesterday has yet to materialise. Further, I am advised that a significant volume of patient records had been made available to the GMC, which it is felt is not necessary to trouble the Interim Orders Committee but which is nonetheless available. It must be right that Dr Barton has the opportunity to consider those records, which I understand to be some 3 feet deep. It may of course be that there is no information which is necessary to place before the Interim Orders Committee in that regard, on behalf of Dr Barton, but unless and until Dr Barton has had the appropriate opportunity to consider the materials, that cannot properly be determined.

Unfortunately, Dr Barton is not immediately able to consider any such documentation even if it were to be made available forthwith. [redacted] She will visit them tomorrow and at the weekend. Her first realistic opportunity to look at any amount of documentation would be on Monday of next week.

5

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
30 September 2004

In addition to Dr Barton's ability or lack of it to consider such a significant quantity of material at this stage, sadly Counsel previously instructed for Dr Barton, Mr Alan Jenkins, remains unavailable for the hearing on 7th October. I appreciate at once that the Interim Orders Committee would not ordinarily be concerned to take Counsel's availability into account. However, this matter has previously been considered on three separate occasions by the Interim Orders Committee – and substantively on each occasion, rather than being merely by way of review. There is therefore a long and significant history from which I would submit that it is desirable that there should be continuity of representation, both for Dr Barton herself, and indeed to assist the Committee.

With reference to the limited information given within the letter of the 24th September to Dr Barton about the matter, which you have kindly quoted in your letter to me of 30th September, it is clear that the matter concern the Gosport War Memorial Hospital. Dr Barton ceased to have any involvement with that hospital some long time ago. It must therefore be the case that any matters raised by the Hampshire Constabulary are historical. As best I am aware of it, there has been no expression whatsoever of concern in relation to Dr Barton's recent practice.

I would respectfully submit that this point is highly relevant in terms of the consideration of the public interest in ensuring that a hearing take place very rapidly. It is also relevant in that regard that on each of the three occasions when Interim Orders Committee has met to consider Dr Barton – on each occasion with reference to the Gosport War Memorial Hospital – the Committee concluded that it was not necessary to make an order affecting Dr Barton's registration.

Accordingly, there is as best I am aware of it no indication that Dr Barton's present behaviour gives any obvious cause for concern, and to the extent that her previous activities as a Practitioner habr been considered in relation to this very hospital, no action has been taken by the IOC. It must surely be the case in those circumstances that the public interest could not reasonably be adversely affected by an adjournment of a mere week to facilitate both the proper consideration of paperwork and representation by established Counsel.

I would be grateful if my further application for adjournment could be given urgent consideration.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

Please quote our reference when communicating with us about this matter

Our ref: ISPB/TOC/0005940/Legal
Your ref: PCH/2000/2047
5 October 2004

THE MDU

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Mr Paul Hylton
Assistant Registrar
General Medical Council
350 Regent's Place
London
NW1 3JN
BY HAND

Dear Mr Hylton

Dr Jane Barton - Interim Orders Committee

I write with reference to your letter to Dr Barton of 30th September 2004. As you will be aware from our various conversations, I represent Dr Barton.

In your letter of 30th September you indicated that you had voluminous patient records available to you and that if Dr Barton required a copy of those records you would arrange for her to receive a copy expeditiously.

You will recall that you and I spoke on the 30th September, and I indicated that Dr Barton would indeed wish to have sight of the records. I understood that you would endeavour to make those records available the same day, if not the following day.

We spoke again on the 1st October and you indicated that it had not been possible to copy the notes in view of the lack of facilities brought about the GMC move of offices, which I do very much understand. As I understood it, the records were then to be made available yesterday afternoon, but as you will appreciate, these records have still to arrive.

My expectation is that the medical records concern the patients in relation to whom information is given by the Hampshire Constabulary in purported summaries and expert observations. I remain concerned on behalf of Dr Barton to have access to the medical records, but have to point out that Dr Barton cannot realistically assist the Committee now in relation to any points involving specific patients in circumstances in which she will not have had the anticipated and hoped for opportunity to consider medical material.

I look forward to your response.

Yours sincerely

Code A

Ian S.P. Barker
Solicitor

Code A

RECEIVED
- 5 OCT 2004

In reply please quote PCH/2000/2047

Your ref. ISPB/TOC/0005940/Legal

By Fax and first class post

5 October 2004

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Mr Ian Barker
The Medical Defence Union
MDU Services Limited
230 Blackfriars Road
London
SE1 8PJ

Dear Ian

Dr Jane Barton – Interim Orders Committee

Thank you for your letter of 5 October 2004, a copy of which I will pass on to Adam Elliott in our Committee Section.

I note your comments regarding the medical records and I should inform you that unfortunately, due to the problems experienced by our Reprographics section in the course of our move to our new premises, it is likely that a copy of the records will not be available until tomorrow at the earliest.

I have considered whether it would be prudent to use a commercial reprographics company. However, given the nature of the information, I decided against that course of action.

I will forward a copy of the records to both you and Dr Barton as soon as they are available.

Yours sincerely

Code A

Paul Hylton
Assistant Registrar

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Your reference ISPB/TOC/0005940/Legal
In reply please quote ACE/JJC/PCH/2000/2047

By courier and fax – Code A

Please address your reply to the Committee Section FPD
Fax 020 7915 7406

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

6 October 2004

Mr Ian Barker
Medical Defence Union
230 Blackfriars Road
London
SE1 8PJ

Dear Mr Barker

Dr Jane Barton – Interim Orders Committee (IOC) 7 October 2004

Further to your letter of 30 September 2004 and our subsequent telephone and e-mail conversations. I can confirm that the Chairman of the Committee did on 1 October 2004 consider your further request to postpone Dr Barton's hearing.

The Chairman considered that whilst the submissions you made may have force in relation to whether or not the Committee should impose an interim order on Dr Barton's registration it was not for the Chairman alone to consider such matters and that in all the circumstances, it was necessary for the reasons given previously and in the public interest that the hearing of Dr Barton's case be expedited notwithstanding that her chosen Counsel is not available.

The hearing scheduled to take place on 7 October 2004 will take place as listed and Dr Barton is invited to appear before the IOC **at 09:30 on 7 October 2004 at the General Chiropractic Council, 44 Wicklow Street, London, WC1X 9HL** if you she so wishes, to address the Committee on whether such an order should be made in relation to her registration.

You are invited to submit observations on the case in writing. Any observations will be circulated to the IOC before they consider your case. Your observations should be marked for my attention. I am grateful for your confirmation that Dr Barton will be attending the hearing and that she will be represented by Mr Foster, Counsel.

The IOC normally meets in private but Dr Barton may if she wishes, under the provisions of rule 9 of the Procedure Rules, direct that the meeting should be held in public.

It is open to you to apply for a further postponement under the terms of Rule 7(1) of the Committee's Procedure Rules and further it is open to you to apply for an

adjournment to the Committee as convened on the day of the hearing as prescribed by Rule 7(2) of the Rules.

The Secretariat having spoken with those that represent the Council also considered the other matters that were raised in your letter of 27 September 2004.

I hope that his letter provides sufficient information for your needs. However, if I can assist further, please do not hesitate to contact me.

Yours sincerely

pp Code A

Adam Elliott
Interim Orders Committee Secretariat

Confidential
Addendum (II)
BARTON

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Interim Orders Committee
13 October 2004

Information: Further information:

1.	Transcript – IOC Hearing – 21 June 2001	**553 – 562**
2.	Expert Review – Catherine Lee	**563**

A

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

B

Thursday, 21 June, 2001

C

Chairman: Professor MacKay

D

Case of:

BARTON, Jane Ann

E

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

F

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

G

H

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.

B The papers before you relate to a patient by the name of Gladys Richards, who was 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.

C 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 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.

D 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 drugs that she was currently taking.

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

E 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.

F 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 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.

B

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.

A

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."

B

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

C

reference to a drug being given for her chest. The pronouncement of death is recorded again at the bottom of that page.

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.

D

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.

E

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?

F

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.

G

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

MISS GRIFFIN: Yes.

H

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

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.

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.

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.

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.

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.

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.

B

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.

E

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.

A

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 "

B

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

C

fluids for this lady. (Same handed to members of the Committee)

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.

D

> "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.

The second proposition raised by the daughters is that the use of a syringe driver for

E

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.

F

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.

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

G

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.

H

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?

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?

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.

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.

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.

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.

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

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.

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

DECISION

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

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.

Expert Review

Catherine Lee

No. BJC/31

Date of Birth: Code A

Date of Death: 27 May 1998

Catherine Lee was admitted to Gosport War Memorial Hospital on 14 April 1998 from the Royal Haslar Hospital where she had been admitted for surgery to repair a fractured neck of femur.

On admission, it was noted that Mrs Lee had poor mobility, was confused at times and needed full assistance with eating and drinking due to poor eyesight and that she had a poor appetite. She needed care for hygiene and dressing.

On admission she was settled on the ward and given oral Morphine.

This was gradually increased during her stay on 5mgs four times a day to 10 mgs by 18 May.

She was transferred to subcutaneous analgesia on 21 May when she was started on Diamorphine and Midazolam.

The experts have raised a question as to whether the indication for Opiates was clear but note that the medical problems were probably enough to account for the final cause of death.

Diazepam 2mg Usual GP

None of the prescriptions under other Drs names have been written by Dr. BARTON

USUAL DR: DR A C KNAPMAN

Surname	First Names	NHS Number	D.O.B	Number
B	H			
C	S			
C	L			
D	P			
D	E			
F	A			
F	B			
G	M			
G	M			
H	D			
H	C			
H	E			
J	U			
K	D			
K	G			
K	G			
L	S			
M	P			
M	T			
M	B			
M	D			
P	O			
R	M			
R	S			
R	N			
R	C			
R	J			
W	R			
W	M			

Code A

USUAL DR: DR A J BARTON

Surname	First Names	NHS Number	D.O.B	Number
A	T			
B	M			
B	K			
F	C			
J	S			
J	J			
K	R			
M	J			
N	S			
R	C			
S	M			
S	A			
S	A			
T	D			
W	M			

Code A

7

-PAB
-EJP
-JAB x2 17.5. 17.5.
-PAB
-PAB
-TCN
-ZL
-PAB
JAB · 12.5 U
EJP
MJB/EJP x 2
-EJP
JAB x2 - 7.11.3 - 29.10.3
JAB
PAB
x2

JSUAL DR: DR E J PETERS

Surname	First Names	NHS NumberD.O.B	Number
A	C		
B	E		
B	I		
B	D		
B	L		
B	S		
C	S		
C	L		
C	P		
C	C		
C	F		
C	J		
D	P		
D	M		
D	P		
F	R		
H	R		
H	G		
J	L		
J	S		
K	J		
M	R		
M	I		
N	G		
N	E		
P	D		
P	V		
S	I		
S	C		
S	R		
T	M		
T	F		
U	P		
V	R		
W	S		
W	J		
W	C		

Code A

USUAL DR: DR M J BRIGG

Surname	First Names	NHS NumberD.O.B	Number
B	R		
C	D		
C	S		
C	R		
C	R		
C	M		
E	H		
G	J		
H	J		
H	K		
J	V		

Code A

K	A
M	E
M	C
M	M
P	M
P	R
P	L
Q	D
R	N
R	D
S	L
S	M
T	D
W	G
W	M

Code A

USUAL DR: DR P A BEASLEY

Surname	First Names	NHS Number	D.O.B	Number
A	A			
A	I			
A	P			
B	B			
B	I			
B	P			
C	H			
C	J			
D	R			
E	M			
F	D			
G	S			
G	G			
H	J			
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I	M			
K	R			
M	W			
M	G			
M	C			
P	P			
S	A			
S	D			
S	L			
S	A			
S	C			
W	E			

Code A

USUAL DR: DR SARAH JANE BROOK

Surname	First Names	NHS Number	D.O.B	Number
A	J			

Code A

A
A
B
C
G
H
H
K
R
Y

J
B
D
P
E
J
P
R
C
S

Total: 150

Code A

GENERAL MEDICAL COUNCIL

INTERIM ORDERS COMMITTEE

THURSDAY 7TH OCTOBER 2004-10-30

CHAIRMAN: DR MACKAY

CASE OF

JANE ANN BARTON

MR R HENDERSON QC instructed by Messrs Field Fisher Waterhouse, solicitors to the Council, appeared for the Council.

MR FOSTER instructed by the Medical Defence Unit appeared on behalf of Dr Barton who was present.

T A REED & CO

THE CHAIRMAN: Good morning. I would just check that everybody has the addendum to the papers, there is addendum 1 which is paginated from 510 to 551 and addendum 2 which seems to be paginated from 533 to 563. Dr Barton this is not the first time you have appeared before the Interim Orders Committee, the location is different, but the principles remain the same. The Panel is at this end of the table. Mrs Atma is to my far right, she is the lay member, Dr McCuggage is the medical member, Mr Swann is the legal assessor, and Ms Varsani is the secretary, Mrs MacPherson is the lay member and Dr Stewart is the medical member of the Panel and my name is Professor Mackay, I am the medical member as well, and also act as chairman. Mr Henderson appears for the council and Mr Foster appears for you. We will start with Mr Henderson.

MR HENDERSON: This matter has a long history but it is not a review hearing because in the previous three hearings no order has been made, nor is it an adjourned hearing, there have been no adjournments. It comes before you because the General Medical Council has just received a statement from Detective Chief Superintendent Watts an officer of the Hampshire Constabulary who is in charge of the investigation comprehending acts and omissions of Dr Barton. The statement shows the scale of the police concern on top of the reference which has already been made by the Preliminary Proceedings Committee to the Professional Conduct Committee of the Council for enquiry into certain matters concerning Dr Barton. There is no application for an adjournment although one has been requested in correspondence which you will have seen and is in one of the addendum bundles.

Because the matter has such a long history it seems to me it would be helpful to you and I provided this morning to my learned friend a chronology. It has already been partly over taken by events in that various things which I saw were missing have been produced but I hope you will find it is helpful and where I know there is some page references I will give them to you.

THE CHAIRMAN: We will refer to this as C1.

MR HENDERSON: The order that I would seek today is that there should be conditional registration of Dr Barton. I do not seek and in my submission it would not be appropriate to seek suspension of Dr Barton. So the primary reason why I seek conditional registration is to protect patients and to protect public interest and it would be my submission that in all the circumstances such conditions would be proportionate and that Dr Barton would be able to continue in medical practice as a general practitioner.

I will come to suggested draft conditions in a few minutes if that will be convenient. If you have the chronology in front of you you will see that it begins on the first page with the period, which was the originally alleged period of inappropriate prescribing to five patients, aged between 75 and 91 at Gosport War Memorial Hospital and concerns two wards Dryad Ward and Daedalus Ward. as you will have seen from the papers, all of whom died at the hospital where Dr Barton was a part-time clinical assistant, that is to say that patients Page,Wilkie, Richards, Cunningham and Wilson.

Before going to those matters and going on may I begin by considering what it is I on behalf of the Council would need to establish and what it is what I would seek from you today. The

primary condition which we would ask for is that otherwise than in a medical emergency Dr Barton should neither issue nor write any prescriptions for nor administer benzodiazepines or opiates. Other fairly standard forms of conditions about notification of employers and prospective employers and not undertaking positions elsewhere where registration is required without informing the IOC secretariat we would also obviously ask for.

The points that I would make apropos such an order for conditional registration are these. I would accept straight away that such conditions limit a general practitioner in his or her practice, but such a condition has not hitherto prevented Dr Barton from such practice. I am not entirely clear whether or not such an undertaking originally lapsed or whether some such undertaking has been in place at all times, but I have been shown today by my learned friend Mr Foster a document of October 2002, headed on AFareham and Gosport Primary Care Trust@ paper which contains a form of undertaking; it is a voluntary undertaking and it may be convenient if at this stage you had that document available to you. (Handed.)

THE CHAIRMAN: D1.

MR HENDERSON: That you have in front of you a file note of a meeting held on the 9th October 2002 a meeting at which Dr Barton was present when Dr Sommerville in the second paragraph confirmed that Dr Barton=s offer of a continued voluntary ban on OP prescribing. This was agreed despite the fact that the GMC does not require it. It was pointed out that this has implications for the remaining practice members. Dr Barton had been advised by her medical defence society to carry a single vial of diamorphine in case she was presented with an absolute medical emergency. It was confirmed that the above arrangement does not, in practice, compromise the patients= safety in her practice list, thanks to the partners in the practice for accepting and dealing with this voluntary restriction. JB agreed her voluntary restriction covers opiates. Benzodiazepines would be prescribed strictly within BNF guidelines.@ It goes into monitoring arrangements with which I do not think is pertinent at the moment unless my friend wants me to read them out. So it would appear that there is in place some form of voluntary undertaking on the part of Dr Barton. The obvious point I will take on behalf of the Council is that it is of course an unwritten undertaking of no particular duration and capable of being withdrawn at any time and incapable of enforcement by the General Medical Council. It is not something which would come to the notice of anybody making enquiries in relation to Dr Barton whereas conditional registration has that important and significant effect. That is a matter which I am conscious you will be perfectly familiar with as being of importance,. Now that the Council for Regulation of Health Care Professionals has appealed a number of cases concerning doctors in the course of the past 12 months or so, we can see the importance that is attached to the public availability of information so that the public can be confident that those things that ought to be able to be known by the public are known by the public, whether they be prospective employers or prospective patients. This sort of undertaking is unfortunately not in any way known to any such persons.

I accept therefore that there are limitations on Dr Barton=s practice, but they are not presently enforceable. I accept, secondly, that the draft condition which I would submit is appropriate in this case can potentially disadvantage patients of the general practitioner, particularly a patient in need of such medication who will come under the aegis of another registered

medical practitioner, but it is clear in this case from what we have seen in the papers that Dr Barton is supported by other medical practitioners in the partnership and that has been obviously important to the patients.
Can I say as a footnote that I am not suggesting that there should be any arrangement in relation to prescription or administration under an appropriate supervising medical practitioner. You will understand from the way I put it that it would be envisaged by the Council that this is a lady who should be able to continue in practice and that I do not rule out some such possibility. What I am concerned about is that there must appropriate protection in all the circumstances of the case.

The third point that I would make is that I would accept that a condition such as I would propose adversely but temporarily affect a doctor=s reputation.

Fourthly, the duty of the GMC is to guide and regulate doctors while protecting the patients and the public interest. Therefore what you are concerned with today as in all these cases is to achieve a proper balance between the competing interests of patient protection, protection of the maintenance of the reputation of doctors in the profession and good practice, and, of course, the interests of the doctor herself.

These, as you will know only too well, are spelt out in section 41A of the 1983 Act as amended and I hope I will be forgiven if I simply go to those opening words of section 41A. I do it in part also because my submission to you today B I endeavoured to forewarn my friend Mr Foster by making sure that he had a copy of the case which I was going to refer to and refer him to B is that a test which has been propounded in past cases and I believe has probably been propounded in this case, at least once, is not in truth the proper test to be applied by an interim orders committee. Section 41A provides

AWhere the Interim Orders Committee are satisfied that it is necessary for the protection for the protection of members of the public or is otherwise in the public interest or is in the interests of a fully registered person, for the.registration of that person to be suspended or to be made subject to conditions, the Committee may make an order ....@

either suspension or registration being conditional with such requirements for a period not exceeding 18 months as the Committee thinks fit to impose. So you have a very very wide discretion in terms of conditions that you think fit to impose. Going back to the opening words it is plain that nothing is said in the Act as to what is the test to be applied. The verb Ayou must be satisfied@ is plain, you must be satisfied in relation to three alternatives which are not exclusive, they can overlap and be accumulative.

What then is the test? The test which has been applied in the past by many interim orders committees was one which I understand was propounded by a legal assessor on an inaugural training day when matters came to be considered in the light of the problems which had been thrown up by the fact that there had been inadequate powers to deal with interim protection of patients and doctors when the PPC could only impose interim conditions if there was a reference to the PCC. So in came the amendment rules and the test which I understand has been consistently applied has been this that there should be cogent and credible prima facie evidence which if proved could amount to seriously deficient performance of serious

professional misconduct or impaired fitness to practice by reason of a physical or mental condition such that the doctor=s registration could be restricted by interim suspension or conditions until matters are resolved.

The difficulty about that test is that, as you will know from experience, as many of your colleagues will know, in many cases a doctor who has been arrested and charged B I use that by way of example, this is a lady who has neither been arrested nor charged at an earlier stage despite some three years of police investigation C with a very serious criminal offence, perhaps relating to patients, perhaps not, the police will probably have made no evidence available to the General Medical Council apropos that document or the evidence which is the subject of the charge. Therefore there would like as not be no evidence, not prima facie evidence, but no evidence in relation to that doctor and yet of course if it be a very serious matter which potentially affects the capacity of that doctor=s safety to behave as a doctor then the problem is that the statute requires that you consider whether it is necessary for the protection of members of the public or patients and others which was otherwise in the public interest that that doctor be suspended or made the subject of conditions. That test I do not understand has been substantially considered in the case law, but in the case of Dr X which I would ask for that to be made available to you if possible, and I know it was made available to your legal assessor yesterday at my request, the Court consisting of Pill LJ and Silber J C(Handed)

THE CHAIRMAN: This will be C2.

MR HENDERSON: The court had to consider the case of Dr X who was applying to quash and I am looking at paragraph 1 now an order of this Committee made on the 2nd March 2001 following an oral hearing on that day. A

"The IOC ordered that the claimant=s registration as a medical practitioner should be suspended with immediate effect for a period of 18 months. It was further ordered that the suspension should be reviewed by the IOC at a further meeting to be held within six months.

The claimant is a general practitioner of premises in the south east of England. Allegations of indecent assault are made against him by two of his nieces (now aged 15 and 13 years). Their father complained to the Social Service Department of the County Council and the Health Authority also became involved. The GMC were informed of the allegations. On the 28th February 2001 the claimant was charged by the police with six counts of indecent assault. He was granted bail subject to conditions. By virtue of Articles 3 and 10 of the Medical Act 1983 Amendment Order 2000 the 1983 Act was amended by the addition of Committee and a new section.@

I have already read you section 41A so I do not need to read it again and subsection 10 we do not need to be concerned. Then paragraph 5:

A The IOC has its origins in the Amendment Order. Similar, though somewhat different, powers were formerly exercised by a different committee of the GMC. At the hearing on 2nd March 2001 both the claimant and the GMC were represented by counsel. The hearing was conducted by a committee of five members advised by a legal assessor. Some of the

A argument before the Committee turned upon the possibility of an interim conditional registration. It is common ground that it is not open to the court to take that course upon this application. The power of the court, subject to its power under section 41A(10)(c) is either to quash or to uphold the order of the IOC.@

From paragraphs 6 - 10 is concerned with the court and I can pass over the courts position and we come to paragraph 11:

B

A The determination complained of was:

A.... the Committee has carefully considered all the evidence before it today.

In accordance with Section 41A of the Medical Act 1983, as amended, the Interim Orders
C Committee has determined that it is necessary for the protection of members of the public, is in the public interest and is in your own interests to make an order suspending your registration, for a period of 18 months with effect from today.

In reaching the decision to suspend your registration the Committee has concluded that there is prima facie evidence of indecent behaviour that, if proved, would seriously undermine the trust the public is entitled to place in the medical profession. The Committee has considered
D the submission made on your behalf that if an order were to be imposed, interim conditions would adequately protect patients. However, after considering all the circumstances in the case, and having regard to its duty to protect the public interest, the Committee has determined that it must suspend your registration.@

I hope I will not need to read all of those. In paragraph 14 five of the charges related to one girl and the sixth related to the younger girl.

E

We come to paragraph 15:

AMr Peacock, who appears for the claimant before this court, also appeared for him before the IOC, and accepted, as in my judgment he had to accept in relation to the charges: AThey are plainly very serious and the doctor is well aware that they are, if proved, extremely serious, and if accepted by a jury in a criminal court of trial they are likely to result in a
F sentence of imprisonment and further conduct proceedings@. It is clear that the allegations have been considered by representatives of the relevant local authorities and by the police, whose code of practice provides that before criminal proceedings are brought there must be Aenough evidence to provide a realistic prospect of conviction@.@.

Can I interpolate that. It is plain that the court was giving weight to the fact that Dr X had been charged. They would clearly have given less weight, as you clearly must give less
G weight, to the fact that here Dr Barton has not been charged. They proceeded however on the basis that the police would not be proceeding to charge unless there was evidence and therefore although there was no evidence in front of the IOC none the less the fact that there was a charge was a relevant matter which should be taken into account and could properly form the basis of the IOC,

H

Can I pass over paragraph 16. Paragraph 17 is informative but not relevant, so I move to paragraph 17:

A Mr Peacock also makes the point that the IOC have relied upon all three grounds in section 41A(1) and have done so cumulatively. If any of them fail, and Mr Peacock submits that the concept of protection of members of the public and the concept of the interests of the claimant himself must fail, then the entire case falls. I say at once that I do not accept that submission. Based, as it is, on the wording of the second paragraph of the determination, it appears to me that, provided one of the criteria was satisfied, the fact that one or more of the others was not satisfied does not, in the circumstances of this case, invalidate the conclusion of the Committee. The wording does not suggest that the satisfaction of all three criteria were, in the view of the Committee, necessary to a conclusion that an order should be made against the claimant.

The second submission is that the Committee were not considering, as the Committee in some of the cases cited were considering, a case where there was a conviction in a criminal court. In this case there is only an allegation or a series of allegations. It is not correct Mr Peacock submits that, even if the allegations are serious, as he has to accept those in this case are, it was appropriate in present circumstances for the IOC to make an order on the mere making of an allegation. He submits that the fact that the police have decided to charge the claimant makes no difference. The Committee must not be permitted to approach its work on the basis that the police would not have charged the claimant if had not done it. That approach, Mr Peacock submits, is quite contrary to legal principle. Mr Peacock draws attention to the difficulties facing a defendant before the IOC in circumstances such as the present. There are obvious constraints on calling evidence before a Committee when criminal proceedings have been commenced. I accept that there may well be difficulties, but the IOC must consider the case on the basis of the material which the GMC and the defendant see fit to call before them.

I am far from criticising the claimant and those who represented him for not in the circumstances of this case calling evidence. I do not leave the point however without stating that there could be cases in which material placed before the Committee when criminal charges were pending might, having regard to the duties of the Committee place allegations of criminal conduct in a very different light from that in which they might otherwise have appeared.@

Just interpolating there on paragraphs 18 and 19 Dr Barton can go further than even Dr X. She can rightly say AI have given evidence before an earlier IOC@ and I will draw your attention to that evidence. She can say AI have not been charged.@. She can even say AI have not been interviewed, therefore we are concerned only with the possibility of allegations being made against me of a criminal character.@ That is also entirely true. That is why I say she can say it. She can no doubt through Mr Foster will say it. The question is what is the test? Before I come to what I suggest a proper test should be can I just continue on at paragraph 20. AThe third submission is as to lack of reasons.@ That is formative but not relevant to my point and I pass over that paragraph and paragraph 21, and can I come to paragraph 22:

A When pressed on the point, Mr Peacock put his third submission rather as a lack of consistency by the Committee, or of disparity between its decision in this case and its decision in other cases. There has been some reference to other decisions of the Committee. I acknowledge the constraints which rest upon both parties in giving particulars of other cases. However, it is essential, as Lord Upjohn put it, that each case is considered upon its own particular circumstances.@

B I would parethenthally if I may underline that sentence. Dr Barton=s case is to be considered in its special and you may think unusually prolonged and difficult circumstances, its own particular circumstances.

A Reference to other cases which Mr Peacock rightly accepts would not be binding upon the Committee is of limited value. Moreover, on the limited information which has been provided by the parties, I am far from satisfied that there can be said to be any inconsistency between the decision taken by the IOC in this case and its decisions in other cases. It is not necessary for present purposes to give details of those other cases.

23. Reference has been made to Article 6.1 of the European Convention. In my judgment in present circumstances that adds nothing to the duties already required by English law. I see no merit in the submission that the decision of the IOC fails either on the ground of lack of reasoning or by reason of disparity between this and other decisions.

24. I have referred to the limited nature of the material which was before the IOC. It was for them to examine the material before them with care. It is plainly a worrying situation when a professional man may be suspended on the basis of allegations of criminal conduct which, as yet, are untested in a court of law. I cannot however accept that the power to suspend by way of interim order provided in section 41A must not be exercised because the allegations are untested in court. Nor, in my judgment, can it be said that the exercise of the power to suspend was inappropriate because the conduct alleged was not towards patients of the claimant.

25. The allegations in this case are undoubtedly serious. They are of offences against the person. Whether or not they are eventually proved it cannot be said that they plainly and obviously lack substance.@

F That is another way in which one can test the matter, ,is what is being put before you something which plainly and obviously lacks substance?

AThey involve an alleged breach of trust towards vulnerable young people. The alleged offences have an obvious impact upon the fitness of the claimant to have that intimate contact with patients which is a necessary part of his duties as a doctor. That being so, it cannot in my judgment be said that the IOC erred in law in reaching the conclusion they did. They were entitled in their discretion to do so on all three grounds in section 41A in my judgment, especially having regard to the breach of trust alleged.@

H

What do I submit is the appropriate test if it be not cogent and credible evidence etc> The formulation which I would respectfully submit would be this that if you are satisfied B I use the same verb - (a) in all the circumstances of this particular case that there may be impairment of Dr Barton=s fitness to practice which poses a real risk to members of the public, or may adversely affect the public interest or her interests (b) after balancing her interests and the interests of the public that an interim order is necessary to guard against such a risk then the appropriate interim order should be made. Such a test is not confined to evidence; it plainly permits consideration of a reliance on materials such as third party reports. In my submission it is implicit in the reasoning of the court in Dr X=s case that that is a more appropriate test if not the test which the court applied.

In terms of the application of that test to this case my submission is that the circumstances should satisfy you that there may be such impairment and that it does pose a real risk potentially to her patients, members of the public and I also submit as a separate consideration that if no conditions are made and the doctor in her circumstances is permitted to practice with no more than a voluntary undertaking that also may adversely affect the public interest by which I refer to the reputation of the profession, and the need of the public to have complete trust and confidence in registered medical practitioners.

I will add this in relation to public interest that confidence would be undermined if upon due enquiry, whether on our website or by telephone or otherwise, nothing was shown which in any way restricted Dr Barton to practice in all the circumstances of this case.

Clearly I have tried to build into that test the proportionately which is essential in respect of Dr Barton=s interests, namely, balancing the interests of practitioners with the interests of the public. That is the test.

As I understand it the difference between us, it being agreed suspension is plainly not appropriate, which I noticed was what was originally asked for on the first hearing, is some condition on the registration in the public interest, but it will permit Dr Barton to continue in practice.

Those are the preliminary submissions which I wish to make before going to the chronology, so can I go to the chronology. If I leave anything out because I am conscious that my learned friend may have access to a few more documents than do I please will he say so so they can go in chronological and present a better picture. Can I add a footnote to the first block in this matter, February to October. That is the period of the five patients. The period of the police investigation has been said as you will see by Detective Chief Superintendent Watts to be between January 1996 and November 1999, but actually that seems to me to be wrong berceuse it is plain from the document which they have just produced to us, which I have not yet seen, or my friend has seen or Dr Barton has seen, the notes that come with it, the case of a patient called Batty, which is at page 490 in the bundle, covers the end of the year 1993 and the beginning of the year 1994. SO we are concerned with a long period in which Dr Barton was a part-time clinical assistant at those particular wards in Gosport.

She resigned from part-time employment and continued in general practice. I have given the page references where I have noted them and they were obviously available; in some instances I have simply taken it straight from what she has said and that comes from her own evidence to an earlier Committee. I am not going to turn up the pages unless anyone wants me to do so.

On the 27th July 2000 at page 9 you have the letter which as I understand it first informs, though I have seen in an earlier transcript it seems to have been said to be later, but this is a letter of the 27th July 2000 where Hampshire Constabulary informed the GMC fitness to practice directory of concerns relating to Dr Barton and a patient called Gladys Richards. She was the subject of an allegation that she had been unlawfully killed as a result of Dr Barton=s medication at one of the wards, so it was put as a very serious allegation back in 2000. Unsurprisingly, it led to a reference to this Committee on the 2lst June 2001. That you will see in my note of the chronology said ANo transcript available@. You of course have that available to you and I will give you the reference to pages 553 to 562. It would be helpful just to have a quick look at one or two matters there. It only concerned the patient Gladys Richards, it was not concerned with any other patients. You will see if you turn to page 554 at the top of the page Ms Griffin on behalf of the Council opened it in her second sentence that the nature of the case as set out in summary was one of unlawful killing and talks about the police investigation continuing. I am going to pass over to page 4 at letter E and you will note there that Ms Griffin submitted on behalf of the Council that although Dr Barton had not been charged or interviewed or arrested that it was her submission that in her view it would not be appropriate to consider conditions on the doctor=s registration, in other words it had to be suspension, and you will see contrary submissions being advanced by Mr Jenkins who appeared all the time although he is not available today and at page 555 at letter C you will note he says AThis case may have been brought prematurely@ and he suggested it should not have been brought at all and so on and he goes into the details and says AAs far as the doctor=s present position is concerned she does not continue to work with the hospital.@ Can I go onto the test which seems to have been applied at page 561 the legal assessor gave advice and you will see at D

AIt is necessary to find the evidence before it amounts to a prima facie case supporting interim action on one or more of the grounds that I have just referred to.@

The determination of the Committee on page 562 AThe Committee have determined that they are not satisfied that it is necessary for the protection of members of the public ...@ and so on. We can put that document away and perhaps not come back to it, can I say the last page there was the expert review which was missing which you may have noted in going through the extra pages which went with Chief Superintendent Watts statement had not been provided until yesterday for which we apologise , but it has been found and now provided.

So much for the first Interim Orders Committee hearing.

There was therefore as you can see at that stage no independent expert opinion. At pages 19 to 52 by a report of the 20th July 2001 you will see Professor Livesleys report. Can I interpolate before looking at this and the next two reports, I would

accept straight away that you would only in the most exceptional circumstances make an order on material which had been decided not to justify making an order in the past by earlier interim orders committees, whether you had been a member of it or not, it would only be in the most exceptional circumstances. Clearly a relevant circumstance was the test which was applied in the other cases and if I persuade you that in fact the prima facie evidence test was not the right test then it would be right I would suggest that you should revisit the totality of the evidence and apply if you are so satisfied in the light of your legal assessors advice is the appropriate test. I do suggest here that it is right that you must look at the totality, you must look at all the circumstances, that is what Pill LJ indicated was appropriate and we need now to consider in the interests of Dr Barton, the interest of all the patients, her patients and other patients of the practice and other members of the public for whom she might prescribe or administer, and equally we must consider the interests of the medical profession and public confidence in it, looking at the totality. I am not going to go through everything at the same pedestrian pace which might be appropriate if you have not seen much of it before, but I understand one member of the committee has not been involved in any of the previous hearings otherwise everybody has had some involvement with this case at some earlier stage, not including the legal assessor. I come freshly entirely as well. If I take matters either too fast or too slow I would ask you to indicate that to me and I will change the pace accordingly.

Professor Liversley=s report begins at page 19 and you will see in the synoposis on page 19, he was considering the case of Gladys Richards, says this at paragraph 1:

A At the age of 91 years Mrs Gladys Richards was an inpatient in Daedalus ward at Gosport War Memorial Hospital. A registered medical Practitioner prescribed the drugs diamorphine, haloperidol, madazolan and hypascine for Mrs Richard. These drugs were to be administered Subcutaneously by a syringe driver over an undetermined number of days. They were given continuously until Mrs Richards became unconscious and died. During this period there is no evidence that Mrs Richards was given life sustaining fluids or food. It is my opinion that as a result of being given these drugs Mrs Richards=s death occurred earlier than it would have done from natural causes.@

There is his synopsis to be seen in the context of the earlier IOC hearing which in the second hearing has made no order having seen that material. I will bring you to that in due course.
Paragraph 2.5 on page 21:

A This report has been presented on the basis of the information available to me - should additional information become available my opinions and conclusions may be subject to review and modification.@

I will pass much of the material here and can I draw your attention in paragraph 4.9 page 25 to some standard which is to be found in the majority of the patients with which we are concerned that Dr Barton said in the notes AI am happy for nursing staff to confirm death.@

Then on paragraph 5 page 29,

A Dr Barton wrote the following drug prescriptions for Mrs Richards ....@
And you have the detail there, we have Oramorph 11th August four hourly and then diamorphine at a dose range of 20 - 200mb to be given subcutaneously in 24 hours. A number of people have drawn attention to that rate, it is a very large range, and it has been subjected to some criticism as being undue, you may think when you see the evidence, which I will draw to your attention of Dr Barton circumstances there is very really little consultant supervision and with precious little and sometimes know medical support at all= so that effectively the circumstances in which she was working was most undesirable by any standard and she was incredibly hard pressed and much will have turned on the circumstances which she has described in her oral evidence as to what was necessary in order to try and provide proper attention to those patients. I am trying to present what I understand to be the picture which may be true, it may be false, but it is one that one can see in the papers. Then hyacine, midazonlan, then haloperidol. On the 12th August oramorph in 10mgs in 5mls to be given orally in a dose of 2.5 mls four hourly.

Then on the 18th August, moving on, diamorphine with a dose range of 40- 200 mg and haloperidol. Then on the 18th, 19th, 20th and 2lst August Mrs Richards was given simultaneously and continuously subcutaneously diamorphine 40mgs and haloperidol 5mgs and midazolam20 mgs during each 24 hours.

If I can go to the conclusion on page 32

A Mrs Gladys Mabel Richards died on 2lst August 1998, while receiving treatment on Daedulus ward at Gosport War Memorial Hospital

Some four years earlier on 3rd August 1994 Mrs Richard had become resident at the Glen Heathers Nursing Home.

Mrs Richards had a confused state that after December 1997 had been aggravated by the loss at the Glen Heathers Nursing Home of her spectacles and both of her hearing aids.

On 29th July 1998 Mrs Richards developed a fracture of the neck of her right femur, thighbone, and she was transferred from the Glen Heathers Nursing Home to the Royal Hospital Haslar, Gosport.

On 11th August 1998 and having been seen by a consultant geriatrician Mrs Richards was transferred for rehabilitation to Daedalus ward at Gosport War Memorial Hospital.

At that time Dr Barton recorded that Mrs Richards was not obviously in pain but despite this Dr Barton prescribed Oramorph to be administered orally four hourly

At that time also Dr Barton prescribed for Mrs Richards diamorphine hyoscine and midazolam. These drugs were to be given subcutaneously and continuously over

periods of 24 hours for an undetermined number of days and the exact dosages were to be selected from wide dose ranges.

Also on 11th August 1998 at the end of a short case note Dr Barton wrote AI am happy for nursing staff to confirm death.@

It is noted that although prescribed on the day of her admission to Daedalus ward at Gosport War Memorial Hospital these drugs, diamorphine, hyoscine and midazolan, were not administered at that time.@
It then goes through the sequence and I have taken you through the prescriptions so far. At paragraph 7.10 he said:

A There is no evidence that Mrs Richards although in pain had any specific life threatening and terminal illness that was not amenable to treatment and from which she could not be expected to recover.

Despite this and on 18th August 1998 Dr Barton while knowing of Mrs Richards= sensitivity to oral morphine and midazolam prescribed diamorphine, midazolam, haloperidol and hyoscine to be given continuously subcutaneously and by a syringe driver over periods of 24 hours for an unlimited period.

Neither midazolam nor haloperidol is licensed for subcutaneous administration.

It is noted however that in clinical practice these drugs are administered subcutaneously in the management of distressing symptoms during end of life care for cancer.

It is also noted that Mrs Richards was not receiving treatment for cancer.

There is no evidence that in fulfilling her duty of care Dr Barton reviewed appropriately Mrs Richard=s clinical condition from 18th August 1998 to determine if any reduction in the drug treatment being given was indicated.@

Then at 7.16
Dr Barton recorded that death was due to bronchopneumonia.

It is noted that continuous subcutaneous administration of diamorphine, haloperidol, midalam and hyoscine to an elderly person can produce unconsciousness and death from respiratory failure associated with pneumonia.@

Then we come to his opinion. I would invite you to read all of this to yourselves. Can I say you find the conclusions at 8.10 and 8.11 perhaps deserving of particular attention. (Pause to read)

You will see that it was his opinion that mrs Gladys Richards, and I am looking particularly at paragraph 8.11 death occurred earlier than it would have done from natural causes and was the result of the continuous administration of diamorphine and other drugs. That was our starting point in relation to the medical evidence none of

which was available at the first hearing. It was part of the material which was put before the second hearing on the 2lst March and led to the making of no order.

The next report was that from Dr Mundy, but before we see Dr Mundy=s report you will note at page 13 of the bundle a letter from the Hampshire Constabulary that there was insufficient evidence to support a viable prosecution against Dr Barton concerning Gladys Richard. That was in relation to the unlawfully killing of Gladys Richards based upon the allegation of her two daughters. I am not going to take you through those statements. My learned friend can call your attention to any part of it which he feels is of assistance to you, but clearly those two ladies have made allegations against a lot of people including Dr Barton in relation to the allegedly untimely death of their mother.

I pass on therefore to Dr Mundy=s report beginning at page 53. He considers the case not just of Gladys Richards, but also those of other patients. He describes the use of opioid analgesics which I will not read to you. He then turns to Mr Cunningham at page 54:

A Mr Cunningham was known to suffer with depression, Parkinsons disease and cogitive impairment with poor short term memory.@

Then can I go to Comments:
A All the prescriptions for opioid analgesics are written in the same hand, and assume they are Dr Barton=s prescriptions although the signature is not decipherable. Morphine was started without any attempts to control the pain with less potent drugs. There was no clear reason why the syringe driver needed to be started as the patient had only received two does of oral morphine, the 24 hour dose requirement of Diamorphine could not therefore be established. The dose of diamorphine prescribed gave a tenfold range from 20mg to 200mg in 24 hours which is an unusually large dose range in my experience. The patient was reviewed by Mr Barton on at least one occasion and the patient was noted to be in some discomfort when moved. The dose was therefore appropriately increased to 40mg per 24 hours but there are no further comments as to why the dose needed to be progressively increased thereafter. In my view morphine was started prematurely, the switch to a syringe driver was made without any clear reason and the dose was increased without any clear indication.@

Mr Cunningham you will see is a patient who has been categorised when you come to Police Chief Superintendent Watts statement as a category 3 case which is to say B and I refer to page 460 and 461 B a case where patient care in respect of these cases has been assessed as Anegligent, that is to say outside the bounds of acceptable clinical practice.@ That is the definition. The reference of mr Cunningham being so categorised is at page 465. So what we do not have to day is a statement from the doctor or doctors who have made that categorisation, it is undoubtedly new information which was not available to any earlier committee. What we do not have today is the notes of papers or documents from which that categorisation has been made, but none the less it has been thought appropriate to bring this matter back to an interim orders committee, clearly matters have moved on, but they are still on going.

Alice Wilkie is considered on page 55. He notes in the latter part of the first paragraph that the dose of 30mgs was given on the 20th August of Midazilam apparently by Dr Barton and the patient was given another 30mg of Diamorphine on the 2lst August and died later that day. The Comment was:

A 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 at 30mg initially was excessive and there is no evidence that the dose was reviewed prior to her death. Again the diamorphine prescription gave a tenfold range from 20mg to 200mg in 24 hours.@

Alice Wilkie is a case where it is said by the police in their statement at page 465 ANo further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.@

Robert Wilson, page 55, was none to suffer alcohol abuse with gastritis hypothyroidism and heart failure. Like many he had fractured bones, a fractured humerus in his case. Turning to page 56:

A A Diamorphine/Midazolam subcutaneous infusion was prescribed on 16th October again in Dr Barton=s handwriting, the dose range from 20 mg to 200 mg in 24 hours. 20 mg of diamorphine was given on 16th October and the nurses commented later that the Apatient appears comfortable.@ The dose was increased to 40mg the next day when copious secretions were suctioned from Mr Wilson=s chest.@

The patient in this case died on the 18th October. Comments:

A Mr Wilson was clearly in pain .from his fractured arm at the time of transfer to Dryad ward. Simple analgesics was prescribed but never given there was an entry earlier in the episode of care that Mr Wilson had refused paracetomol. No other analgesia was tried prior to starting morphine. Mr Wilson had difficulty in swallowing medication. The Oramorphine was converted to subcutaneous diamorphine in appropriate dose as judged by the BNF guidelines. The patient was reviewed by a doctor prior to the final increase in diamorphine. Once against the diamorphine prescription had a tenfold dose range as prescribed.

It is clear that Mr Wilson=s condition suddenly deteriorated probably due to a combination of worsening heart failure and terminal bronchopneumonia and I consider that the palliative care given was appropriate. A Do Not Resuscitate decision had been made by Dr Lord on 29th September.@

Now that needs to be contrasted with this that that assessment was in effectively an exonerated assessment you may think in relation to Mr Wilson, but if you turn to page 465 you will see that it has been categorised as category 3.

The next patient was Eva Page and known to suffer with hypertension, ischaemic heart disease with heart failure and paroxysmal atrial fibrillation, depression, episodic confusion and had sustained a minor stroke in the past. The comments page 57:

A Mrs Page had a clinical diagnosis of lung cancer. There was no documentation of any symptoms relevant to this and no evidence of metastatic disease. There was no documentation of any pain experienced by the patient. When she was transferred to Dryad Ward most medication was stopped but she required sedative medication because of her distress and anxiety. No psychogeriatric advice was taken regarding her symptom control and she was started on opioid analgesia.in my view inappropriately following her spitting out of medication and she was given a topical form of an opioid analgesic, fentanyl. A decision was taken to start a syringe driver because of her distress, this included Midazolam which would have helped her agitation and anxiety.

The prescription for subcutaneous diamorphine infusion again showed a tenfold range from 20 mg to 200 mg. It clear that her physical condition deteriorated rapidly and I suspect that she may have had a stroke from the description of the nursing staff shortly prior to death.

CONCLUSIONS: I felt that the nursing records at Gosport War Memorial Hospital were comprehensive on the whole. The reason for starting opioid therapy was not apparent in several of the cases concerned. There had been no mention of any pain, shortness of breath, or cough requiring relief. In several of the cases concerned oral morphine was not given for long enough to ascertain the patient=s dose requirements, the reason for switching to parenteral diamorphine via subcutaneous infusion was not documented and the prescription of a tenfold range 20 mg to 200 mg of diamorphine on the as required section of the drug charge is in my view unacceptable. In my view the dose of diamorphine should be prescribed on a regular basis and reviewed regularly my medical staff in conjunction with the nursing team. There was little indication why the dose of diamorphine was increased in several of the cases and the dose appears to have been increased without the input of medical staff on several occasions.

Specimen signatures of Dr Lord and Dr Barton are necessary to confirm the identity of the prescribers and doctors making entries into the clinical notes.

I believe that the use of diamorphine as described in these four cases suggest that the prescriber did not comply with standard practice. There was no involvement as far as I could tell from a palliative care team or specialist nurse advising on pain control. I believe these two issues requires further consideration by the Hospital Trust.@

That was the view of Dr Mundy a consultant physician and geriatrician.

Then we have the opinion of Dr Ford concerning the five patients, not four, pages 59 to 97, he is a Professor of Pharmacology of Old Age in the Wolfson Unit of Clinical Pharmacology in the University of Newcastle and a consultant physician in Clinical Pharmacology at Freeman Hospital. He then reviews the case of Gladys Richards, from pages 62 through until 71. I am only going to draw your attention to paragraph 2.29 on page 70 under the heading Appropriateness and justification of the decisions that were made@.

A A There were a number of decisions made in the care of Mrs Richards, that I consider to be inappropriate. The initial management of her dislocated hip prosthesis was sub-optimal. The decision to prescribe oral morphine without first observing the response to milder opiate or other analgesic drugs was inappropriate. The decision to prescribe diamorphine, haloperidol and midazolam by subcutaneous infusion was, in my opinion, highly inappropriate.@

B The under Summary:

AGladys Richards was a frail older lady with dementia who sustained a fractured neck of femur, successfully surgically treated with a hemiarthroplasty, and then complicated by dislocation. During her two admissions to Daedualus 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.@

C

Arthur Cunningham he considers from page 72 and following. At paragraph 3.10 at page 74 second sentence:

A I consider the decision by Dr Barton to prescribe and administer diamorphine and midazolam by subcutaneous infusion the same evening he was admitted was highly inappropriate particularly when there was a clear instruction by Dr Lord that he should be prescribed intermittent underlined instruction doses of oramorph earlier in the day. I consider the undated prescription by Dr Barton of subcutaneous diamorphine 20-200 mg/24 hr prn, hyoscine 200-800 microg/24 hr and midazolam :20-80 mg/24hur to be poor practice and potentially very hazardous. A

D

E He at paragraph 3.14 was concerned by the note which we have seen in relation to a number of the patients that Dr Barton was happy for nursing staff to confirm death. Then at paragraph 3.16 he considered it very poor practice that midazolam was increased from 20 to 60 mg every 24 hours on the 23rd September. Then under duty of care issues at page 77 under 3.23 the last sentence:

A In my opinion this duty of care was not adequately met and the denial of fluid and diet and prescription of high dosage of diamorphine and midazolam was poor practice and may have contributed to Mr Cunningham=s death.

F

In summary although Mr Cunningham was admitted for medical and nursing care to attempt to heal and control pain from his sacral ulcer. Dr Barton and the ward staff appear to have considered Mr Cunningham was dying and had been admitted for terminal care. The medical and nursing records are inadequate in documenting his clinical state at this time. The initial prescription of subcutaneous diamorphine, midazolam and hoscine by Dr Barton was in my view reckless. The dose increases undertaking 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

G

H

drugs most likely contributed to the death through pneumonia and/respiratory depression.@

Alice Wilkie is considered at pages 70 to 82. Can I go to the summary at page 82:

AIn 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. However, mrs Wilkie was a frail very dependent lady with dementia who was at high risk of developing pneumonia. It is possible she would have died from pneumonia even if she had not been administered the subcutaneous sedative sand opiate drugs.@

Then Mr Wilson is considered and the conclusion is at page 87

A Mr Wilson was a frail elderly man with early dementia who was physically dependent. Following his admission to Dryad ward he was, in my opinion, inappropriately treated with high does of opiate and sedative drugs. These drugs are likely to have produced respiratory depression and/or the development of bronchopneumonia and may have contributed to his death.@

Then Eva Page the summary at page 92:

A Mrs Page was a frail elderly lady with probable carcinoma of the bronchus who had been deteriorating during the two weeks prior to admission to Dryad ward. 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 the 3rd March. In my view this was an inappropriate potentially hazardous prescription. I would consider it highly likely that Mrs Page experienced respiratory depression and profound depression of conscious level from the combination of these two drugs and fentanyl but I cannot exclude other causes for her deterioration and death at this time such as stroke or pneumonia.@

Then he concludes at pages 93 and 94. And at 7.3:

A My principle concerns relate to the following three areas of practice: prescription and administration of subcutaneous infusions of opiate and sedative drugs in patients with non-malignant disease, lack of training and appropriate medical supervision of decisions made by nursing staff, and the level of nursing and non-consultant medical skills on the wards in relation to the management of old people with rehabilitation needs.

7.4: In all five cases subcutaneous infusions of diamorphine and in combination with sedative drugs were administered to older people who were mostly admitted for rehabilitation. One patient with carcinoma of the bronchus was admitted for palliative care. Although intravenous infusion of these drugs are used frequently in intensive care settings, very close monitoring of patients is undertaken to ensure respiratory depression does not occur. Subcutaneous infusion of these drugs is also used in palliative care, but the British National Formulary indicates this route should be used

only when the patient is unable to take medicines by mouth, has malignant bowel obstructions or where the patient does not wish to take regular medication. In only one case were these criteria clearly fulfilled, i.e. in Mrs Page who was refusing to take oral medication. Opiate and sedative drugs used were frequently used at excessive does and in combination with often no indication for dose escalation that took place. There was a failure by medical and nursing staff to recognise or respond to severe adverse effects of depressed respiratory function and conscious level that seemed to have occurred in all five patients. Nursing and medical staff appeared to have little knowledge of the adverse effects of these drugs in older people.

7.5 Review of the cases suggested that the decision to commence and increase the dose of diamorphine and sedative drugs might have been made by nursing staff without appropriate consultation with medical staff. There is a possibility that prescriptions of subcutaneous infusions of diamorphine midazolam and hyoscine ay have been routinely written up for many older frail patients admitted to Daedalas and Dryad wards, which nurses then had the discretion to commence. This practice if present was highly inappropriate, hazardous to patients and suggests failure of the senior hospital medical and managerial staff to monitor and supervise care on the ward. Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of involuntary euthanasia existed on the ward. Closer enquiry into the ward practice, philosophy and individual staff=s understanding of these practices would be necessary to establish whether this was the case. Any problems may have been due to inadequate training in management of older patients. 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. 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. My review of Dr Lord=s medical notes and her statement leads me to concluder she is a competent thoughtful geriatrician who had a considerable clinical workload during the period the above cases took place.@

7.6 I consider the five cases raise serious concerns about the general management of older people admitted for rehabilitation on Daedalus and Dryad wards and that the level of skills of nursing and non-consultant medical staff, particularly Dr Barton, were not adequate at the time these patients were admitted.@

There are then the appendices which I do not need to turn to.

On the 6th February 2002 the Crown Prosecution Service decided not to institute criminal proceedings concerning Richards and they disclosed their papers to the GMC, that is on page 15 and 16.

On the 2lst March 2003 we had the second interim orders committee hearing. You have the partial transcript in your earlier papers and you now have the full transcript available.. The submission was that Dr Barton should not be suspended but that her registration should not remain unrestricted and that the voluntary arrangements should be formalised so that was to be found on page 4 of the transcript. I will take you to the full transcript if that was thought helpful. I do not know whether you have had a

proper chance to consider it. I was presently minded not to take you to it, and I have taken you thought what much would have then been said.

THE CHAIRMAN: We have all read it.

MR HENDERSON: Can I move on from the 2lst March emphasising that what I have just been drawing your attention to has been considered query with the appropriate test by an earlier interim orders committee and which resulted in no order being made.

You see at the top of the second page of my chronology I say at the end of March 2002 Dr Barton=s undertaking to the Health Authority not to prescribe opiates or benzodiazepines ceased., see pages 453 and 454. That was taken from the submissions made on her behalf by Mr Jenkins her counsel and perhaps we ought to look at it because I anticipate one of the matters you will want to know what is the true state of affairs and what has been the position in the recent past. At H Mr Jenkins said

A The condition to which she agreed with the Health Authority B that she would not prescribe opiates or benzodiazepines - lapsed at the end of March of this year because there was initially a time limit put on it and the health authority did not see fit to invite her to renew that undertaking. So far as the circumstances changing since the last hearing before the IOC 21 March 2002, I think that is the only change, I am sorry condition that she did not prescribe benzodiazepines or opiates was lifted by the Health Authority.@

It seems there was a slight change in instruction of the understanding. I am not in a position to assist you further with that. I have no document to assist further all I have is the document produced at D1 today, but clearly there was in October of that year an informal undertaking in the respects you have seen. So on the 11th July 2002 the rule 6(3) notice was provided to Dr Barton. If we could look at that briefly. You will see there were a number of headings to the allegations that in relation to Eva Page, item 2, Alice Wilkie item 3, Gladys Richards item 4, Arthur Cunningham item 5, Mr Wilson item 6, there were respectively effectively inappropriate prescription, particular diamorphine, hyoscine and midazolam, inappropriate administration of the treatment of those patients should be the subject of a proper inquiry by the PCC for the reasons there set out. I am not going to go into the detail because it is repetitious. That rule 6(3) notice duly led to a reference. But there was a detailed reply from the medical defence union on behalf of Dr Barton at pages 404 to 412. You will see that in essence what was said on her behalf was the substance of what she then gave by way of oral evidence to the third committee hearing. Since I am going to take you to that in some detail I will not take you through this, but clearly I will put it this way that what was being advanced on her behalf was that there was seriously deficient support, that she was seriously pressed to cope, she was doing everything she could to cope and that the treatment of these patients was appropriate. In addition to that she was saying that such were the pressures it meant that she could not keep proper note and that therefore what was the true condition of those patients is not adequately described in those notes, and therefore the problems were acute. I hope that is a fair summary.

THE CHAIRMAN: There was a second IOC hearing in March 2002?

MR HENDERSON: What I have failed to do is to go to what she said in the earlier hearing, could I go to that, it is at page 413. Rather than read it out to you can I invite you even if you have read it before to reread pages 413 through to 429 so that what she has said on oath is in your minds when you come to make your decision. If you could do that now.

THE CHAIRMAN: Yes, we can do that, I am sure we already have that.

MR HENDERSON: Yes, I am sure you have, I just wanted to make sure that her side had been put fairly and squarely before you not just by my learned but by me.

THE CHAIRMAN: Very well, if you give us a moment to read it. (Pause to read) Yes, we have read it.

MR HENDERSON: To continue the chronology the matter came before the preliminary proceedings committee on the 29th August 2002 and it was decided that Dr Barton=s case should be referred to the Professional Conduct Committee; unsurprisingly the police investigations were still continuing some two years later. That hearing is still awaiting. There was notice given on the 13th September of a third hearing and you have a transcript of the third hearing at pages 437 to 455. You will see that Ms Horlick on behalf of the Council said at page 439: AIn other words what has changed in a sense is the fact that the matter is now being referred on to the PCC and the possibility of criminal proceedings has raised its head again.@ That was the way it was put, in other words not new medical evidence, but the referral on to the PCC and the continued police investigation. The view of the committee was at page 455

A There is no new material in this case .since the previous hearing of the Interim Orders Committee on 2lst March 2002. The Committee has reached this determination in the light of this and the legal assessor=s advice.@

The legal assessor's advice is at page 454 in relation to what he said in camera namely

AIn the light of the fact that there was no new evidence it would be unfair to the doctor for the Committee to consider the matter any further.@

The earlier advice I pass over at page 453.

THE CHAIRMAN: This might be a convenient moment to have a break.

(Adjourned for a short time)

MR HENDERSON: The next entry in the chronology is September 2002 to date, the police investigation continues, pages 458 to 460 AThe first papers of selected cases are likely to go to the CPS in December of this year or early 2005.@ I should add straight away if there is a sufficiency of evidence and you can see immediately that that is bringing in the police new evidence. You might like for your own assistance

A just to have the complete chronology in this sense that D1 seemed to me to go in immediately after that block of September 2002, that is to say the file note evidencing the undertaking of Dr Barton with the Gosport NHT 9th October2002.

Can I go to page 456 and following and to the statement of Chief Superintendent Watts of the Hampshire Constabulary Criminal Investigation Department, senior investigating officer in respect of this operation, given a code name.

B

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

C

The strategic objective of the investigation is to establish the circumstance surrounding the deaths of those patients to gather evidence and with the Crown Prosecution Service to establish whether there is any evidence that an individual has criminal culpability in respect of the deaths

During the investigation a number of clinical experts have been consulted.@.

D

Dr Livesley reported on the death of Mrs Richards in 2000 and you have seen Professor Ford statement and you have seen that statement of Professor Mundy.

AThe Aforementioned reports has all been made available to the GMC. Between October 2001 and May 2002 the Commission for Health Improvement interviewed 59 hospital staff in respect of the deaths and concluded that A a number

E of factors contributed to a failure of trust systems to ensure good quality patient care.@ Between September 2002 and May 2004 the cases of 88 patients including those named above at the Gosport War Memorial Hospital were fully reviewed at my request by a team of five experts in the disciplines of toxically, general medicine, palliative care, geriatrics and nursing. All the cases examined were elderly patients (79 to 99 years of age) their deaths occurring at Gosport War Memorial hospital between January 1996 and November 19999. A common denominator in respect of

F the patient care is that many were administered opiates authorised by Dr Jane Barton prior to death.

The expert team was commissioned to independently and then collectively assess the patient care afforded to the 88 patient4s concerned, examining in detail patient records, and to attribute a score according to their findings against agreed criteria. A further group of cases were included in this review following a report by Dr Baker

G commissioned by the Chief Medical Officer. That report is confidential to the CMO and may not be discussed further without his agreement.@

It is not before you, I have not seen it.

A The team of experts has scored the cases as follows.@ Just interpolating if I may the Detective Chief Superintendent says that these are against agreed criteria. We do

H

not have an appendix showing what the agreed criteria were or are, therefore the quality of our knowledge is imperfect.

Category 1 there were no concerns in respect of these cases upon the basis that optimal care had been delivered to patients prior to their death.@

Interpolating again you have behind this statement a number of summaries relating to patients, 40 in number, and you will see that 19 are referred to in category 2. Mr Hilton on seeing the 19, looked at them, some of them did not appear to come into category 2, they appeared to come in to category 1, and that is why you only have 14.

A These cases are currently undergoing a separate quality assurance process by a medico-legal expert to confirm their rating. 19 of these cases that have been confirmed have been formally released from police investigation and handed to the General Medical Council for their consideration.@
So it is those of which you have a number behind the statement,.

AA number of cases have been identified as appropriate for further scrutiny to confirm grading, and the quality assurance process in respect of the remaining cases will be complete by early October 2004.@

Category 3 patient care in respect of these cases has been assessed as Anegligent, that is to say outside the bounds of acceptable clinical practice@. The police investigation into these cases is therefore continuing. The five experts commenced their analysis of patient records in February 2003. That is my next block in the chronology. AAs part of the ongoing investigative strategy, since May 2004, a further tier of medical experts,in geriatrics and palitiative care have been instructed to provide an evidential assessment of the patient care in respect of in the category three cases.. The work of these experts is ongoing and is not likely to have been fully completed until the end of 2004 when if appropriate papers will be reviewed and considered by the Crown Prosecution Service. At the same time the police investigation team continue to take statements from healthcare professionals, liaise with key stakeholders, provide a family liaison service, formulate and deliver strategies in respect of witness suspect interviews, deal with exhibits, complete disclosure schedules and populate the major crime investigation AHolmes@ system a national police IT application used to record and analyse information relating to serious/complex police investigations. To date 330 witness statements have been taken and 349 officers reports created.. 1243 actions have been raised, each representing a specific piece of work to be completed arising from an issue raised within a document or other information source. This is a major investigation which has required a considerable input and commitment of human and financial resources on the part of .Hampshire Constabulary. A

Stopping there for the moment, what weight and what relevance does that have? If you are concerned with the test of prima facie evidence the answer is none at all. If we are concerned with the test which I have propounded them it is of some relevance. In exactly the same way, I would suggest, as a charge on Dr Barton would be of some relevance, in exactly the same way it is reference from the PPC to the PCC is of some relevance. The question is what weight is attached to it. Plainly if it is of this scale

you give it the weight that you think that it deserves. It clearly falls less than and lower than an arrest or a charge, none the less I submit it should be given appropriate weight or suitable weight and in that context one needs not to look at the interests of Dr Barton one must also look at the context that there is out there a large number of members of the public who are well aware of this investigation which is taking place, who are therefore very well aware that a doctor or doctors and nurse or nurses are under the scrutiny of the police, and that there have been allegations made of unnatural and untimely death brought about by lack of care.

How then do you balance this matter in that context? That must be for you to say. If my learned friend advances the old test as being appropriately then effectively I would say that is wrong as a matter of law. When we look at the section 41A test effectively you need to give it such weight as you think is right considering what is the public entitled to think in the present circumstances of what it knows in the context of what we know we know and what we do not know.

Back to the statement if I may.

A Whilst investigations will be fully completed in respect of all the category three cases a small number of sample cases have been selected and work is being prioritized around those with a view to forwarding papers to the CPS as soon as possible by way of expedition.@

It does seem as though in that sentence he is saying in terms there is a number of category 3 cases which will be referred to the Crown Prosecution Service.

A Timescales for this action are clearly dependent upon completion of expert review of these cases and completion of the witness statements of key healthcare professionals. This is necessarily a lengthy process. In the event that there is considered a sufficient of evidence to forward papers to the CPS it is estimated that this will be completed on an incremental basis. The first cases arriving in December 2004 or early 2005.@

That sentence or those sentences appear to somewhat undermine the first sentence of the preceding paragraph

AI understand the General Medical Council has a duty to provide the fullest possible evidence for consideration by the Interim Orders Committee. I am also aware that they also have a duty to disclose the same information in its entirety to those appearing before the committee. in my view this situation has the potential to compromise the integrity and effectiveness of any interviews held under caution with health care professionals involved in this enquiry. Police investigative interviewing operates from seven basic principles .....@

I am not going to read out aloud the next matter. Effectively it summarises why it is that they conceive it to be their public duty not to divulge to the General Medical Council the information which is available to them at this stage. There is clearly tension is there not between the protection of patients which the GMC provides and the protection of the patients which might derive from prosecutions. It is not

concerned with the protection of patients, it is concerned with conviction of criminals and that tension does not seem to be very happily met when we have a three plus year investigation as we have here, which is still continuing, and plainly will be continuing into 2005. Again that is a reason I would submit why the test which I say should apply is likely to be right, rather than the earlier test.

Turning over from the explanations providing an effective investigation he acknowledges on page 464 in the sixth line:

A As the senior investigating officer I acknowledge the primacy of the public protection issues surrounding this case. I understand that there is a voluntary agreement in place between Dr Barton and the Fareham and Gosport Healthcare Trust of November 2002....@

I assume he is referring to this document at D1. and he quotes from that. My learned friend has shown to me today another document which I will not try and anticipate which relates to the prescription of drugs by Dr Barton. It does not come to quite that number but it matters not, but he doubtless be in a better position to explain the true state of affairs.

AI have been asked by the General Medical Council to provide an update as to the current position in respect of four cases previously considered by interim orders committee during September 2000.
Arthur Cunningham - this has been assessed as a category three case and is being investigated.
Robert Wilson - again a category three case.
Gladys Richards - assessed as a category two case by the clinical team, this assessment has been queried through the quality assurance process and is to be subject of further review by the clinical experts in early October 2004.
Alice Wilkie - no further police action to be taken in respect of this investigation. The medical records available are not sufficient to enable an assessment.

In closing it is appropriate for me to emphasize some key points:
1. There is no admissible evidence at this time of criminal culpability in respect of any individual.
2. The information adduced by the investigation thus far and the findings of the experts lead me to have concerns that are such that in my judgment the continuing investigation and the high level of resources being applied to it are justified.@

That concluding sentence is obviously important. What does it mean? In a sense I would suggest to you that it may be presumptuous for me to try and say what it means, but you may think one thing for certain is assured and that is this that a Detective Chief Superintendent in charge of the investigation amongst others of Dr Barton considers with the benefit of expert medical advice that the investigation should continue at a very high level. What relevance is that if you were to accept the test I have propounded its relevance is this is it not? It falls short of saying this lady is ever going to be charged, materially short of that, but it does say that there is a very real cause for concern and which this Committee and any member of the public, and of course you contain two quite specific members of the public as well as being

members of the public in your medical capacity, would if they knew that be entitled to say to themselves AWell, are we being properly protected against a person whose qualitive medical care is under such serious criminal investigation by either suspension or conditions?@ At the moment there are none, there is no suspension, no conditions. There have been voluntary undertakings. Are they sufficient? In my submission the answer is No and that in all the circumstances the test I have propounded brings in this matter. I recognise straight away it falls short of and is not an allegation in relation to a charge, a lady who has ever been arrested, or anything of the kind.

That brings me to the final documents as to how I approach this. For a reason which I will show you in a moment I am going to give them no great weight. Firstly, the documents which go with them, which I assume are in those piles over there and this pile here, a foot high, they are unseen by me appearing for the Counsel, they have only just been reproduced, they have not been seen by my learned friend Mr Foster or Dr Barton, and I do not know the extent to which these documents are a reasonable analysis of those documents when done by counsel or solicitors with experience in this sort of field. Secondly, I do not know who has done this analysis; I do not know their qualifications, I do not know their expertise, and therefore it is a matter which is only to be approached with considerable reservations, very considerable reservations.

The third concern, it seemed to me on looking at the first of these cases Harry Hadley if you look over the page at 468 you will find that the prescriptions are normally done by persons other than Dr Barton. Say, for example, the 5th October, Dr Pennells is involved and he discontinues the diazepam. Dr Shawcross is to rewrite MST. Dr Pennells on the 7th October commences the syringe driver of 16 mls of diamorphine. On the 8th October Dr Shenton commences the second, on the 9th October we have a Dr Yale and a Dr Chilvers involved. Therefore to have assumed that where Dr Barton is not mentioned that she was involved would seem to me to be an assumption which should not properly be made by you and I am not going to invite you to do it. Therefore I am only going to invite you to do it, and therefore I am only going to invite you to even look at five of these cases and they are Taylor, page 403, Abbott page 406, Batty 490, Lee 499 and Carby 502.

I am going to take this simply because you may think the appropriate thing to do is to draw your attention to the matter and highlight any matter which seems to be potentially relevant with all the reservations which I have already expressed. At page 483, Daphne Taylor, Dr Barton is identified at the foot page on the 7th October, seen by Dr Barton and Daphne Barton appeared to be in pain, she was a lady of some 70 years of age, one of the examples of the age group not being as we have been told.; also seen by Dr.Llloyd. 9th August the nursing staff may confirm death. 17th October summary left arm elbow still very painful on movement. Dr Barton seen X-ray from Haslar has requested.repeat x-ray. 18th October summary AAM very unsettled night appeared distressed and in pain. Syringe driver set up with 40mgs, diamorphine and midazolam 20 mgs over 24 hours. Fentanyl patch removed appears more comfortable. PM appears more peaceful and relaxed no pain on turning. Family seen by Dr Barton and informed of poor prognosis. 19th October condition deteriorating chesty very bubbly. 20th October died peacefully, verified by the nurses.

Daphne Taylor=s expert view by the doctor who I cannot identify, perhaps I had better read all of it A

Mrs Taylor was admitted to the Royal Haslar Hospital on 29th September 1996 after suffering a cerebrovascular acciden4t. She was transferred to the Gosport War Memorial Hospital on 3rd October 1996 for rehabilitation.

On 7 October 1996 Mrs Taylor was felt to be in pain and was prescribed fentanyl patches. Mrs Taylor was noted to be in a great deal of pain and the strength of the fentanyl patches were increased.

On 18th October following a very unsettled night when Mrs Taylor appeared to be distressed and in pain a syringe driver was set up with 40mgs of diamorphine and 20 mgs of midazolam over twenty four hours.

Although Mrs Taylor had a severe stroke which left her unable to swallow or speak, she was being tube fed. However she was prescribed rapidly escalating does of opioids without there appearing to be a comprehensive assessment made for her pain.

The experts note that she had an irrecoverable cerebrovascular and would have died soon in any event.@
You may think that that is a criticism, it is a criticism which potentially affects Dr Barton and her care in particular the pharmalogical care of these elderly ladies by an anonymous expert or experts.

Victor Abbat is the next one and the summary is at page 486. He was a 77 year old. We are dealing with one of the latest ones, May 1990, he was admitted to Gosport Hospital on the 29th May as an emergency requested by Dr Barton. His wife could no longer cope with him at home. Mr Abbatt died .at five minutes past midnight 30th May and son and daughter informed. Death certified. by ....@ The expert review

A He was diagnosed with as having a chest infection with mild heart failure. He was noted to be cyanosed by the nursing staff when they put him to bed at 21.20 on the day of admission. He was then administered 10 mgs temazepam apparently which had been written up for him. The experts criticised the use of a small dose of temazepam in a patient who is cyanosed. They note though that Mr A bbatt was already very.unwell.@

.Unfortunately when you look back at the cyanosis in the summary it is not there but it is referred twice in the expert review.

The next one is Charles Batty and he is at page 490 and you see on the 28th December1993 Mr Batty a gentleman of 80 was seen by Dr Barton and oramorph 10mg 6 hourly prescribed was prescribed. On the 30th December the oramorph was increased and syringe driver commenced diamorphine 40mgs.... 3lst December general condition deteriorates. On the 2nd January he died at 10-05. The summary in relation to him page 492

AIn December.1993 he was complaining of generalised pain and started on Oramorph. Dr Lawson notes that Mr Batty went from little analgesis to oramorph 60mgs in twenty four hours. The dose was gradually increased and when he had difficulty swallowing it was changed to a syringe driver. It was difficult to assess his pain because of his dementia but it is not clear on the face of the notes whether his condition was deteriorating prior to starting opiate treatment. The experts review has determined that the treatment was sub optimal due to the high does especially midazolam. Cause of death was felt to be unclear by the expert team.@

Working with the material available to us that you may think does not subtract but adds to potential criticism of Dr Barton but I do not think I can add any useful submission in relation to that.

THE CHAIRMAN: Dealing with Mr Batty=s case the summary does indicate on the 28th December he was seen by Dr Barton and then we go to the entry of the 30th December, but it does not specifically say that Dr Barton made these prescriptions.

MR HENDERSON: You are absolutely right.

THE CHAIRMAN: I think also with Mr Taylor.

MR HENDERSON: You are absolutely right. I hope I am deliberately minimising which I concede to be relevant and readable for your proper consideration. The reason why I thought it right to draw it to your attention was, one, she was obviously involved in the orothorm, I cannot say for certain whether or not she was involved in the driver. It may be that Dr Barton can say and remember, it may well she cannot and we may need to look at the notes, but what one does know is this that she has certainly said before a constitution of this committee on earlier occasions that she was generally the only person there, yes there were others involved which is why I drew your attention to the notes in the first case. I would leave it as an entirely open question and whether it is right to draw an inference against her in relation to that diamorphine and the syringe driver you may think is not enough material to do so, but none the less right to draw it to your attention.

THE CHAIRMAN: The other case I had in mind was the Victor Abbatt case where DrBarton arranged the admission but there is no specific mention in the summary as to who it was who prescribed the diazepam. It does not specify it.

MR HENDERSON: You are quite right about that . The next one was Catherine Lee at page 499. She went to the Dryad Ward, this is the top of page 500, where Dr Barton was pretty well in daily contact. On the 14th April 1988 the normal entry A happy for nursing staff to confirm death.@ Turning down to the 15th May 1998 summary seen by Dr Barton re pain oramorph increased to 10mgs 4 hourly. 2lst May clinical notes further deterioration uncomfortable ad restless . Happy for nursing staff to confirm death. Summary - restless, agitated. Seen by Dr Barton. Syringe driver commended diamorphine 20mg at 09.40.. Then she deteriorated further. There is no further reference to Dr Barton and I drew your attention earlier on in the summary in relation to Catherine Lee.

Lastly Stanley Carby. He was admitted to the Daedulus Ward on the 26th April 1999,again one of Dr Barton=s two wards and on the 27th April he was seen by her that is shown in the fourth line, ASeen by Dr Barton and family spoken to. Cyanosed and clammy. Wife thinks he will not survive. Dr said AI will make him comfortable.@@ In terms f his then state of health he had left hemiplegia secondary to CVA, angina, obese, hypertension, cardiac failure, non insulin dependent diabetic, prostatic hypertropy depression.
In terms of commentary by the expert, third paragraph

A A syringe driver.was set up with a high dose of diamorphine and midazolam. Mr Carby died forty five minutes later. All the experts agree that he would not have received enough of either drug to have influenced his survival. Dr Naysmith noted that he ay well have received less than normal since he had low blood pressure and was peripherally cyanosed.

The cause of death was shown as cerebral vascular accident and was certified by Dr Barton. Mr Carby was cremated.

The large dose of diamorphine makes the care sub optimal but it had no effect on Mr Carby=s prognosis.@

That is the supplementary evidence.

My submission is that if you apply the test which I have propounded as to how you balance the public interest in doctors reputation, patient interest, both patient interest of the patients of Dr Barton and the patient interest in having trust in doctors, with Dr Barton=s position that she is able subject to conditions still to practice as a general practitioner, it would be disproportionate for her to be suspended, but it would be proportionate and necessary that you should be satisfied that it is necessary that she be the subject of conditions either in the terms which I have suggested or in similar terms,otherwise than in an medical emergency she should neither issue nor write prescriptions or administer denzolbiate or opiates is of course limited to those where problems appear to have arisen. Look at the totality, look at all the circumstances of this case, it is clearly going to be a continuing enduring one for months still to come and you have three consultants who have criticised her in respects of which the condition is designed to deal with. You have a PCC reference, PPC has concluded in the past that there was a reasonable prospect that she would be found to be guilty of serious professional misconduct, you have police categorisation on expert advice that a number of cases in which she has been concerned are cases where there has been negligence in the sense of being beyond acceptable clinical practice and you have the scale of the police investigation. It is a different state of affairs from that which came before the first, second and third committee. Some of the evidence, much of it, has been before different committees and you must obviously bear that in mind to be fair. At the same time if the test that they have applied has been a conditional test I question whether or not it has been the right test. Those are my submissions.

THE CHAIRMAN: I will see if we have got any questions.

MRS MACPHERSON: It is really just a query on the documentation. I notice that the GMC=s notice of the hearing of Dr Barton is dated 24th September which is at page537. It refers in the first paragraph to the President deciding on the referral. AAfter considering the information provided by the Hampshire Constabulary@ and then we have the report or summary from the Hampshire Constabulary which you have gone through in detail for us which was dated 30th September which is obviously after the date of this notice of the hearing. I wonder whether you have any comment on that?

MR HENDERSON: Clearly it was anticipated that there would be a statement forthcoming and that it was going to be forthcoming earlier than it was. We may have had anticipation of somewhat different from what came into the state in which it was produced. I do not know. One way or the other at the time that the letter of the 24th September was written the limit of what could be said was said in paragraph 3 and it gave the earliest possible notice of a hearing. There is nothing in the rules which says it has to be seven days. As a convention one goes for seven days. In truth we are exactly on seven days, it came in on the 30th September and was electronically forwarded on the same day. In effect it was early notice of the 7th October hearing with sufficient supporting material at that stage, about which reasonable concerns were expressed on behalf of Dr Barton but there has been no application for an adjournment and we are here on both sides to go ahead today.

MRS MACPHERSON: There is no further information available to us which would indicate why the President made his decision?

MR HENDERSON: That is correct.

THE CHAIRMAN: We do not have any further questions. Mr Foster?

MR FOSTER: I should begin by saying that I am very grateful to my learned friend for his thoroughness and for his even-handedness. Both of those things mean that I can be a lot briefer than I originally thought that I would have to be. I have to say a little bit about the background and could I begin by inviting you to look again at the letter which is at page 404 of the bundle MDU written on Mrs Barton=s behalf in August 2002. My learned friend has referred to this and I know you have read it before and I k now you will read it again but there are some matters which I wish to highlight. It is Dr Barton=s position that she was forced because of the conditions in which she had to work to choose between optimal note keeping and proper patient care and notekeeping was a casualty, patient care was not. If you look at pages 404 and 405 you will see that she compressed her clinical sessions at the hospital into three and a half sessions each week. In the two wards over which she had responsibility there were a total of 48 beds for her patients care which were extremely high, and he points out in paragraphs 3 and 4 on page 405 which indicates that Dr Barton lacked effective consultant support and indeed during the time in which the formal allegations took place the second consultant Dr Tandy was on leave, so already he inadequate consultant support if there was any was cut in half.

The penultimate paragraph on page 405 tells the story of Dr Barton=s frantic life. She arrived at the hospital at 7-30 and she would visit both wards, reviewing patients and

liaising with staff before she commenced he general practitioner duties at 9 am. She visited the wards, she would do her general practitioner appointments between nine and lunch time and would often go back at lunch time to review patients and then after doing her afternoon session as a general practitioner she would frequently go back to the hospital about seven and stay there for sometime.

That is a picture of an extremely concerned and diligent doctor doing her best under horrific circumstances. Those circumstances were made clear by Dr Barton to the management on a number of occasions APlease help, we need more funds, we need more staff@ but unfortunately those tries went unheeded. With the benefit of hindsight it might very well be the case that the wisest thing to have done would be to have resigned and of course Dr Barton facing the problems that she has faced over the last few years regrets very much that she did not do that. That would have been the only way in which the management would have taken any notice, but unfortunately she did not want to let the patients down, she did not want to let down the nurses with whom she had a very close relationship and so she battled on. In battling on she did not make the notes that she should have made therefore it is not clear, it is accepted in relation to many patients, just what the clinical indication was for the prescription which is recorded.

This is a case of poor documentation, it is not case of poor patient care. My learned friend has taken you to the transcript of Dr Barton=s evidence on page 413 and when you are making your deliberations today I would invite you to look at that again. There is some useful cross-referencing which deals with the position of the hospital which is to be found in the Commission about Health Improvement Report which was published in July 2002. I do not propose to burden you with what is a bulky document, there are quite enough pages in this case. There are a few passages I wish to highlight.

THE CHAIRMAN: Has Mr Henderson seen this?

MR FOSTER: No, I do not imagine there will be huge surprises. Does Mr Henderson want to see it?

Mr HENDERSON: The answer is yes I want to, what I suggest when we have the break I suggest my learned friend goes ahead and if he could make it available to me during the lunch hour adjournment and anything I ought to say I will let you know, would that be a convenient way of dealing with it?

THE CHAIRMAN: Yes.

MR FOSTER: There are three paragraphs I wish to refer. The first is paragraph 6. 8, this relates to the appraisal of supervision of clinical assistance. (Paragraph read) There the commission concluded that the work place was intolerable and the sessions that were allocated to Dr Barton were inadequate to deal with the work she was required to do. The next paragraph is 7.9 (Paragraph read) Finally in this report there is a heading at 7.11 headed AOther trust lessons@. (Paragraph read)

That is a long boring list which indicates what had to be done in order to do properly the job which Dr Barton was required to do. The conclusion I would invite you to draw from that is that Dr Barton was operating in circumstances which made full notekeeping quite impossible.

The other important bit of background which has been referred to repeatedly this morning of course is that there have been three successive IOCs hearing which have not found any order is necessary. In the transcript at page 438 of the bundle, which relates to the IOC hearing on the 19th September 2002 there was a good deal of discussion between the Committee and the legal assessor and counsel about whether it was proper to make any order no new evidence having been adduced. It was decided there that no new order should be made because there was no significant new evidence. That in my submission is the proper way to deal with it in my submission. The question therefore arises what has changed since the last IOC hearing?
The important point which my friend makes is that the test which was applied on previous occasions is wrong and accordingly you have to reconsider all the material which was before previous Committees and apply the proper test, that was part of the reason for detailed consideration of all the previous evidence. He invited your attention to the case of Dr X and he invited you to adopt an alternative test which said if you are satisfied (a) in all the circumstances of this particular case that there may be impairment of Dr Barton's fitness to practice which poses a real risk to members of the public or may adversely affect the public interest or her interests and (b) on balancing her interests and the interests of the public an interim order is necessary to guard against the risk then the order should be made. I do not have a lot of dissent to that formulation save I suggest it should read if you are satisfied (a) in all the circumstances of this particular case a sufficiently robust case has been made that there may be impairment of Dr Barton=s fitness to practice; that caveat is necessary to avoid a potentially ludicrous result. If one adopts that formulation then I would respectfully submit that for all intents and purposes the right test has been applied by previous committees. Both Mr Henderson=s formulation of the test and the test which I have formulated today begs the really important question which is the question begged by section 41A itself, how are you satisfied?
Mr Henderson=s test does not answer that question. It cannot be the case having regard to basic principles of fairness described if you like in terms of Article 6, that a malicious allegation by a patient of a serious offence can have the effect of causing the interim orders committee to apply a draconian order affecting a doctor in practice.

There must be implicit in the statutory requirement "to be satisfied" a basic requirement that you look for some evidence. What therefore amounts to satisfactory evidence, evidence sufficiently cogent for you to be satisfied? My learned friend says that the additional evidence which you have in this case is the fact of an ongoing police inquiry. That with respect does not add anything to the position which had obtained previously, the police inquiry had been going on for an awfully long time, yes it is right that we have now been told that the police inquiry will look at among other things the patients whose summarises are contained in the back of the IOC bundle. But we have known for a very long time that patients including these patients had previously been looked at, and there is not the slightest reason to suppose that those patients were not among the patients who were being looked at and in any event my learned friend I would say very fairly down played the weight which you should

attach to those summaries for all the reasons which he has identified; we do not know anything about their authorship, but without wanting to be flippant those summaries could have been compiled by a secretary with medical knowledge in the police department.

The neutral stance I would take is that it is simply more of what we have seen before. If we believe everything which is said in those summaries there is evidence of hurried and in some cases incomplete medical records. There is no indication there has been any inappropriate prescribing. There is sometimes inadequate documentation of the implication of prescribing but again I do not want to be flippant but it is important to understand the context in which this police investigation has happened. This has been an absolutely massive police investigation. When those instructing me spoke to the police in September 2003 my solicitors were told that a team of six detectives had been working full time on the case and as you have heard already that a number of experts have been called in, including experts from nursing, from forensic psychology, general practice, care and so on. I respectfully and rhetorically say that after all that expenditure, money time and manpower is that the best that there can be? They have been unable to put any firm allegations against Dr Barton in the sense of new charges. In relation to the weight which my learned friend says he should attach to the fact that the preliminary proceedings committee have referred to the professional conduct committee, point 1 that is a matter which has already been considered by the committee and, two, a test in which the police are deciding whether to bring charges. We know what the police=s view of the present situation is because Chief Superintendent Watts has been very candid about it and a portion of his evidence has been read out ANo evidence of any criminal charges and we really do not know where we are going to go from here". Again I rhetorically ask should that be sufficient for you to say that there has been new material upon which you could be satisfied that the position has changed from previous IOC hearings and that statutory criteria in section 41A has been met?

Chief Superintendent Watts obviously thought that he had a very cogent point to bring before the committee, that was the issue of the undertaking about the opiates and benzodiazepines prescriptions; he thought as his statement makes clear that he had caught Dr Barton out in breaching her undertaking. That quite plainly is not the case. You have seen the document in D1 Which is the formalised second undertaking which was given. You will see the terms where Dr Barton prescribed diazepam where there was a clinical indication for doing so which was endorsed by the British National Formula. Dr Barton has undertaken the exercise of looking at her prescribing over the period which is dealt with by Chief Superintendent Watts in his statement.A computer print out has been generated and if copies could be handed up. This is D2. My learned friend has seen this. It requires some explanation. It relates to diazepam prescriptions by other partners in the practice where Dr Barton works during the material period. The names of the national health service numbers of the patients have been deleted so confidentiality is secure. You will see at the bottom of the first page Dr Barton=s name and she is described there as the usual doctor, so all the entries under her name relate to prescritpions of diazepam which were given to patients for whom Dr Barton was the usual doctor. That does not mean, as the medical people will know, that all the prescriptions were written out by Dr Barton herself. The prescriptions which were written out by Dr Barton herself are indicated on the right

hand side of the page by the initial JAB. You will see four occasions on which Dr Barton has herself written out prescriptions for diazepam. The other prescriptions were written out by other doctors whose initials appear on the right hand side of the page on behalf of patients who were the usual patients of Dr Barton. In relation to each of the four prescriptions and Dr Barton has gone back and checked all this and they were all for muscular type pain which is a legitimate prescription for that. That indicates Superintendent Watts killer point before you, namely this is a doctor who breaks her undertakings and incontinently prescribes diazepam is a wrong point.

You are left solely with the question whether there is new evidence which justifies the departure from the IOC previous findings that there is need for an order in Dr Barton=s case.

There is no evidence at all that Dr Barton is unable to prescribe safely in the GP context. That is the only context in which she now prescribes. There is every reason to suppose that all the concerns arose solely because of the pressures which arose in an appalling environment which a long time ago now she prescribed, it is a long time now since she was working on these wards and she has no intention of going back.

That being the case no proper public confidence issues arise. In her general practice she has an acceptable work load, the work load is divided between several partners and accordingly record keeping is simply not an issue either. Is it therefore necessary again for there to secure public safety that she has an order in the terms suggested by my learned friend? Absolutely not. The necessary protection was given by the undertakings which she has made and manifestly by this evidence has complied with. The Committee I know will be keen to guard against the tendency which arises in many high profile public cases of complying with what can amount to mob rule of a doctors inability to practice being interfered with simply because people make unsubstantiated allegations.
For all those reasons I suggest that there is no material on which you can properly conclude that the earlier committees were wrong in deciding that no order be made. Those are my submissions.

THE CHAIRMAN: I will just see if we have any questions.

DR STEWART: It is just to clarify a matter to do with the D2, the diazepam. Under the usual doctors, Dr Barton=s list it is quite clear that other doctors whose names appear on this document have prescribed for her patients. Dr Beasley has prescribed morphine on a couple of occasion on Dr Barton=s list and Dr Peters has. What you have not indicated to us is how many of these prescriptions under the names of Dr Knapman Dr Peters, Dr Brigg or Dr Beasley and Dr Brooke were actually written by Dr Barton rather than by the doctors whose names appear at the top of the list. That is information that I think would be useful for the Committee to have if you are asking it to consider that this is an indication of the number of frequency that diazepam prescriptions are prescribed by Dr Barton?

MR FOSTER: I can tell you, sir that none of the other prescriptions under other doctors names were written out by Dr Barton.

DR McCUGGAGE: Just on that point that Dr Stewart made. Perhaps when we look at the prescription under A J Barton under JAB it appears twice. Were there two prescriptions written by Dr Barton.

MR FOSTER: I understand it was an error.

DR BARTON: It was an error, I think what it was when it was pressed down the computer generated two prescriptions.

MS RAZI: I just wanted to check when this report is dated.

MR FOSTER: July 2002.

THE CHAIRMAN: We have in our bundle doctors arrested on suspicion of an offence and we have others who are formally charged and clearly we are aware of the police investigations which have been going on for some time. Has there ever been any stage where Dr Barton has been arrested on suspicion?

MR FOSTER: No, sir. She has been interviewed under caution in relation to the case of Gladys Richards and the police decided there would be no proceedings. The police interviewed her and the papers were sent to the Crown Prosecution Service and the answer came back that was the end of the case.

THE CHAIRMAN: So it was the CPS who decided in that case?

MR FOSTER: Yes.

THECHAIRMAN: At this stage we would normally ask the legal assessor for advice, but since Mr Henderson is going to look at this document at the lunch break it might be better if we break now and reconvene later.

MR HENDERSON: Could I just respond in relation to the legal matter and on the matter of a correction. The first is this my learned friend=s submission seeks to add some words to my test and he is trying to say effectively what does satisfy mean and the test he applied that it must be sufficient robust and goes on to say the basic requirement is that this committee must look at some evidence. This in my submission is obviously more important in this case essentially but I would suggest to you that that reason is wrong. The reason we can see it is wrong is Dr X. We know in Dr X there was no evidence, there was a charge, they did not look at the evidence underlying the charge, therefore in my submission the additional words which he implies do not add anything when he says what he means by it, they actually go further than they properly should.

In relation just to a correction he says we do not know anything about the authorship but in fact we know something. We know what Chief Superintendent Watts has said about it. In addition if one looks at page 507 we know one of the experts, Dr Macey, is expressly identified,therefore it cannot have been, to use my learned friend=s

forensic flourish simply a medical secretary. It may be a medical secretary who typed it but the substance of the matter cannot be limited to that.

In relation to other matters I would like to see the document and I will come back to you.

MR FOSTER: I wonder if I can respond very briefly to that. I would accept that if a police investigation resulted in a charge then that charge is evidence within the ambit of the test proposed, but in the case of Dr Barton we are a million miles from that; not only do we not have any charges, you have it indicated by the police on several occasions to take no action, so to suggest it is parallel with the case of Dr X where there were charges simply do not stand up.

THE CHAIRMAN: Right we will adjourn to 2pm

(Adjourned for a short time)

MR HENDERSON: I mentioned to my learned friend that I wanted to draw attention to one or two passages in this report. It is the only copy with have here. He has highlighted certain passages and when you retire you can look at the report. I could not hear clearly what Dr Barton said but I understood it to be the case that the pressing down twice explained duplication of prescriptions in relation to the 15 items where they are duplicated. I think along side you will see some dates. While obviously that may well be the case, I am not questioning one way or the other, that in relation to the first entry, the third shown, nor the one April 9th, the one after that three from the end, the patient 1959 No 111496, you have got two different dates, one of which was the 7th November and the other 28th October and that would not marry with that explanation. The last is the penultimate one, that is dated 28th May but I merely draw that to your attention.
Can I respond to the report. The function of CHI which produces this report is not to investigate particular doctors and therefore the point my learned friend makes, there is no criticism of individual doctors, with respect is clearly limited, the absence of criticism is not a basis for the answer that none is to be found. This came into existence particularly to deal with systematic or systemic organisational problems in the provision of health care.Its remit is at paragraph 1.4 and I mention this in this context because you will find the passages to which I am going to draw your attention show that one would not generally expect to find individual criticisms and the terms of reference which were agreed on the 9th October 2001 are as follows.

AThe investigation will look at whether since 1998 there has been a failure of trust systems to ensure good quality patient care. The investigation will focus on the following elements within the services of older people inpatient and continuing and rehabilitative care at Gosport War Memorial Hospital. ...(reading to the words) .....care for older people.@

In the context of that remit none the less there are certain key conclusions and at page vii in the key conclusions I will alert you to this:

ACHI concludes that a number of ..... reading to .....were not identified.@

Those are amongst the key findings, the first one under Chapter 4, under the heading

AArrangements for the prescription administration and review@ ACHI have serious concerns ..... reading to ..... Would have been questioned.@

Then in relation to Chapter 5 under the heading of AQuality of care and patient experience.@
A Relatives speaking to CHI had some ..... ward now.@

Then in chapter 4 at paragraph 4.2, a chapter headed AArrangement for the prescription, administration and review of the calling of medicines, police enquiry and expert witness reports@

A Police expert witnesses .....reading to ..... to reach the conclusions in this chapter.@

I have already given you the conclusions in the chapter at the beginning.

Then in relation to paragraph 4.4 on page 13 under the heading AMedicine usage@

A Experts commissioned by the police ..... number of patients treated.@

On the next page you have graphs.

Then paragraph 4.5

A The Trust=s own data ..... 2000 and 2001.@

Then there is the graph. Finally paragraph 7.9, my learned friend read the first sentence and could I read to the end

A Gosport Health Care NHS .....reading to ..... April 2001.@

Sir, are the paragraphs which I thought I would draw your attention to, there is nothing else I wish to say. Thank you very much.

MR FOSTER: Could I just say this there is no new evidence which my friend read out which should alter your approach to this case. You may feel that the simple question for this committee to decide is whether it is proper for the IOC committee to impose conditions on Dr Barton's fitness to practice on evidence primarily of a police officer's assertions that an enquiry is continuing without being able to give a coherent indication as to the nature of the enquiry or the evidence that the enquiry has. In my submission the answer to that question must be No.

THE CHAIRMAN: I will now ask our legal assessor for his advice?

THE LEGAL ASSESSOR: This is an application under section 41A of the Medical Act 1983 for an interim order that conditions should be placed on the registration of Dr Barton. It is not suggested that her registration should be suspended.

I advise that the approach the Committee should now take is to consider all the particular circumstances of Dr Barton=s case as they prevail today. This must include the circumstances as at the time of the three previous hearings when no order was made and to consider it in the light of the new material which is before them today.

I advise that before any order may be made the Committee must be satisfied that by reason of Dr Barton=s intending to practice it is necessary for the protection of the public, or is otherwise in the public interest, for example, to maintain public confidence in the medical profession, or in the doctor=s own interest that conditions should be imposed on her registration. The Committee must consider proportionality. The protection of the public, particularly patients, and the maintenance of confidence in the medical profession, must be balanced against the consequences of an order for the doctor, such as interfering with her ability freely to practice her professional and the staining of her reputation.

Mr Henderson, for the General Medical Council, has suggested a new test should be applied as to when the Committee should make an order. The advice which I have just given is in the same or similar terms to the advice which has always been given to this Committee since its inception with the omission of the words Aby cogent and credible prima evidence@ after Athe Committee must be satisfied@. With that omission my advice is in broad terms identical to Mr Henderson=s new formulation, although perhaps not so elegantly expressed.

Mr Foster, for the doctor, does not criticise Mr Henderson=s new formulation save he speaks to add Athat the committee must be satisfied that a sufficiently robust case has been madeMy advice is this: the Committee must act on the material which the General Medical Council and the defendant sees fit to call before it and that is a quotation from paragraph 18 of the case of Dr X to which reference has been made. This often includes material such as the mere fact of the doctor being charged or arrested for an offence or third party report. which would not possibly be evidence admissible in the criminal court or before the Professional Conduct Committee. That follows necessarily from the nature of the interim Order Committee function and the point in the proceedings at which that function is performed.

However, I advise the Committee that they are not required to act upon any material put before them. They must first consider its weight and quality; put another way, as was done by Pill LJ at paragraph 25 of Dr X they should consider whether the material put before them in support of the application Aplainly and obviously lack substance.@ That may be no more than another way of saying AIs the material credible and cogent?@ If the Committee is satisfied that the material relied upon by the General Medical Council plainly and obviously lacked substance or is not credible and cogent they will not be satisfied that it is necessary to make an order.

That is my advice.

THE CHAIRMAN: Right if you could withdraw while we consider the matter.

(The Committee conferred in private)

THE CHAIRMAN: Dr Barton, the Committee has carefully considered all the information before it today, including the statement dated 30th September 2004 made by Detective Chief Superintendent Watts of the Hampshire Constabulary, the submissions made by Mr Henderson QC on behalf of the General Medical Council and the submissions made by Mr Foster on your behalf.

The Committee has determined 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 to make an order in accordance with section 41A of the Medical Act 1983 as amended.

In reaching its decision the Committee has noted that the police investigation is at present ongoing and that you have noet as yet been arrested or charged with any offence. The Committee has taken into account the new material before it today, but it is of the opinion that this taken with the information before the IOC at previous hearings is insufficient to justify the imposition of an interim order. The statement provided by Hampshire Constabulary provides little substantive information and the Committee is unable to place sufficient weight on the supporting documentation.

The Committee has taken into account that no concerns have been revealed about your work in General Practice. The Committee has also noted that you have made a voluntary undertaking to Fareham and Gosport Primary Care Trust regarding the prescribing of opiates and benzodiazepines.

Notification of this decision will be served upon you in accordance with the Committee's Procedure Rules.

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CPT DOCUMENTS
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